Model Toxics Control Act (Chapter 70.105D RCW) and its regulations (Chapter 173-340 WAC).

[Statutory Authority: Chapter 70.149 RCW. 97-20-094, § 374-80-040, filed 9/29/97, effective 10/30/97.]

WAC 374-80-050 Reimbursement. (1) The agency shall collect, from the heating oil tank owner or operator requesting advice and assistance, the costs incurred in providing such advice and assistance.

(2) Funds received by the agency from cost reimbursement must be deposited in the heating oil pollution liability trust account.

(3) Costs incurred that shall be covered in reimbursement may include travel costs and expenses associated with monitoring site assessment, review of reports and analyses and preparation of written opinions and conclusions. The fee for such advice and assistance will be $350.00.

(4) The fee must be paid prior to the agency issuing its report of review and assessment of data.

[Statutory Authority: Chapter 70.149 RCW. 97-20-094, § 374-80-050, filed 9/29/97, effective 10/30/97.]

WAC 374-80-060 Liability. (1) The state of Washington and/or the pollution liability insurance agency accepts no liability, nor portion of liability, from the heating oil tank owner or operator.

(2) The state of Washington, the pollution liability insurance agency, and its officers and employees are immune from all liability, and no cause of action arises from any act or omission in providing, or failing to provide, advice, opinion, conclusion, or assistance under this program.

[Statutory Authority: Chapter 70.149 RCW. 97-20-094, § 374-80-060, filed 9/29/97, effective 10/30/97.]

Title 380 WAC
PRINTING AND DUPLICATING COMMITTEE

Chapters

Chapter 380-10 WAC
PRACTICE AND PROCEDURE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

380-10-010 Regular meeting dates. [Order 1, § 380-10-010, filed 11/14/73.] Repealed by 98-01-114, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 43.77.040.

WAC 380-10-010 Repealed. See Disposition Table at beginning of this chapter.

Title 388 WAC
SOCIAL AND HEALTH SERVICES, DEPARTMENT OF (PUBLIC ASSISTANCE)

Chapters

Chapter 388-11 WAC
CHILD SUPPORT—OBLIGATIONS

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-11-405 Physical custodians receiving AFDC—Rights to participate in hearings. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-405, filed 4/10/96, effective 5/11/96.] Repealed by 97-16-037, filed 7/30/97, effective 8/30/97. Statutory Authority: RCW 34.05.220(1) and 74.20A.055.

WAC 388-11-400 Physical custodians—Rights to participate in hearings. (1) This section and WAC 388-11-410 through 388-11-425 of this chapter govern the rights of physical custodians receiving support enforcement services to participate in hearings based on support establishment notices.

(2) In a hearing based on a support establishment notice, the physical custodian shall have all the rights of a party to an adjudicative proceeding authorized by the Administrative Procedure Act, chapter 34.05 RCW. The exercise of those rights is governed by WAC 388-11-400 through 388-11-430, and chapters 10-08 and 388-08 WAC.

[Statutory Authority: RCW 34.05.220(1) and 74.20A.055. 97-16-037, § 388-11-400, filed 7/30/97, effective 8/30/97. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-400, filed 4/10/96, effective 5/11/96.]

WAC 388-11-405 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-11-410 Notice of proposed child support amount. (1) This section describes and governs agency action in cases under WAC 388-11-400(2).

(2) Before serving a support establishment notice on a responsible parent, the IV-D agency shall serve a notice containing a summary of the proposed terms of the notice on the physical custodian by regular mail to the physical custodian's last known address.

(3) The physical custodian shall respond to the notice within twenty days by notifying the IV-D agency in writing that the custodian:

(a) Accepts the proposed child support amount and authorizes the IV-D agency to sign an agreed settlement or consent order if the order amount is greater than or equal to the proposed child support amount; or

(b) Objects to the proposed child support amount.

(4) A physical custodian who objects to the proposed child support amount must include a specific dollar amount the physical custodian believes to be the correct monthly child support obligation with the objection.

(5)(a) The IV-D agency cannot proceed to serve the responsible parent and may initiate case closure action under WAC 388-14-420 (1)(g) unless the physical custodian responds to the notice as required under subsection (3) of this section.

(b) If a physical custodian receiving public assistance fails to respond to the notice, the IV-D agency shall proceed as if the physical custodian had accepted the proposed child support amount. The physical custodian's failure to respond shall not be the basis of a claim of noncooperation.

(6) The IV-D agency may attempt to reconcile the proposed child support amount with the physical custodian's claim through negotiation or requests for production of documentary evidence. If the IV-D agency and the physical custodian reach agreement on a new proposed child support amount, upon written or telephonic acceptance by the physical custodian, the IV-D agency shall proceed under WAC 388-11-415.

(7) The notice of proposed child support amount shall inform the physical custodian of the custodian's rights and responsibilities under this section.

(8) The notice of proposed child support amount shall inform the physical custodian that at a hearing, the presiding

officer will enter a support order based on the Washington state child support schedule, in an amount which may be different from the proposed child support order amount.

[Statutory Authority: RCW 34.05.220(1) and 74.20A.055. 97-16-037, § 388-11-410, filed 7/30/97, effective 8/30/97. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-410, filed 4/10/96, effective 5/11/96.]

WAC 388-11-415 Support establishment notice—Physical custodian accepts proposed child support amount. (1) When the physical custodian accepts the proposed child support amount, the IV-D agency shall proceed to serve the responsible parent with the appropriate support establishment notice.

(2) If the responsible parent objects to the support establishment notice, the physical custodian may participate in the hearing to the extent allowed under WAC 388-11-400(2) and 388-11-425, including the right to appeal an adverse decision.

(3) The presiding officer shall conduct a hearing requested under this section according to the terms of:

(a) WAC 388-11-425;

(b) The statute and rules authorizing the support establishment notice;

(c) Chapter 10-08 WAC; and

(d) Chapter 388-08 WAC.

(4) The IV-D agency may accept a settlement, without the physical custodian's approval, for an amount equal to or greater than the proposed notice amount accepted by the physical custodian under WAC 388-11-410 (3)(a) or (6).

(5) The IV-D agency shall mail a copy of a settlement entered under subsection (4) of this section to the physical custodian within five working days of the date the settlement is entered.

[Statutory Authority: RCW 34.05.220(1) and 74.20A.055. 97-16-037, § 388-11-415, filed 7/30/97, effective 8/30/97. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-415, filed 4/10/96, effective 5/11/96.]

WAC 388-11-420 Support establishment notice—Physical custodian objects to the proposed child support amount. (1) When the physical custodian objects to the proposed child support amount, the IV-D agency shall proceed to serve a support establishment notice according to the terms of this section.

(2) In addition to the requirements of the section of this chapter authorizing the notice, the IV-D agency shall include the following in a support establishment notice served under this section:

(a) The physical custodian's claimed support amount;

(b) The agency's claimed support amount; and

(c) Notice that:

(i) The agency and the physical custodian disagree on the proper support amount;

(ii) A hearing will be scheduled to resolve the dispute;

(iii) The responsible parent is a party to that hearing;

(iv) If the responsible parent fails to appear for the hearing, the parent will be held in default and the child support amount may be resolved by agreement of the remaining parties at any amount equal to or lower than the highest amount claimed by the agency or the custodian;

(v) If the responsible parent fails to appear for the hearing, the parent will be held in default and the presiding officer may hold a hearing and enter an order based on the Washington state child support schedule, which order may be higher or lower than the amounts stated in the notice; and

(vi) The responsible parent may argue and present evidence at the hearing to show that the support obligation should be different from that claimed by the agency or the physical custodian.

(3) When the IV-D agency serves the responsible parent with a notice under this section, the office of administrative hearings shall send a notice of the hearing to the physical custodian and the responsible parent at their last known mailing address.

(4) The presiding officer shall conduct a hearing requested under this section according to the terms of:

(a) WAC 388-11-425;

(b) The statute and rules authorizing the support establishment notice;

(c) Chapter 10-08 WAC; and

(d) Chapter 388-08 WAC.

[Statutory Authority: RCW 34.05.220(1) and 74.20A.055. 97-16-037, § 388-11-420, filed 7/30/97, effective 8/30/97. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-420, filed 4/10/96, effective 5/11/96.]

WAC 388-11-425 Hearings on support establishment notices. (1) In a hearing under this section, the IV-D agency shall proceed first to document the support amount the IV-D agency believes to be correct. Following the IV-D agency's presentation, the physical custodian and the responsible parent may proceed in turn to show why the agency position is wrong.

(2) If any party appears for the hearing and elects to proceed, absent the granting of a continuance the presiding officer shall hear the matter and enter an initial decision and order based on the evidence presented. The presiding officer shall include a party's failure to appear in the initial decision and order as an order of default against that party. The direct appeal rights of the party who failed to appear shall be limited to an appeal on the record made at the hearing.

(3) If neither party appears and elects to proceed, the presiding officer shall enter an initial decision and order on default, declaring the IV-D agency's claim for support to be final subject to collection action.

(4) If the physical custodian appears and the responsible parent fails to appear, the IV-D agency or the custodian may seek an order of default against the responsible parent. On obtaining the default order, the IV-D agency and the custodian may execute an agreed settlement or consent order setting the support obligation, so long as the settlement is no more than the greatest amount stated in the notice.

(5) The IV-D agency shall not take action to collect support under an order based on subsection (4) of this section until:

(a) The default order becomes a final order, and

(b) The order has been sent by regular mail to the responsible parent with a copy of the default order.

(6) A party against whom the presiding officer has entered an order of default may petition to vacate the order under WAC 388-11-120. However, a physical custodian

who has accepted the proposed notice amount under WAC 388-11-410 (3)(a) may vacate an order based on that amount only on a showing of fraud or misconduct in obtaining the custodian's acceptance of the proposed child support amount.

(7) When a party has advised the presiding officer that they will participate by telephone, the presiding officer shall attempt to contact that party on the record before beginning the proceeding or ruling on a motion. The presiding officer shall not disclose a telephone number or the location of the party appearing by phone.

[Statutory Authority: RCW 34.05.220(1) and 74.20A.055. 97-16-037, § 388-11-425, filed 7/30/97, effective 8/30/97. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-425, filed 4/10/96, effective 5/11/96.]

WAC 388-11-430 Settlement and consent order. (1) Except as provided in this section, a consent order or agreed settlement entered under WAC 388-11-415 through 388-11-425 is not valid until it is signed by all parties to the action. However, the physical custodian's telephonic approval may be substituted for his or her signature.

(2) A presiding officer may issue a consent order without the signatures of the parties after reviewing the terms of the order with the parties and making a finding that the parties understand and accept the terms of the order.

(3) A consent order or agreed settlement entered according to WAC 388-11-410 (3)(a) becomes valid without the signature of the physical custodian.

(4) A presiding officer may enter an order of default against a party who fails to appear at hearing, and that order of default shall substitute for the defaulting party's signature if the remaining parties enter into a consent order or agreed settlement.

[Statutory Authority: RCW 34.05.220(1) and 74.20A.055. 97-16-037, § 388-11-430, filed 7/30/97, effective 8/30/97. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-430, filed 4/10/96, effective 5/11/96.]

Chapter 388-14 WAC
SUPPORT ENFORCEMENT

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-14-275 Fifty dollars disregard payment. [Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-14-275, filed 6/9/92, effective 7/10/92. Statutory Authority: RCW 74.04.057. 91-10-026 (Order 3162), § 388-14-275, filed 4/23/91, effective 5/24/91; 89-10-070 (Order 2794), § 388-14-275, filed 5/3/89.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-14-400 Order to withhold and deliver—Issuance and termination. [Statutory Authority: RCW 74.08.090. 86-05-009 (Order 2340), § 388-14-400, filed 2/12/86.] Repealed by 97-13-092, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035.

388-14-405 Order to withhold and deliver—Responsibilities of employer. [Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-405, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-405, filed 2/12/86.] Repealed by 97-13-092, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035.

388-14-425 Payroll deduction—Notice and order—Issuance and termination. [Statutory Authority: RCW 26.23.060. 92-13-026 (Order 3403), § 388-14-425, filed 6/9/92, effective 7/10/92. Statutory Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-425, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-425, filed 3/4/88.] Repealed by 97-13-092, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035.

388-14-430 Income withholding action. [Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-430, filed 3/4/88.] Repealed by 97-13-092, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035.

WAC 388-14-020 Definitions. The definitions contained in WAC 388-11-011 are incorporated into and made a part of this chapter.

Unless context clearly requires otherwise, the definitions in this section apply throughout this chapter.

"Absent parent" means **"responsible parent"** as defined in this section.

"Aid" or **"public assistance"** means aid to families with dependent children (AFDC) or AFDC foster care, temporary assistance for needy families (TANF), federally-funded or state-funded foster care, and includes day care benefits, and medical benefits to families as an alternative or supplement to AFDC or TANF.

"Applicant/custodian" means the person who is the physical custodian of any dependent child or children on whose behalf nonassistance support enforcement services are being provided by the IV-D agency under RCW 74.20.040, chapter 26.23 RCW, and 42 USC Sec. 654(6) or 657(C).

"Applicant/recipient," "applicant," and **"recipient"** include the caretaker relative, the children, and any other person whose needs are considered in determining the amount of public assistance. See also WAC 388-22-030.

"Disposable earnings" means that part of earnings of a person remaining after the deduction of amounts required by law to be withheld.

"Earnings" means compensation paid or payable for personal services.

(1) Earnings include:

(a) Wages or salary;

(b) Commissions and bonuses;

(c) Periodic payments under pension plans, retirement programs, and insurance policies of any type;

(d) Disability payments under Title 51 RCW;

(e) Unemployment compensation as provided for under RCW 50.40.020 and 50.40.050, and Title 74 RCW;

(f) Gains from capital, labor, or from both combined; and

(g) The fair value of nonmonetary compensation received in exchange for personal services.

(2) Earnings do not include profit gained through the sale or conversion of capital assets.

"Employee" means a person in employment to whom an employer is paying, owes, or anticipates paying earnings as the result of services performed.

"Employer" means any person or organization having any person in employment. It includes:

(1) Partnerships and associations;

(2) Trusts and estates;

(3) Joint stock companies and insurance companies;

(4) Domestic and foreign corporations;

(5) The receiver or trustee in bankruptcy;

(6) The trustee or the legal representative of a deceased person.

"Employment" means personal services of whatever nature, including service in interstate commerce, performed for earnings or under any contract for personal services. The contract may be written or oral, express or implied.

"Family" means the person or persons on behalf of whom support is sought, which unit may include a custodial parent or other person and one or more children or a child or children in foster care placement.

"Foster care case" means a case referred to the IV-D agency by the Title IV-E agency or the state division of child and family services.

"Head of household" means the responsible parent or parents with whom the dependent child or children were residing at the time of placement in foster care.

"Income" includes:

(1) All appreciable gains in real or personal property;

(2) Net proceeds from the sale or exchange of real and personal property;

(3) Earnings;

(4) Interest and dividends;

(5) Proceeds of insurance policies;

(6) Other periodic entitlements to money from any source; and

(7) Any other property subject to withholding for support under the law of this state.

"Income withholding action" includes all withholding action the IV-D agency is authorized to take. The term includes, but is not limited to actions to:

(1) Assert liens under RCW 74.20A.060;

(2) Serve and enforce liens under chapter 74.20A RCW;

(3) Issue orders to withhold and deliver under chapter 74.20A RCW, and notices of payroll deduction under chapter 26.23 RCW;

(4) Obtain wage assignment orders under RCW 26.18.080.

"Payment services only" or **"PSO"** means a case on which the IV-D agency's activities are limited to recording and distributing child support payments, and maintaining case records. A PSO case is not a IV-D case.

"Physical custodian" means the natural or adoptive parent, or other person, with whom a dependent child resides a majority of the time. The physical custodian may be either an applicant/recipient or applicant/custodian.

"Putative father" includes all men who may possibly be the father of the child or children on whose behalf the application for assistance or support enforcement services may be made.

The **"required support obligation for the current month"** means the amount of a superior court order, tribal court order, or administrative order for support or the periodic future support amount that is or will be owing for the current month.

"Resident" means a person physically present in the state of Washington who intends to make their home in this state. Temporary absence from the state does not destroy residency once established.

"Residential care" means foster care as defined under WAC 388-70-012.

"Responsible parent" means the natural parent, adoptive parent, responsible stepparent, or a person having signed an affidavit acknowledging paternity which has been filed with the state center for health statistics, from whom the IV-D agency seeks support for a dependent child.

"Responsible stepparent" means a stepparent having established an in loco parentis relationship with the child or children.

(1) The status shall continue until the relationship is terminated by death, dissolution of marriage, or by superior court order as provided under RCW 26.16.205.

(2) A rebuttable presumption of an in loco parentis relationship is created when the stepparent:

(a) Lives with the child and the parent; or

(b) Provides care, support or guidance for the child.

"Secretary" means the secretary of the department of social and health services, the secretary's designee, or authorized representative. For all purposes in chapter 74.20A RCW, secretary shall mean the designee of the secretary, the director of the IV-D agency, or the director's designee, except as is provided for under the definition of **"secretary"** in WAC 388-11-011 or where for the purposes of RCW 74.20A.055 **"secretary"** has another meaning.

"Support enforcement services" for the purposes of chapters 388-11 and 388-14 WAC, means all action the IV-D agency is required to perform under Title IV-D of the Social Security Act and state law. This includes, but is not limited to, action to establish, enforce, and collect child and

medical support obligations, action to enforce and collect spousal support obligations, action to establish paternity, action to modify support order, and distribution of support moneys.

"Title IV-D" means Title IV-D of the Social Security Act established under Title XX of the Social Security amendments and as incorporated in Title 42 USC.

"Title IV-D agency" or **"IV-D agency"** means the agency currently known as the division of child support or the Washington state support registry, formerly known as the support enforcement division or the office of support enforcement, which is the agency responsible for carrying out the Title IV-D plan in the state of Washington.

"Title IV-D plan" means the plan established under the conditions of Title IV-D and approved by the secretary, Department of Health and Human Services.

"Title IV-E" means Title IV-E of the Social Security Act established under Title XX of the Social Security amendments and as incorporated in Title 42 USC.

"Title IV-E case" means a **"foster care case"** as defined in this section.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-020, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 26.23.035. 92-13-026 (Order 3403), § 388-14-020, filed 6/9/92, effective 7/10/92. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-020, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-020, filed 2/12/86; 83-21-014 (Order 2036), § 388-14-020, filed 10/6/83; 80-01-026 (Order 1465), § 388-14-020, filed 12/14/79; Order 1054, § 388-14-020, filed 9/25/75.]

WAC 388-14-030 Confidentiality. (1) Under RCW 26.23.120, all information and records, concerning persons who owe a support obligation or for whom the IV-D agency provides support enforcement services, are private and confidential. The IV-D agency shall disclose information and records only as follows:

(a) The IV-D agency shall disclose information and records only to:

(i) A person or entity listed and for the specific purpose or purposes stated in federal law;

(ii) The person who is the subject of the information or records, unless the information or records are exempt under RCW 42.17.310;

(iii) Local, state, and federal government agencies for support enforcement and related purposes;

(iv) A party to a judicial proceeding or a hearing under chapter 34.05 RCW, if the presiding officer enters an order to disclose. The presiding officer shall base the order on a written finding that the need for the information outweighs any reason for maintaining privacy and confidentiality;

(v) A party under contract, including a federally recognized Indian tribe, if disclosure will allow the party to assist in the program's management or operation;

(vi) A person or entity, including a federally recognized Indian tribe, when necessary to the administration of the program or the performance of functions and duties in state and federal law. The IV-D agency may publish information about a responsible parent for locate and enforcement purposes;

(vii) A person, representative, or entity if the person who is the subject of the information and records consents, in writing, to disclosure;

(viii) The office of administrative hearings or the office of appeals for administration of the hearing process under chapter 34.05 RCW. The presiding officer or review judge shall not include the address of either party in an administrative order, or disclose a party's address to the other party. The review judge and the presiding officer shall:

(A) State in support orders that the address is known by the Washington state support registry; and

(B) Inform the parties they may obtain the address by submitting a request for disclosure to the IV-D agency under this section.

(b) The last known address of, or employment information about, a party to a court or administrative order for, or a proceeding involving, child support may be given to another party to the order. The party receiving the information may only use the information to establish, enforce, or modify a support order. Disclosure of address information is subject to the provisions of WAC 388-14-035, 388-14-040, 388-14-045, and 388-14-050;

(c) The last known address of natural or adoptive children may be given to a parent having a court order granting that parent visitation rights with, legal custody of or residential time with the parent's natural or adoptive children. The parent may only use this information to enforce the terms of the court order. Disclosure of this information is subject to the provisions of WAC 388-14-035, 388-14-040, 388-14-045, and 388-14-050;

(d) The IV-D agency may disclose the Social Security Number of a dependent child to the responsible parent to enable the parent to claim the dependency exemption as authorized by the Internal Revenue Service;

(e) Financial records of an individual obtained from a financial institution may be disclosed only for the purpose of, and to the extent necessary, to establish, modify, or enforce a child support obligation of that individual.

(2) Except as provided under WAC 388-14-035, 388-14-040, 388-14-045, and 388-14-050, chapter 388-320 WAC governs the process of requesting and disclosing information and records.

(3) The IV-D agency shall take timely action on requests for disclosure. The office shall respond in writing within five working days of receipt of the request.

(4) If a child is receiving foster care services, the party shall contact the party's local community services office for disclosure of that child's address information.

(5) The rules of confidentiality and penalties for misuse of information and reports that apply to a IV-D agency employee, shall also apply to a person who receives information under this section.

(6) Nothing in these rules:

(a) Prevents the IV-D agency from disclosing information and records when such disclosure is necessary to the performance of its duties and functions as provided by state and federal law;

(b) Requires the IV-D agency to disclose information and records obtained from a confidential source.

[Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-030, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-14-030, filed 2/10/93, effective 3/13/93; 91-17-063 (Order 3234), § 388-14-030, filed 8/20/91, effective 9/20/91. Statutory

Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-030, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-030, filed 3/4/88; Order 1054, § 388-14-030, filed 9/25/75.]

WAC 388-14-035 Requests for address disclosure—Form of request. (1) A person shall submit a request for disclosure of a parent or child's address in writing and in person, with satisfactory evidence of identity, at any office of the IV-D agency;

(2) If the request is made by the person's attorney, the agency may waive the provisions regarding submission in person with satisfactory evidence of identity;

(3) If the person is unable to appear at the IV-D agency in person, the IV-D agency may waive the provision requiring submission in person if the person submits a notarized request for disclosure;

(4) The requester shall attach the following to a request for disclosure of an address:

(a) A copy of the superior court order on which the request is based. The IV-D agency shall waive this provision if the IV-D agency has a true copy of the order on file;

(b) A sworn statement by the individual that the order has not been modified; and

(c) A statement explaining the purpose of the request and how the information will be used.

[Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-035, filed 9/2/97, effective 10/3/97.]

WAC 388-14-040 Authorization for address release. (1) Any party to a support order may authorize the IV-D agency to release his or her address to the other party with no prior notice.

(2) An authorization to release an address shall be:

(a) In writing;

(b) Notarized; and

(c) Effective for any period designated by the party up to three years or until the IV-D agency is notified in writing that the party has revoked the authorization, whichever is sooner.

[Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-040, filed 9/2/97, effective 10/3/97.]

WAC 388-14-045 Requests for address disclosure—Notice of request—Standards for nonrelease. (1) The following provisions apply to a request for disclosure of the address of a party to the order or a dependent child under WAC 388-14-030 through 388-14-050. The IV-D agency shall not release the address if:

(a) The department has determined, under WAC 388-215-1450, that the physical custodian has good cause for refusing to cooperate;

(b) The order, on which the request is based, restricts or limits the address requesting party's right to contact or visit the other party or the child by imposing conditions to protect the party or the child from harm;

(c) An order has been entered finding that the health, safety, or liberty of a party or child would be unreasonably put at risk by the disclosure of the information; or

(d) The IV-D agency has information which gives the agency reason to believe that release of the address may result in physical or emotional harm to the other party or to the children.

(2) Whenever the IV-D agency denies a request for disclosure under subsection (1) of this section, the IV-D agency shall notify the nonrequesting party that disclosure of the address was requested and was denied.

(3) Prior to disclosing the address of a party or a child, the IV-D agency shall mail a notice to the last known address of the party whose address is sought, except as provided under subsection (4) of this section. The notice shall advise the party that:

(a) A request for disclosure has been made;

(b) The IV-D agency will disclose the address after thirty days from the date of the notice, unless:

(i) The IV-D agency receives a copy of an order which:

(A) Enjoins disclosure of the address;

(B) Restricts the address requesting party's right to contact or visit the other party or a child by imposing conditions to protect the party or the child from harm, including, but not limited to, temporary orders for protection under chapter 26.50 RCW; or

(C) States that the health, safety, or liberty of a party or child would be unreasonably put at risk by disclosure of address or other identifying information.

(ii) The party requests an adjudicative proceeding which ultimately results in a decision that release of the address is reasonably anticipated to result in harm to a party or a dependent child;

(iii) In any hearing under this section, either party may participate in the proceeding by telephone, from any prearranged location. The location and phone number shall not be disclosed by the presiding officer.

(4) The IV-D agency shall not mail a notice prior to disclosure if:

(a) The requesting party presents a facially valid warrant or a judicial finding that:

(i) The other party will likely flee to avoid service of process; or

(ii) The other party will likely flee and that:

(A) A court of competent jurisdiction of this state or another state has entered an order giving legal and physical custody of a child whose address is requested to the requesting party; and

(B) The custody order has not been altered, changed, modified, superseded, or dismissed; and

(C) A child was taken or enticed from the address requesting party's physical custody without that party's consent; and

(D) The address requesting party has not subsequently assented to being deprived of physical custody of the children; and

(E) The address requesting party is making reasonable efforts to regain physical custody of the child; or

(b) The records of the IV-D agency contain a written authorization for address release under WAC 388-14-040.

[Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-045, filed 9/2/97, effective 10/3/97.]

WAC 388-14-050 Requests for address disclosure—Hearings. (1) In any adjudicative proceeding requested under WAC 388-14-045 (2)(b)(ii):

(a) The parent requesting address disclosure and the other party to the order or action are independent parties in the adjudicative proceeding;

(b) Either party may participate by telephone, provided the party:

(i) States in the request for the adjudicative proceeding that participation will be by telephone; or

(ii) Advises the office of administrative hearings at least five calendar days prior to the scheduled hearing that participation will be by telephone; and

(iii) Provides the office of administrative hearings with a telephone number where the party can be reached for the hearing, at least five calendar days before the scheduled hearing.

(c) The presiding officer shall not disclose the location or phone number from which the party is appearing;

(d) The initial burden of proof is on the party requesting address disclosure, to show that the address request is for a purpose for which disclosure is specifically permitted under WAC 388-14-030 through 388-14-050;

(e) If the party requesting address disclosure:

(i) Fails to meet this burden, the presiding officer shall enter an order denying the address request;

(ii) Establishes that the address was requested for a purpose for which disclosure is permitted, the other party must then show that it is reasonable to anticipate that physical or emotional harm to the party or a child will result from release of the address. The party objecting to address release:

(A) May demonstrate reasonable anticipation of harm by any form of evidence admissible under chapter 34.05 RCW; and

(B) Is not required to provide corroborative evidence required by WAC 388-215-1450, to establish a reasonable anticipation of harm.

(f) If either party fails to appear, the presiding officer may enter an order on default:

(i) If the party objecting to disclosure fails to appear, the order shall require the IV-D agency to release the address unless the record contains documentary evidence which provides the basis for a finding that physical or emotional harm will likely result from release of the address;

(ii) If the address requesting party fails to appear, the default order shall deny the request for address information.

(g) The office of administrative hearings shall arrange the attendance of the parties by telephone or other procedure showing due regard for the safety of the parties and the children;

(h) The IV-D agency shall issue a final response to the disclosure request within five working days of the exhaustion of administrative remedies.

(2) If the physical custodian requests a hearing under this section in response to a department initiated review of the support order for modification, both parties to the support order shall be independent parties in the address disclosure hearing.

[Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-050, filed 9/2/97, effective 10/3/97.]

WAC 388-14-260 Interstate cases. (1) When a child support enforcement agency in another state, operating a child support program under Title IV-D of the Social Security Act, submits a request for support enforcement services under RCW 74.20.040(3) or chapter 26.21 RCW, the IV-D agency shall initiate appropriate action to establish, enforce, and collect the support obligation, including any medical support obligation. The request shall be signed by an authorized official of the state agency and shall contain appropriate information and be accompanied by appropriate documentation to support the action to establish, enforce, and/or collect the support obligation. In addition, the request may be forwarded by use of electronic referral systems such as the child support enforcement network (CSENET). The following is a list of some of the information/documentation that may be submitted with the request for support enforcement services:

(a) The responsible parent's name, address, Social Security number, date of birth, present or last known employer, earnings or ability to earn, employment history, property and resources, and physical description;

(b) The custodian's name, address, and Social Security number;

(c) The names, address, Social Security numbers, and dates of birth of the dependent children;

(d) A certification that the request is being submitted under Title IV-D of the Social Security Act and identification of the case as a public assistance or nonassistance case;

(e) A copy of any superior court order or administrative order establishing the support obligation and any order, tribal court order modifying the court or administrative order;

(f) A copy of any official record of support payments made by the responsible parent or, if no such record exists, an affidavit setting forth the amount of support due under the superior court order, tribal court order or administrative order, the period during which support was due and payable, and the amounts and dates of support payments;

(g) If there is no superior court order, tribal court order or administrative order for support, an affidavit setting forth the following:

(i) A statement of facts establishing or tending to establish the existence of a legally enforceable support obligation;

(ii) A statement of the dates and amounts of any public assistance payments or a statement reflecting the needs of the children for food, clothing, shelter, medical support, or other necessities if no such assistance has been provided.

(2) If a superior court order or tribal court order has been entered establishing the responsible parent's support obligation, the IV-D agency may proceed under chapters 26.18, 26.21, 26.23, 74.20, and 74.20A RCW to enforce the support obligation and initiate further enforcement and collection action as authorized by law.

(3) If an administrative order has been entered by an agency in another state establishing the responsible parent's support obligation, the IV-D agency may issue a notice of support debt under RCW 26.21.460.

(4) If there is no superior court order, tribal court order or administrative order, the IV-D agency may issue a support establishment notice.

(5) If the IV-D agency is unable to establish, enforce, and/or collect the support obligation in response to the request or otherwise deems it appropriate under the circumstances, the case may be referred to the county prosecuting attorney, attorney general's office, or Indian tribe for collection action.

(6) If the IV-D agency is unable to locate the responsible parent after reasonable and diligent efforts, the requesting agency fails to provide sufficient information to locate the responsible parent and/or establish and enforce the support obligation, or the case does not appear to have collection potential for the foreseeable future, the agency may discontinue support enforcement services and return the request and accompanying documentation to the requesting agency.

(7) If the IV-D agency is notified by the requesting agency that the custodian of the dependent child or children is moving to another state, support enforcement services on behalf of the custodian may be continued for a period not to exceed five months.

(8) When the responsible parent is residing and/or employed in another state and support enforcement services are being provided under RCW 74.20.040 (1) or (2), the IV-D agency may execute and submit a request or an electronic referral for support enforcement services similar to the request described in this section to the IV-D agency of that state, or may refer the case to the county prosecuting attorney or the attorney general's office for appropriate action.

(9) Upon request from another state, the IV-D agency shall provide available information/documentation from case files, including but not limited to copies of superior court orders, administrative orders, pay records, and statements/affidavits of support debts, employment, and public assistance records.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-260, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-14-260, filed 2/5/90, effective 3/1/90. Statutory Authority: 74.08.090. 85-23-019 (Order 2304), § 388-14-260, filed 11/13/85; Order 1054, § 388-14-260, filed 9/25/75.]

WAC 388-14-270 Distribution of support payments. (1) The IV-D agency shall distribute support money it collects or receives, in accordance with state and federal law and the provisions of this section, to the:

(a) Department when the department provides or has provided public assistance payments for the support of the family unit, household, or a member of the family unit or household;

(b) Payee under the order, or to the physical custodian of the child according to WAC 388-14-271;

(c) Child support enforcement agency in another state or foreign country which submitted a request for support enforcement services;

(d) Indian tribe which has a TANF program and/or a cooperative agreement regarding the delivery of child support services; or

(e) Person or entity making the payment when the IV-D agency is unable to identify the person to whom the support money is payable after making reasonable efforts to obtain identification information.

(2) If the IV-D agency is unable to distribute support money because the location of the family or person is unknown, it shall exercise reasonable efforts to locate the family or person. When the IV-D agency does not locate the family or person, it shall handle the money in accordance with chapter 458-65 WAC, the uniform unclaimed property act rules.

(3) The IV-D agency shall apply the following rules when distributing support money:

(a) Record payments in exact amounts without rounding;

(b) Distribute support money within eight days of the date the IV-D agency receives the money, unless it is unable to distribute the payment for one or more of the following reasons:

(i) The location of the payee is unknown;

(ii) The IV-D agency does not have sufficient information to identify the accounts against which or to which it should apply the money;

(iii) An action is pending before a court or agency which has jurisdiction over the issue to determine whether support money is owed or how the IV-D agency should distribute the money.

(iv) The IV-D agency receives prepaid support money which it is holding for distribution in future months under subsection (4) of this section;

(v) The IV-D agency mails a notice of intent to distribute support money to the physical custodian under WAC 388-14-271; or

(vi) Other circumstances exist which make a proper and timely distribution of the money impossible through no fault or lack of diligence of the IV-D agency.

(c) Distribute support money based on the date of collection, except as provided under subsection (3)(f) of this section and WAC 388-14-275. The date of collection is the earliest of the following dates:

(i) The date the IV-D agency or a political subdivision actually making the collection receives the money;

(ii) The date the support enforcement agency or other legal entity of another state or political subdivision, actually making the collection, receives the money; or

(iii) The date income, earnings, wages, labor and industries benefits, or employment security benefits were withheld.

(d) Except as provided in subsection (3)(f) of this section, when the responsible parent has more than one case under Title IV-D or Title IV-E, the IV-D agency shall distribute support money:

(i) First, to the current support obligation on each Title IV-D or foster care case, in proportion to the amount of the current support order on each case; and

(ii) Second, to the total of the support debts whether owed to the family or to the department for the reimbursement of public assistance on each Title IV-D or foster care case, in proportion to the amount of support debt owed by the responsible parent on each case; and

(iii) Third, after distribution under subsection (3)(d)(ii) of this section, within each Title IV-D or foster care case according to subsection (3)(e) of this section.

(e) Apply support money within each Title IV-D case:

(i) First, to satisfy the current support obligation for the month the IV-D agency, or the support enforcement agency or other legal entity of another state or political subdivision, collected the money;

(ii) Second, to the responsible parent's support debts owed to the family;

(iii) Third, to the responsible parent's support debts assigned to the department to reimburse public assistance payments;

(iv) Fourth, to prepaid support as provided for under subsection (4) of this section.

(f) Apply intercepted federal income tax refunds in accordance with 45 CFR 303.72(h), as follows:

(i) First, under federal law to the responsible parent's support debts assigned to the department to reimburse public assistance payments; and

(ii) Second, to support debts that are not assigned to the department; and

(iii) To support debts only, not to current and future support obligations. The IV-D agency shall refund any excess to the responsible parent.

(g) Apply amounts to a support debt owed for one family or household and distribute the amounts accordingly, rather than make a proportionate distribution between support debts owed to different families, when:

(i) Proportionate distribution is administratively inefficient; or

(ii) The collection resulted from the sale or disposition of a specific piece of property against which a court awarded the physical custodian a judgment lien for child support; or

(iii) The collection resulted from a contempt order in a particular case.

(h) Report amounts distributed to a family, receiving public assistance, to the community services office. This requirement shall not relieve the recipient of the duty to report receipt of support money; and

(i) Pay a family, receiving cash assistance under the aid to families with dependent children program, up to the first fifty dollars of each child support payment as provided under WAC 388-14-275.

(4) If the IV-D agency receives or collects support money representing payment on the required support obligation for future months, it shall:

(a) Apply the support money to future months when the support debt is paid in full;

(b) Distribute the support money on a monthly basis when payments become due in the future; and

(c) Mail a notice to the last known address of the person entitled to receive support money. The notice shall inform the person that:

(i) The IV-D agency received prepaid support money;

(ii) The IV-D agency will distribute the prepaid money as support payments become due in the future; and

(iii) If the support order is a court order, the person may petition the court that entered the support order for an order requiring the immediate distribution of the prepaid support money; or

(iv) If the support order is an administrative order, the person may request a conference board under WAC 388-14-385 to determine if the prepaid support money should be immediately distributed.

(d) The IV-D agency shall not mail the notice referred to in (4)(c) of this section if the prepaid support is equal to or less than one month's support obligation.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-270, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 26.23.035. 92-13-026 (Order 3403), § 388-14-270, filed 6/9/92, effective 7/10/92. Statutory Authority: RCW 74.08.090. 90-17-001 (Order 2979), § 388-14-270, filed 8/2/90, effective 9/2/90. Statutory Authority: RCW 74.04.057. 89-10-070 (Order 2794), § 388-14-270, filed 5/3/89. Statutory Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-270, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-270, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-270, filed 2/12/86; 85-01-004 (Order 2174), § 388-14-270, filed 12/6/84; 80-01-026 (Order 1465), § 388-14-270, filed 12/14/79; Order 1054, § 388-14-270, filed 9/25/75.]

WAC 388-14-271 Notice of intent to distribute support money. (1) The IV-D agency may distribute support money to a physical custodian other than the payee under the support order if the physical custodian signs a sworn statement that:

(a) The physical custodian has physical custody of and is caring for the child; and

(b) Is not wrongfully depriving the payee of physical custody.

(2) Before the IV-D agency begins distributing support money to a physical custodian who is not the payee under the support order, it shall send the payee under the support order and the responsible parent a notice of intent to distribute support money and a copy of the sworn statement of the physical custodian to their last known addresses by first class mail. The notice shall state:

(a) The IV-D agency will distribute support money collected under the support order to the physical custodian; and

(b) The name of the physical custodian.

(3) The IV-D agency shall distribute support money to the physical custodian when the notice of intent to distribute support money becomes final.

(a) A notice served in the state of Washington becomes final unless the payee under the support order, within twenty days of the date of mailing of the notice of intent to distribute support money, files a request with the IV-D agency for a hearing under subsection (4) of this section. The effective date of a hearing request is the date the IV-D agency receives the request.

(b) A notice of intent to distribute support money served in another state becomes final according to WAC 388-14-496.

(4) A hearing on a notice of intent to distribute support money is for the limited purpose of resolving who is entitled to receive the support money.

(5) A copy of the notice of any hearing scheduled under this section shall be mailed to the alleged physical custodian at the physical custodian's last known address. The notice shall advise the physical custodian of the right to participate in the proceeding as a witness or observer.

(6) The payee under the support order may file a late hearing request on a notice of intent to distribute support money.

(a) The payee under the support order does not need to show good cause for filing a late hearing request under WAC 388-11-310.

(b) The IV-D agency may not reimburse the payee under the support order for amounts the IV-D agency sent to the physical custodian before the administrative order on a late hearing request becomes final.

(7) The payee under the support order must give the IV-D agency and the physical custodian notice of any judicial proceeding to contest a notice of intent to distribute support money.

(8) If the support order is a court order, the IV-D agency shall file a copy of the notice of intent to distribute support money or the final administrative order entered on a notice of intent to distribute support money with the clerk of the court where the support order was entered.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-271, filed 6/18/97, effective 7/19/97.]

WAC 388-14-272 Notice to recover a support payment. (1) The IV-D agency may serve a notice to recover a support payment on the person who received the payment when the IV-D agency:

(a) Distributed the money in error;

(b) Distributed the money based on a check that is later dishonored;

(c) Is required to refund or return the money to the person or entity that made the payment; or

(d) Distributed money under a support order that was later modified so as to create an overpayment.

(2) The IV-D agency shall serve a notice to recover a support payment like a summons in a civil action or by certified mail, return receipt requested.

(3) In the notice, the IV-D agency shall identify the support payment the IV-D agency seeks to recover.

(4) The IV-D agency may take action to enforce the notice to recover a support payment without further notice once the notice becomes final.

(a) A notice to recover a support payment becomes final unless the person who received the payment requests a hearing under subsection (5) of this section within twenty days of service of the notice to recover a support payment in Washington. The effective date of a hearing request is the date the IV-D agency receives the request.

(b) A notice to recover a support payment may be served in another state to recover a payment disbursed by the IV-D agency under RCW 26.21.385. A notice to recover a support payment served in another state becomes final according to WAC 388-14-305.

(5) A hearing on the merits of a notice to recover a support payment is for the limited purpose of resolving the existence and amount of the debt the IV-D agency is entitled to recover.

(6) A person who files a late request for a hearing on a notice to recover a support payment must show good cause under WAC 388-11-310.

(7) In nonassistance cases and payment services only cases, the IV-D agency may recover a support payment under a final administrative order on a notice to recover a support payment by retaining ten percent of current support and one hundred percent of amounts collected on arrears in addition to any other remedy authorized by law.

(8) If a public assistance recipient receives a support payment directly from a responsible parent and fails to remit it to the IV-D agency as required, the IV-D agency shall recover the money as retained support under WAC 388-14-200.

(9) The IV-D agency may enforce the notice to recover a support payment as provided in subsection (7), or may act according to RCW 74.20A.270 as deemed appropriate.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-272, filed 6/18/97, effective 7/19/97.]

WAC 388-14-274 Distribution notice. (1) The IV-D agency shall mail a distribution notice once each month, or more often, to the last known address of a person for whom it received support during the month, except as provided under subsection (6) of this section.

(2) The IV-D agency shall include the following information in the notice:

(a) The current support and support debt owed under the order;

(b) The amount of support money the IV-D agency received and the date of collection;

(c) A description of how the IV-D agency allocated the support money between current support and the support debt; and

(d) The amount the IV-D agency claims as reimbursement for public assistance paid, if applicable.

(3) The person to whom a distribution notice is sent may file a request for a hearing under subsection (4) of this section within ninety days of the date of the notice to contest how the IV-D agency distributed the support money. A requestor shall state specific objections to the distribution notice. The effective date of a hearing request is the date the IV-D agency receives the request.

(4) A hearing under this section is for the limited purpose of determining if the IV-D agency correctly distributed the support moneys in the contested notice.

(5) A person who requests a late hearing under WAC 388-11-310 must show good cause.

(6) This section does not require the IV-D agency to send a notice to a recipient of payment services only under WAC 388-14-300(1) and 388-14-310 (2)(a).

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-274, filed 6/18/97, effective 7/19/97.]

WAC 388-14-275 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-14-276 Total versus total notice. (1) The IV-D agency shall identify cases needing a "total versus total" calculation, which will compare amounts of public assistance paid to the assistance unit with amounts of support collected and uncollected support debt. The IV-D agency shall perform a total versus total calculation upon the request of the physical custodian or a IV-D agency field office.

(a) The total versus total calculation will allocate the uncollected support debt between the state and the physical custodian, based on the amounts of public assistance paid to the family.

(b) The total versus total calculation will indicate the amounts of support paid by each responsible parent and how the support was distributed.

(c) The IV-D agency may at any time review a case to determine if a total versus total calculation is appropriate.

(2) When a total versus total calculation is completed at the request of the physical custodian, the IV-D agency shall mail a total versus total notice to the last known address of the former assistance recipient.

(3) The person to whom a total versus total notice is sent may within ninety days of the date of the notice file a request for a conference board under WAC 388-14-385 to contest the distribution of support money and the allocation of uncollected support debt. The requestor shall state specific objections to the total versus total notice. The effective date of a hearing request is the date the IV-D agency receives the request.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-276, filed 6/18/97, effective 7/19/97.]

WAC 388-14-300 Nonassistance support enforcement services—Persons eligible for services. (1) As authorized by RCW 26.23.045 and 74.20.040, the IV-D agency shall provide payment processing and records maintenance services under RCW 26.23.050(8) to parties to a court order who are not receiving a public assistance grant when:

(a) A Washington superior court order, tribal court order administrative order, or wage assignment order under chapter 26.18 RCW directs payments through the IV-D agency or the Washington state support registry (WSSR);

(b) The physical custodian of a dependent child or a responsible parent requests payment services only, provided that:

(i) A responsible parent's request for payment services only shall not cause a reduction of service from the level of service provided under subsection (2) of this section, or WAC 388-14-200, 388-14-203, or 388-14-205; and

(ii) The support obligation is set by a Washington superior court, tribal court, administrative, or wage assignment order, directing payment to the IV-D agency or WSSR.

(2) The IV-D agency shall provide full IV-D support enforcement services to physical custodians or responsible parents who are not receiving a public assistance grant when:

(a) The physical custodian or former physical custodian of a child requests support enforcement services;

(b) A responsible parent submits a support order for inclusion in or support payment to the Washington state support registry, together with an application for support enforcement services;

(c) A public assistance recipient stops receiving a cash grant under the aid to families with dependent children or under temporary assistance to needy families;

(d) The department provides Medicaid-only benefits to the physical custodian on behalf of a dependent child, unless the recipient of Medicaid-only benefits declines support enforcement services not related to paternity establishment, medical support establishment or medical support enforcement; or

(e) A man requests paternity establishment services alleging he is the dependent child's father.

(3) The IV-D agency shall provide payment processing, records maintenance, paternity establishment, medical support establishment, and medical support enforcement services when a recipient of Medicaid-only benefits declines support enforcement services.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-300, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090 and 45 CFR 303.106. 94-15-046 (Order 3754), § 388-14-300, filed 7/15/94, effective 8/15/94. Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-14-300, filed 6/9/92, effective 7/10/92; 90-16-041 (Order 3043), § 388-14-300, filed 7/24/90, effective 8/24/90; Order 1054, § 388-14-300, filed 9/25/75.]

WAC 388-14-376 Recovery of excess daycare and special child rearing expense payments. (1) A responsible parent who has paid child support under a court or administrative order and believes that daycare or special child rearing expenses were not actually incurred in the amount of the order may file an application for an administrative hearing to determine if an overpayment of at least twenty per cent has occurred and how the overpayment should be reimbursed.

(a) A petition for reimbursement shall cover a twelve-month period; and

(b) The twelve-month period may be:

(i) A calendar year; or

(ii) The twelve-month period following the anniversary date of the support order; or

(iii) The twelve-month period following an adjudication under this section.

(c) Twelve-month periods under this section may not overlap.

(2) The application shall be in writing and shall at a minimum state:

(a) The twelve-month time period to be considered;

(b) The date of the order requiring the payment of daycare or special child rearing expenses;

(c) The amounts required by the court or administrative order for day care or special child rearing expenses for that time period;

(d) The amounts actually paid by the responsible parent for that time period;

(e) The total amount of day care or special child rearing expenses which the responsible parent claims the physical custodian actually incurred for that time period;

(f) The responsible parent's proportionate share of the expenses actually incurred; and

(g) The amount of reimbursement for overpayment to which the responsible parent claims to be entitled for that time period.

(3) An application for hearing under this section shall be considered an application for full support enforcement services if there is not already an open enforcement case.

(4) The effective date of a hearing request is the date the IV-D agency receives the written request.

(5) The IV-D agency shall send notice of a hearing under this subsection to the responsible parent and the physical custodian. The responsible parent and the physical custodian shall participate in the hearing as independent parties with the same procedural rights.

(6) The responsible parent has the burden of proving the amounts actually paid by the responsible parent under the order.

(7) The physical custodian has the burden of proving the amounts actually incurred for day care and special child rearing expenses.

(8) The physical custodian is not required to provide the address of the day care provider unless the presiding officer finds that such information may be disclosed under the standards set forth in WAC 388-14-030(6) for the disclosure of the address of the physical custodian.

(9) If the responsible parent fails to appear for the hearing, upon proof of service of the notice of hearing the presiding officer shall issue an order of default against the responsible parent and dismiss the petition for reimbursement.

(10) If the physical custodian fails to appear for the hearing, upon proof of service of the notice of hearing the presiding officer shall issue an order of default against the physical custodian and hold a hearing on the merits of the petition for reimbursement.

(11) A hearing under this subsection is for the limited purpose of determining whether the amount paid by the responsible parent exceeds the responsible parent's proportionate share of the amount actually incurred for day care and special child rearing expenses.

(a) If the presiding officer determines that the overpayment amounts to twenty percent or more of the responsible parent's share of annual day care and special child rearing expenses, the presiding officer shall enter an order stating:

(i) The twelve-month time period in question;

(ii) The amount of the overpayment; and

(iii) The method by which the overpayment shall be reimbursed by the obligated party.

(b) If the presiding officer determines that the overpayment amounts to less than twenty percent of the responsible parent's share of annual day care and child rearing expenses, the presiding officer shall enter an order stating:

(i) Whether the responsible parent has overpaid or underpaid the day care and special child rearing expenses;

(ii) If an overpayment has occurred, by what percentage of the annual proportionate share; and

(iii) That reimbursement under this section is denied for that twelve-month period.

(12) Any ordered overpayment reimbursement shall be applied an as offset to any nonassistance child support arrearages owed by the responsible parent on that case only. If there are no nonassistance arrearages owed on that case, the reimbursement shall be:

(a) In the form of a credit against the responsible parent's future child support obligation:

(i) Spread equally over a twelve-month period commencing the month after the administrative order becomes final; or

(ii) When the future support obligation will terminate under the terms of the order in less than twelve months, spread equally over the life of the order; or

(b) With the consent of the obligated party, in the form of a direct reimbursement by the obligated party to the responsible parent.

(13) The responsible parent may not pay more than his or her proportionate share of day care or other special child rearing expenses in advance and then deduct the overpayment from future support transfer payments unless:

(a) Specifically agreed to by the physical custodian; and

(b) Specifically agreed to in writing by the IV-D agency for periods when the physical custodian or the dependent child receives public assistance.

(14) This section applies only to amounts paid during the twelve-month period ending May 31, 1996 or later.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-376, filed 6/18/97, effective 7/19/97.]

WAC 388-14-385 Conference board. (1) A conference board may inquire into, determine facts of, and attempt to resolve matters in which a responsible parent, physical custodian, payee under a court order, or other person feels aggrieved by an action taken by the office under:

(a) Chapters 26.23, 74.20, 74.20A RCW; or

(b) Title IV-D of the Social Security Act (Title 42 U.S.C.).

(2) The intent and purpose of the conference board is to facilitate the informal speedy resolution of grievances.

(3) The director, or director's designee may assemble a conference board on application of an aggrieved person or on the director's own motion. The conference board shall dissolve upon issuance of a decision on the matter for which it was appointed.

(4) An applicant for a conference board shall have made a reasonable attempt and have failed to resolve the grievance before a conference board may act to attempt to resolve the issue.

(5) The conference board's jurisdiction shall include, but shall not be limited to, the following areas:

(a) A complaint as to the conduct of an individual staff member while acting within the scope of the staff member's duties. The board shall send a copy of the decision to the staff member's first line supervisor for action as appropriate;

(b) Review of a denial of an application for or termination of nonassistance support enforcement services;

(c) Review of an allegation of error as to the distribution of support moneys;

(d) Review of a denial to collect support arrears in nonassistance cases under RCW 74.20.040;

(e) Resolution of the amount of arrears claimed due and rate of repayment;

(f) A request to release or refund money taken under RCW 26.23.060 or 74.20A.080 to provide for the reasonable necessities of a responsible parent and minor children in the responsible parent's home;

(g) A request for deferral of support enforcement action;

(h) A request for partial or total charge-off of support arrears under RCW 74.20A.220;

(i) A request to waive interest;

(j) A request to waive or defer the nonassistance support enforcement fee under RCW 74.20.040;

(k) Review of a determination that a support obligation has been satisfied or is no longer legally enforceable;

(l) A specific request for administrative review of cases submitted to the IRS for offset of a tax refund in accordance with federal statutes and regulations;

(m) Any other matter requiring explanation of or application of policy or law to an issue in a specific case or clarification of facts in said case;

(n) The IV-D agency's action in reporting a support debt to a consumer reporting agency;

(o) Review of a total versus total calculation under WAC 388-14-276; and

(p) A request to release a payroll deduction notice on a claim that:

(i) The support obligation was not due at the time the payroll deduction notice was issued and the support order did not authorize immediate wage withholding; or

(ii) The payroll deduction causes extreme hardship or substantial injustice.

(6) When a person states a grievance or requests a conference board, the IV-D agency shall provide a copy of the conference board information form.

(7) The effective date of a conference board request is the date the IV-D agency receives the request.

(8) When a person requests a conference board, the director or the director's designee may take such action, as deemed appropriate, and may exercise any of the authority provided for in this regulation, when the:

(i) Grievance does not involve a factual dispute; or

(ii) Disputed fact or facts even if resolved in favor of the person would not provide a basis upon which relief could be granted to the person by a conference board.

(9) When a person requests a conference board and the grievance involves an apparent factual dispute:

(a) The director or director's designee shall assemble a conference board composed of the director or director's designee, who shall serve as chair and two staff members, if deemed necessary;

(b) The chair shall mail a notice of conference board to the applicant, the applicant's representative, and any other person or agency who is a party in interest to the proceeding. The notice of conference board shall state that a conference board has been scheduled and inform the parties of the time and place of the conference board;

(c) Where the department is not providing public assistance to the payee under a court order, and the responsible parent timely requests a conference board to contest the debt stated in a notice of support debt, the conference board shall be scheduled for a date at least thirty days after the notice of conference board is issued, and the notice shall include statements that:

(i) The payee has twenty days (or sixty days under the circumstances described in WAC 388-14-440(4)) from the date the notice of conference board was given to request that the grievance be addressed in a hearing under WAC 388-14-435;

(ii) If the payee does not timely request a hearing, the department will deem that the payee has elected to have the grievance heard in a conference board and the:

(A) Conference board decision will become the final agency position on the debt claimed under the notice of support debt; and

(B) A payee's late application for a hearing shall be denied unless the payee shows good cause for the late application;

(iii) If the payee does not appear at either a conference board or a hearing, the presiding officer's or the board's decision may be adverse to the payee's interest including, but not limited to, a reduction in the support debt stated in the notice of support debt.

(d) If the payee requests a hearing under WAC 388-14-435, the office shall inform the:

(i) Responsible parent that the parent's request for conference board is declined, and the responsible parent must appear at the hearing requested by the payee to raise objections to the notice of support debt; and

(ii) Payee that the conference board previously scheduled has been declined due to the payee's application for a hearing.

(10) The conference board chair may issue subpoenas under RCW 74.04.290 and administer oaths, take testimony, and compel the production of such papers, books, records, and documents deemed relevant to the resolution of the grievance under consideration. The conference board chair may take additional evidence by affidavit or other written submission when necessary or practicable together with written or oral argument. The chair may designate persons having specific familiarity with the matter at issue or technical expertise with the subject to advise the board.

(11) The conference board chair shall make a written decision stating the facts found, policies applied, and the board's decision.

(a) The board's decision, including a decision to deny a request for a conference board, shall be in accordance with applicable statutes, case law, department rules and regulations, published office manuals, support enforcement policy bulletins, and the exercise of reasonable administrative discretion.

(b) The board shall base a decision under RCW 74.20A.220 to grant partial or total charge-off of arrears owed to the department under RCW 74.20A.030, 74.20A.250, 74.20.320, 74.20.330, or 42 U.S.C. 602 (a)(26)(A) on the following considerations:

(i) Error in law or bona fide legal defects that materially diminish chances of collection; or

(ii) Substantial hardship to minor children in the household of the responsible parent or other minor children for whom the responsible parent actually provides support; or

(iii) Costs of collection action in the future that are greater than the amount to be charged off;

(iv) Settlement from lump-sum cash payment that is beneficial to the state considering future costs of collection and likelihood of collection; or

(v) Excessive debt arising from a default administrative order to the extent that an assignment of child support rights covers the arrears period, upon a finding of substantial hardship under subsection (12) or (13) of this section.

(c) If the decision is the result of a conference board, that decision shall represent the decision of a majority of the board. The director shall vacate decisions inconsistent with the standards in this section and remand the application for issuance of a new decision in compliance with the standards.

(12) In making a determination of substantial hardship under subsection (11) of this section, the board shall measure the net income and all available assets and resources of the responsible parent against the need standard for public assistance for the appropriate family size, as stated in WAC 388-250-1250. The board shall consider the necessity to apportion the responsible parent's income and resources on an equitable basis with the child for whom the arrears accrued. When reviewing a claim of substantial hardship,

the board may consider the following information including, but not limited to:

(a) The child on whose behalf support is owed is reunited with the responsible parent because the:

(i) Formerly separated parents have reconciled; or

(ii) Child has returned to the responsible parent from foster care, the care of a relative, or the care of a nonrelative custodian.

(b) The responsible parent is aged, blind, or disabled and receiving Supplemental Security Income, Social Security, or other similar benefits;

(c) The mother of the child is seeking charge off of debt accrued on behalf of a child who was conceived as a result of incest or rape, and presents evidence of rape or incest, acceptable under 45 CFR 232.43(c);

(d) Payment on the arrears obligation interferes with the responsible parent's payment of current support to a child living outside the home;

(e) The responsible parent has limited earning potential due to:

(i) Dependence on seasonal employment that is not considered in the child support order;

(ii) Illiteracy;

(iii) Limited English proficiency; or

(iv) Other similar factors limiting employability or earning capacity;

(f) The responsible parent's past efforts to pay support and the extent of the parent's participation in the child's parenting;

(g) The size of the responsible parent's debt and the prospects for increased income and resources; and

(h) The debt arises from a default administrative order and an assignment of child support rights covers the arrears period.

(13) The board may find that substantial hardship exists for a responsible parent, without finding hardship to a dependent child.

(a) In making a determination of substantial hardship to an individual without a dependent child, the board shall measure the applicant's income, assets, and resources against the need standard. In combination with the income test, the board may consider the following factors when reviewing a claim of substantial hardship:

(i) The responsible parent is aged, blind, or disabled and receiving Supplemental Security Income, Social Security, or other similar benefits;

(ii) The mother of a child is seeking relief from debt accrued on behalf of a child who was conceived as a result of incest or rape, and presents evidence of rape or incest, acceptable under 45 CFR 232.43(c);

(iii) The responsible parent has limited earning potential due to:

(A) Dependence on seasonal employment that is not considered in the child support order;

(B) Illiteracy;

(C) Limited English proficiency; or

(D) Other similar factors limiting employability or earning capacity.

(iv) The debt arises from a default administrative order and an assignment of child support rights covers the arrears period.

(b) The board may agree to a reduced payment on the support debt, or a conditional reduced payment on the support debt, when there is substantial hardship to the responsible parent but not a hardship to a dependent child. The other remedies for substantial hardship under this section are not available when there is no showing of hardship to a dependent child.

(14) The board may:

(a) Reduce collection on the responsible parent's support debt to an amount that alleviates the hardship without altering the amount of the support to address situations in which substantial hardship exists, but the circumstances creating the hardship are temporary. Temporary hardship situations may include the factors listed under subsection (12) or (13) of this section and the applicant's receipt of public assistance on:

(i) Applicant's behalf; or

(ii) Behalf of a child in the applicant's home.

(b) Create incentives to promote payment or family unity by agreeing to a conditional:

(i) Total or partial charge off, if charge off is available under subsection (11) of this section; or

(ii) Reduced payment on the support debt.

(c) Condition reduced payment, or total or partial charge off on:

(i) Continued payment according to a payment schedule imposed by the board; or

(ii) Continued reconciliation; or

(iii) A family remaining off of cash assistance.

(15) When creating incentives or providing conditional relief under subsection (14) of this section, the board shall:

(a) Not create a conditional charge off without specifying a period of performance after which the charge off is irrevocable;

(b) Not create a charge off conditioned on the parties remaining reconciled unless the parties have been reconciled for at least six months at the time of the conference board;

(c) Consider whether the conditions would create:

(i) Incentives for abuse or intimidation of the other party to the order;

(ii) Incentives for fraud; or

(iii) Unreasonable reluctance to obtain financial or medical assistance necessary for the health and best interests of the children.

(16) When the responsible parent violates the terms of the conditional charge off or reduced repayment rate imposed by a conference board decision under subsection (14) of this section:

(a) Any amount charged off by the board under the decision prior to the violation shall remain uncollectible;

(b) The IV-D agency may collect any further amount that would have been charged off under the decision after the date of violation with no further notice to the responsible parent; and

(c) The responsible parent may not reinstate terms of the decision by renewed compliance with the terms of the decision, unless the IV-D agency agrees in writing to reinstate the conditional charge off or repayment rate.

(17) The board shall distribute a copy of the decision to the applicant, the applicant's representative, other parties in

interest, the appropriate field office for action consistent with the decision of the board, and the director.

(18) A conference board is not an adjudicative proceeding subject to review by the superior court and is not a substitute for any constitutionally or statutorily required hearing. An aggrieved party may be represented before the board by a person of the party's choice. The department shall not pay any costs incurred by the aggrieved person in connection with the conference board.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-385, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 94-15-045 (Order 3753), § 388-14-385, filed 7/15/94, effective 8/15/94; 93-05-020 (Order 3512), § 388-14-385, filed 2/10/93, effective 3/13/93; 91-09-018 (Order 3133), § 388-14-385, filed 4/9/91, effective 5/10/91. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-14-385, filed 2/5/90, effective 3/1/90. Statutory Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-385, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-385, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-385, filed 2/12/86; 81-05-021 (Order 1605), § 388-14-385, filed 2/11/81; 80-01-026 (Order 1465), § 388-14-385, filed 12/14/79; 78-07-015 (Order 1305), § 388-14-385, filed 6/15/78.]

WAC 388-14-390 Hearing when collection action is initiated against a bank account—Exemptions—Burden of proof. (1) If the IV-D agency initiates collection action against a bank account, safe deposit box, or other property held by a bank, credit union or savings and loan, the responsible parent or the joint owner of record of the bank account, safe deposit box or other property may contest the action in a hearing. The effective date of a hearing request is the date the IV-D agency receives the request.

(2) The responsible parent or the joint owner shall file the hearing request within twenty days of the date the IV-D agency mailed a copy of the order to withhold and deliver to the:

(a) Responsible parent; or

(b) Last known address of the joint owner of record of the account, by certified mail.

(3) The responsible parent or joint owner of record shall state in the application the facts supporting the allegation by the responsible parent or the joint owner that the funds or property, or a portion of the funds or property, are exempt from satisfaction of the child support obligation of the responsible parent.

(4) On the application of the responsible parent, the joint owner of record, or the IV-D agency, the IV-D agency shall schedule a hearing solely for the purpose of determining whether or not one of the following exemptions applies to the funds in the bank account, or to the other property attached by the order to withhold and deliver:

(a) Pursuant to RCW 26.16.200 and 74.20A.120, the property or funds in the community bank account, joint bank account, or safe deposit box, or a portion of the property or funds which can be identified as the earnings of the spouse not owing a support obligation to the child or children of the responsible parent, are exempt from satisfaction of the child support obligation of the responsible parent.

(b) The funds in a bank account, or a portion of those funds which can be identified as AFDC funds, TANF funds, SSI monies, or other kinds of funds having been legally exempted from collection action, are exempt from satisfaction of the child support obligation of the responsible parent; or

(c) The funds or property attached by the order to withhold and deliver which can be identified as being solely owned by the joint owner of record of the bank account or safe deposit box not owing a child support obligation to the child or children of the responsible parent, are exempt from satisfaction of the child support obligation of the responsible parent.

(5) The responsible parent or joint owner of record shall have the burden of tracing the funds and proving the property or funds in the bank account, or property in a safe deposit box, are exempt from satisfaction of the child support obligation of the responsible parent.

(6) The IV-D agency shall hold moneys or property withheld as a result of collection action initiated against a bank account or safety deposit box and delivered to the IV-D agency at the time of the granting of an application pending the final administrative order or during the pendency of any appeal to the courts.

(7) If the final decision of the department or courts on appeal is that the IV-D agency has caused money or property that is exempt from satisfaction of the child support obligation of the responsible parent to be withheld by the bank or delivered to the department, the IV-D agency shall:

(a) Promptly release the order to withhold and deliver; or

(b) Refund the proportionate share of the funds having been identified as being so exempt. The department shall not be liable for any interest accrued on any moneys withheld pursuant to RCW 74.20A.080.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-390, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090 and 45 CFR 303.106. 94-15-046 (Order 3754), § 388-14-390, filed 7/15/94, effective 8/15/94. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-14-390, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 83-21-014 (Order 2036), § 388-14-390, filed 10/6/83.]

WAC 388-14-400 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-14-405 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-14-415 Notice of support owed. (1) The IV-D agency may serve a notice of support owed on a responsible parent under RCW 26.23.110 to establish a fixed dollar amount of monthly support and accrued support debt if a support obligation under a court order is not a fixed dollar amount, or to implement an adjustment or escalation provision of the court order.

(a) The notice of support owed shall include day care costs and medical support if the court order provides for such costs.

(b) The IV-D agency shall serve a notice of support owed on a responsible parent like a summons in a civil action or by certified mail, return receipt requested.

(c) Following service on the responsible parent, the IV-D agency shall mail a notice to payee under WAC 388-14-440.

(2) In a notice of support owed, the IV-D agency shall include the information required by WAC 388-11-210 and RCW 26.23.110 and:

(a) The factors stated in the order to calculate monthly support;

(b) Any other information not contained in the order that was used to calculate monthly support and the support debt; and

(c) Notice of the right to request a review of the order once yearly or on the date, if any, given in the order for an annual review.

(3) The responsible parent must make all support payments after service of a notice of support owed to the Washington state support registry. The IV-D agency shall not credit payments made to any other party after service of a notice of support owed except as provided in WAC 388-11-015 and 388-11-280.

(4) A notice of support owed becomes final as defined in this subsection.

(a) A notice of support owed becomes final and subject to immediate wage withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW unless the responsible parent, within twenty days of service of the notice in Washington:

(i) Contacts the IV-D agency, and signs an agreed settlement;

(ii) Files a request with the IV-D agency for a hearing under subsection (5) of this section. The effective date of a hearing request is the date the IV-D agency receives the request; or

(iii) Obtains a stay from the superior court.

(b) A notice of support owed served in another state becomes final according to WAC 388-14-496.

(5) The IV-D agency may enforce at any time:

(a) A fixed or minimum dollar amount for monthly support stated in the court order or by prior administrative order entered under this section;

(b) Any part of a support debt that has been reduced to a fixed dollar amount by a court or administrative order; and

(c) Any part of a support debt that neither party alleges is incorrect.

(6) A hearing on the merits of a notice of support owed is for the limited purpose of interpreting the court order for support and any modifying orders and not to change or defer the support provisions of the order. The hearing is only to determine:

(a) The amount of monthly support as a fixed dollar amount;

(b) Any accrued arrears through the date of hearing; and

(c) If a condition precedent in the court order to begin or modify the support obligation was met.

(7) If the responsible parent requested the hearing, he or she has the burden of proving any applicable defenses to liability under WAC 388-11-065 or that the amounts stated in the notice of support owed are incorrect.

If the payee under the order requested the hearing, see WAC 388-14-440.

(8) The IV-D agency shall send notice of a hearing under this subsection to the responsible parent and payee. The payee may participate in the hearing as an independent party with the same procedural rights as the responsible parent.

(9) If only one party appears and wishes to proceed with the hearing, the presiding officer shall either continue the hearing or hold a hearing and issue an initial decision based on the evidence presented.

(a) The presiding officer shall include an order of default against the nonappearing party in the initial decision, and the appeal rights of the nonappearing party are limited to the record made at the hearing.

(b) If neither party appears or wishes to proceed with the hearing, the presiding officer shall issue an order of default against both parties.

(10) A notice of support owed or an initial or review decision issued under subsection (6) of this section shall inform the parties of the right to request a review of the order once yearly or on the date, if any, given in the order for an annual review.

(11) If a responsible parent requests a late hearing under WAC 388-11-310, the responsible parent must show good cause for filing the late hearing request if it is filed more than one year after service of the notice of support owed.

(12) A notice of support owed shall fully and fairly apprise the responsible parent of the rights and responsibilities in this section.

(13) For the purposes of this section, "payee" shall include "physical custodian."

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-415, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-14-415, filed 6/9/92, effective 7/10/92; 91-09-018 (Order 3133), § 388-14-415, filed 4/9/91, effective 5/10/91. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-14-415, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-415, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-415, filed 2/12/86.]

WAC 388-14-420 Termination of support enforcement services. (1) After the IV-D agency begins providing services under chapter 74.20 RCW and RCW 26.23.045 (1)(a), (b), (c), (e), or (f), the IV-D agency may terminate services when:

(a) There is no current support order and the support debt is less than five hundred dollars or cannot be enforced under the laws of the state of Washington;

(b) The IV-D agency determines that the responsible parent or putative father is dead and has no available assets, income, or estate subject to collection action;

(c) The IV-D agency determines that the responsible parent does not have any available assets, income, or estate subject to collection action, and is and will be unable to pay support because the parent is:

(i) Institutionalized in a psychiatric facility;

(ii) Incarcerated without possibility of parole; or

(iii) Medically verified as totally and permanently disabled with no evidence of support potential.

(d) The applicant, agency, or person receiving nonassistance services submits a written request to terminate services, and no current assignment to the state of medical support rights exists. If there is accrued debt under a support order that is assigned to the state:

(i) That portion of the case shall remain open; and

(ii) The IV-D agency may close the nonassistance portion of the case.

(e) The IV-D agency makes reasonable efforts to identify or locate the responsible parent, using local, state, and federal locate sources over a three-year period and does not find new locate information;

(f) The IV-D agency is unable to contact a nonassistance physical custodian within a thirty-day period using both a telephone call and one or more registered letters;

(g) The IV-D agency documents:

(i) Instances of the physical custodian's failure or refusal to cooperate with the IV-D agency; and

(ii) That the physical custodian's cooperation is essential for the next step in providing support enforcement services;

(h) The IV-D agency cannot obtain a paternity order because:

(i) The putative father is dead;

(ii) A genetic test has excluded all known putative fathers and no other putative father can be identified;

(iii) The child is eighteen years of age or older; or

(iv) The department, a court of competent jurisdiction, or an adjudicative proceeding determines that paternity establishment would not be in the best interest of the child in a case involving:

(A) Incest;

(B) Rape; or

(C) Pending adoption.

(i) The department or a court of competent jurisdiction finds the person receiving services has wrongfully deprived the responsible parent of physical custody of a dependent child under WAC 388-11-065(3);

(j) The department or a court of competent jurisdiction finds that action establishing or enforcing a support obligation cannot proceed without risk of harm to the child or the child's custodian;

(k) The IV-D agency has provided locate-only services in response to a request for state parent locator services;

(l) The responsible parent is a citizen of, and lives in, a foreign country and:

(i) Does not have any assets which can be reached by the IV-D agency; and

(ii) Washington state has been unable to establish reciprocity in child support matters with that country; or

(m) The dependent child is confined to a juvenile rehabilitation facility for a period of ninety day or more; or

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

(2) After the IV-D agency provides services under RCW 26.23.045 (1)(d), the IV-D agency shall:

(a) Terminate support enforcement services;

(i) If a court of competent jurisdiction orders the IV-D agency to terminate services based on:

(A) An approved alternate payment plan under RCW 26.23.050; or

(B) A finding that it is not in the child's best interest for the IV-D agency to continue providing services.

(ii) After filing a satisfaction of judgment with the court as provided under WAC 388-14-205; or

(iii) If the responsible parent is dead and the IV-D agency receives proof there is no available estate.

(b) Terminate services, except records maintenance and payment processing:

(i) For the reasons stated under subsections (1)(c), (d), (e), (f), (g), (j), (k), (l), or (m) of this section; or

(ii) If the payee under the order fails to submit an application for support enforcement services.

(3) Sixty days before terminating services, the IV-D agency shall mail a notice to the physical custodian. The IV-D agency shall:

(a) Send the notice by regular mail to the last known address of the physical custodian;

(b) Include in the notice the reasons for terminating services; and

(c) State in the notice that the physical custodian may ask for a hearing to contest the decision terminating services.

(4) After terminating support enforcement services, the IV-D agency shall return support money the IV-D agency receives to the payor except as provided under subsection (2)(b) of this section.

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

WAC 388-14-425 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-14-430 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-14-435 Notice of support debt. (1) The IV-D agency may serve a notice of support debt on a responsible parent under RCW 74.20A.040 to provide notice that the IV-D agency is enforcing a court order or foreign administrative order for support.

(2) The IV-D agency shall serve a notice of support debt like a summons in a civil action or by certified mail, return receipt requested.

(3) In a notice of support debt, the IV-D agency shall include the information required by WAC 388-11-210, the amount of current and future support, accrued support debt, any health insurance coverage obligation, and any day care costs under the court or administrative order.

(4) The responsible parent must make all support payments after service of a notice of support debt to the Washington state support registry. The IV-D agency shall not credit payments made to any other party after service of a notice of support debt except as provided in WAC 388-11-015 or 388-11-280.

(5) A notice of support debt becomes final and subject to immediate wage withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW, subject to the terms of the order, unless, within twenty days of service of the notice in Washington, the responsible parent:

(a) Files a request with the IV-D agency for a conference board under WAC 388-14-285. The effective date of a conference board request is the date the IV-D agency receives the request;

(b) Obtains a stay from the superior court; or

(c) A notice of support debt served in another state becomes final according to WAC 388-14-496.

(6) Enforcement of the following are not stayed by a request for a conference board or hearing under this section or WAC 388-14-440:

(a) Current and future support stated in the order; and

(b) Any portion of the support debt that the responsible parent or payee under the order fail to allege is not owed.

(7) Following service of the notice of support debt on the responsible parent, the IV-D agency shall mail to the last known address of the payee under the order:

(a) A copy of the notice of support debt; and

(b) A notice to payee under WAC 388-14-440 regarding the payee's rights to contest the notice of support debt.

(8) If the responsible parent requests a conference board under subsection (5)(a) of this section, the IV-D agency shall mail a copy of the notice of conference board to the payee under the order informing the payee of the payee's right to:

(a) Participate in the conference board; or

(b) Request a hearing under WAC 388-14-440(3) within twenty days of the date of a notice of conference board that was mailed to a Washington address. If the notice of conference board was mailed to an out-of-state address, the payee may request a hearing within sixty days of the date of the notice of conference board. The effective date of a hearing request is the date the IV-D agency receives the request.

(9) If the payee requests a hearing under subsection (8) of this section, the IV-D agency shall:

(a) Stay enforcement of the notice of support debt except as required under subsection (6) of this section; and

(b) Notify the responsible parent of the hearing.

(10) If a payee requests a late hearing under subsection (8) of this section, the payee must show good cause for filing the late request.

(11) A notice of support debt shall fully and fairly apprise the responsible parent of the rights and responsibilities in this section.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-435, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-14-435, filed 2/10/93, effective 3/13/93; 91-09-018 (Order 3133), § 388-14-435, filed 4/9/91, effective 5/10/91.]

WAC 388-14-440 Notice to payee. (1) The IV-D agency shall send a notice to a payee under a court order or foreign administrative order for support when the IV-D agency receives proof of service on the responsible parent of:

(a) A notice of support owed under WAC 388-14-415; or

(b) A notice of support debt under WAC 388-14-435.

(2) The IV-D agency shall send the notice to payee by first class mail to the last known address of the payee and enclose a copy of the notice served on the responsible parent.

(3) In a notice to payee, the IV-D agency shall inform the payee of the right to file a request with the IV-D agency for a hearing on a notice of support owed under WAC 388-14-415 or a notice of support debt under WAC 388-14-435 within twenty days of the date of a notice to payee that was mailed to a Washington address.

(4) If the notice to payee was mailed to an out-of-state address, the payee may request a hearing within sixty days of the date of the notice to payee.

(5) The effective date of a hearing request is the date the IV-D agency receives the request.

(6) A hearing on a notice of support debt is for the limited purpose of determining the amount of accrued support debt through the date of the hearing under the order.

(7) The IV-D agency shall send a notice of hearing on a notice of support debt to the responsible parent and payee. The responsible parent may participate in the hearing as an independent party.

(8) If only one party appears and wishes to proceed with the hearing, the presiding officer shall hold a hearing and issue an initial decision based on the evidence presented or continue the hearing.

(a) An initial decision issued under this subsection shall include an order of default against the nonappearing party and limit the appeal rights of the nonappearing party to the record made at the hearing.

(b) If neither the responsible parent nor the payee appears or wishes to proceed with the hearing, the presiding officer shall issue an order of default against both parties.

(9) If the payee requests a late hearing under WAC 388-11-310 on a notice of support owed or a notice of support debt, the payee must show good cause for filing the late hearing request.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-440, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 91-09-018 (Order 3133), § 388-14-440, filed 4/9/91, effective 5/10/91.]

WAC 388-14-445 Notice of proposed settlement. (1) The IV-D agency shall send a notice of proposed settlement to a payee when the IV-D agency and the responsible parent sign an agreed settlement or consent order in cases where the support obligation is being set under a court order which does not specify a fixed dollar amount.

The IV-D agency shall send the notice of proposed settlement by first class mail to the last known address of the payee and enclose a copy of the agreed settlement or consent order.

(2) A proposed settlement becomes final according to this subsection.

(a) A proposed settlement under this section becomes final and subject to enforcement unless the payee, within twenty days of the date of a notice of proposed settlement that was mailed to a Washington address:

(i) Approves the proposed settlement; or

(ii) Files a request with the agency IV-D for a hearing on a notice of support owed under WAC 388-14-415 or a notice of support debt under WAC 388-14-435. The effective date of a hearing request is the date the IV-D agency receives the request.

(b) If the notice of proposed settlement was mailed to an out-of-state address, the payee may request a hearing within sixty days of the date of the notice of proposed settlement.

(3) The payee may not request a late hearing under WAC 388-11-310 on a notice of proposed settlement.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-445, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 91-09-018 (Order 3133), § 388-14-445, filed 4/9/91, effective 5/10/91.]

WAC 388-14-450 Debt adjustment notice. (1) The IV-D agency shall mail a debt adjustment notice to the payee under a court order within thirty days of the date the IV-D agency reduces the amount of the court-ordered support debt it intends to collect if that reduction was due to:

(a) A mathematical error in the debt calculation;

(b) A clerical error in the stated debt;

(c) Proof the support obligation should have been suspended for all or part of the time period involved in the calculation; or

(d) Proof the responsible parent made payments that had not previously been credited against the support debt.

(2) The debt adjustment notice shall state:

(a) The amount of the reduction;

(b) The reason the IV-D agency reduced the support debt, as provided under subsection (1) of this section;

(c) The name of the responsible parent and a statement that the responsible parent may attend and participate as an independent party in any hearing requested by the payee under this section; and

(d) The IV-D agency will continue to provide support enforcement services whether or not the payee objects to the debt adjustment notice.

(3) A debt adjustment notice becomes final under this subsection.

(a) A debt adjustment notice becomes final unless the payee, within twenty days of service of the notice in Washington, files a request with the IV-D agency for a hearing under subsection (4) of this section. The effective date of a hearing request is the date the IV-D agency receives the request.

(b) A debt adjustment notice served in another state becomes final according to WAC 388-14-496.

(4) A hearing under this section is for the limited purpose of determining if the IV-D agency correctly reduced the support debt as stated in the notice of debt adjustment.

(5) A payee who requests a late hearing under WAC 388-11-310 must show good cause for filing a late hearing request if it is filed more than one year after the date of the notice of debt adjustment.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-450, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 91-09-018 (Order 3133), § 388-14-450, filed 4/9/91, effective 5/10/91.]

WAC 388-14-460 Notice of intent to enforce—Health insurance coverage. (1) The IV-D agency may issue a notice of intent to enforce a responsible parent's obligation to provide health insurance coverage under a court or administrative order if the order:

(a) Requires the responsible parent to provide health insurance coverage or prove that coverage is not available; and

(b) Does not inform the parent that failure to provide coverage or prove that coverage is not available may result in direct enforcement of the order.

(2) The IV-D agency shall serve the notice on the responsible parent by certified mail, return receipt requested or by personal service.

(3) The IV-D agency shall state on the notice of intent to enforce that the responsible parent must submit proof of coverage, proof that coverage is not available, or proof that the parent has applied for coverage to the IV-D agency within twenty days of the date:

(a) Of service of the notice; or

(b) Health insurance coverage becomes available through the parent's employer or union.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-460, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 26.18.170 and 26.18.180. 92-13-026 (Order 3403), § 388-14-460, filed 6/9/92, effective 7/10/92.]

WAC 388-14-495 Registering an order from another state for enforcement or modification. (1) A support enforcement agency, or a party to a child support order or an income-withholding order for support issued by a tribunal of another state, may register the order in this state for enforcement pursuant to chapter 26.21 RCW.

(a) The order may be registered with the superior court pursuant to RCW 26.21.490 or it may be registered with the administrative tribunal according to subsection (2) of this section, at the option of the IV-D agency. Either method of registration shall be considered valid registration.

(b) A support order or income-withholding order issued in another state is registered when the order is filed with the registering tribunal of this state.

(c) A registered order issued in another state is enforceable in the same manner and is subject to the same procedures as an order issued by a tribunal of this state.

(2) The IV-D agency shall give notice to the nonregistering party when it administratively registers a support order or income-withholding order issued in another state.

(a) The notice must inform the nonregistering party:

(i) That a registered order is enforceable as of the date of registration in the same manner as an order issued by a tribunal of this state;

(ii) That a hearing to contest the validity or enforcement of the registered order must be requested within twenty days after the date of receipt by certified or registered mail or personal service of the notice given to a nonregistering party within the state and within sixty days after the date of receipt by certified or registered mail or personal service of the notice on a nonregistering party outside of the state;

(iii) That failure to contest the validity or enforcement of the registered order in a timely manner will result in confirmation of the order and enforcement of the order and the alleged arrearages and precludes further contest of that order with respect to any matter that could have been asserted; and

(iv) Of the amount of any alleged arrearages.

(b) The notice must be:

(i) Served by certified or registered mail or by any means of personal service authorized by the laws of the state of Washington; and

(ii) Accompanied by a copy of the registered order and any documents and relevant information accompanying the order submitted by the registering party.

(c) The effective date of a request for hearing to contest the validity or enforcement of the registered order is the date the IV-D agency receives the request.

(3) A hearing under this section is for the limited purpose of determining if the nonregistering party can meet the burden of proving one or more of the defenses enumerated in RCW 26.21.540(1).

(a) If the contesting party presents evidence establishing a full or partial defense under RCW 26.21.540(1), the presiding officer may:

(i) Stay enforcement of the registered order;

(ii) Continue the proceeding to permit production of additional relevant evidence; or

(iii) Issue other appropriate orders.

(b) An uncontested portion of the registered order may be enforced by all remedies available under the law of this state.

(c) If the contesting party does not establish a defense under RCW 26.21.540(1) to the validity or enforcement of the order, the presiding officer shall issue an order confirming the registered order.

(d) The physical custodian, or payee of the order, shall be a party to any hearing under this section.

(4) Confirmation of a registered order shall preclude further contest of the order with respect to any matter that could have been asserted at the time of registration. Confirmation may occur:

(a) By operation of law upon failure to contest registration; or

(b) By order of the presiding officer.

(5) A party or support enforcement agency seeking to modify, or to modify and enforce, a child support order issued in another state may register the order in this state according to RCW 26.21.560 through 26.21.580.

(a) The order shall be registered in the same manner provided in subsection (1)(a) if the order has not yet been registered.

(b) A petition for modification may be filed at the same time as a request for registration, or later. The petition must specify the grounds for modification.

(c) The IV-D agency may enforce a child support order of another state registered for purposes of modification, in the same manner as if the order had been issued by a tribunal of this state, but the registered order may be modified only if the requirements of RCW 26.21.580 have been met.

(6) Interpretation of the registered order shall be governed by RCW 26.21.510.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-495, filed 6/18/97, effective 7/19/97.]

WAC 388-14-496 Uniform Interstate Family Support Act—Notices served in another state. (1) The agency may serve the following legal actions in another state by certified mail, return receipt requested, under chapter 26.21 RCW:

(a) A notice of intent to distribute support money under WAC 388-14-271;

(b) A notice to recover a support payment under WAC 388-14-272;

(c) A notice of support owed under WAC 388-14-415;

(d) A notice of support debt under WAC 388-14-435;

(e) A notice to payee under WAC 388-14-440;

(f) A notice of proposed settlement under WAC 388-14-445.

(2) The agency may serve a distribution notice under WAC 388-14-274, a debt adjustment notice under WAC 388-14-450 or a total versus total notice under WAC 388-14-276 in another state by first class mail.

(3) A notice becomes final and, if applicable, subject to immediate wage withholding and enforcement without further notice if applicable under chapters 26.18, 26.23, and 74.20A RCW unless the recipient of the notice, within sixty days of service in another state:

(a) Contacts the IV-D agency and signs an agreed settlement; or

(b) Files a request for a hearing under the applicable section in subsection (1) of this section. The effective date of a hearing request is the date the IV-D agency receives the request.

(4) Administrative hearings on notices served in another state under this section may be conducted under the special rules of evidence and procedure in chapter 26.21 RCW.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-496, filed 6/18/97, effective 7/19/97.]

WAC 388-14-500 Oral requests for hearing. (1) Notwithstanding the requirement for a written request for hearing found in other sections of chapters 388-11 and 388-14 WAC, the IV-D agency shall accept an oral request for hearing from a person who wishes to contest any action taken by the IV-D agency for which a hearing right exists. If a person wishes to petition for modification of an existing administrative support order, or to petition for relief under WAC 388-14-376, the request for hearing must be in writing.

(2) The effective date of an oral hearing request is the date that a complete oral hearing request is communicated to any IV-D agency representative. An oral hearing request is deemed "complete" if it advises the IV-D agency of the following:

(a) Requestor's name;

(b) Identifying information such as requestor's social security number, case number, or names of the children and of the physical custodian;

(c) Requestor's mailing address;

(d) Requestor's daytime phone number, if available;

(e) Agency action to which the requestor is objecting; or

(f) Other pertinent information that would assist the IV-D agency in identifying the specific case or cases involved in the hearing request.

(3) An oral request for hearing may be left on the hearing request voice mail box of the automated phone system of each IV-D agency field office.

(4) The IV-D agency will process incomplete requests when the appellant provides adequate information to identify the appellant's case.

(5) The IV-D agency will process an oral hearing request in the same manner as a written hearing request. If the IV-D agency determines that an oral hearing request deals with matters that are properly before the conference board under WAC 388-14-385, the agency shall process that request as a request for conference board, absent a specific request for administrative hearing under chapter 34.05 RCW.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-500, filed 6/18/97, effective 7/19/97.]

Chapter 388-15 WAC
SOCIAL SERVICES FOR FAMILIES, CHILDREN AND ADULTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-15-010 Definition of service goals. [Statutory Authority: RCW 74.08.090. 81-20-063 (Order 1708), § 388-15-010, filed 10/5/81; 78-09-098 (Order 1335), § 388-15-010, filed 9/1/78; Order 1238, § 388-15-010, filed 8/31/77; Order 1088, § 388-15-010, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-15-020 Eligible persons. [Statutory Authority: RCW 74.12.340. 87-22-091 (Order 2552), § 388-15-020, filed 11/4/87. Statutory Authority: RCW 74.08.090. 81-18-045 (Order 1697), § 388-15-020, filed 8/28/81; 81-10-013 (Order 1645), § 388-15-020, filed 4/27/81; 81-01-087 (Order 1581), § 388-15-020, filed 12/19/80; 80-02-049 (Order 1477), § 388-15-020, filed 1/16/80; 79-01-041 (Order 1360), § 388-15-020, filed 12/21/78; 78-09-098 (Order 1335), § 388-15-020, filed 9/1/78. Statutory Authority: RCW 43.20A.550. 78-04-004 (Order 1276), § 388-15-020, filed 3/2/78; Order 1238, § 388-15-020, filed 8/31/77; Order 1204, § 388-15-020, filed 4/1/77; Order 1171, § 388-15-020, filed 11/24/76; Order 1147, § 388-15-020, filed 8/26/76; Order 1124, § 388-15-020, filed 6/9/76; Order 1120, § 388-15-020, filed 5/13/76; Order 1088, § 388-15-020, filed 1/29/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-15-110 Information and referral services. [Statutory Authority: RCW 74.08.090. 84-15-059 (Order 2125), § 388-15-110, filed 7/18/84; 82-11-095 (Order 1811), § 388-15-110, filed 5/19/82; Order 1238, § 388-15-110, filed 8/31/77; Order 1088, § 388-15-110, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-15-190 Day care for the aged—Age 60 and over. [Order 1238, § 388-15-190, filed 8/31/77; Order 1088, § 388-15-190, filed 1/19/76.] Repealed by 97-18-052, filed 8/28/97, effective 9/28/97. Statutory Authority: RCW 74.08.090 and 1997 c 409 § 209.

388-15-192 Long-term care services—Estate recovery procedures. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-192, filed 9/28/95, effective 10/29/95.] Repealed by 97-18-052, filed 8/28/97, effective 9/28/97. Statutory Authority: RCW 74.08.090 and 1997 c 409 § 209.

388-15-340 Alcoholism treatment. [Order 1238, § 388-15-340, filed 8/31/77; Order 1088, § 388-15-340, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-15-500 Redetermination of service eligibility. [Order 1238, § 388-15-500, filed 8/31/77; Order 1088, § 388-15-500, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-15-550 Service delivery. [Order 1238, § 388-15-550, filed 8/31/77; Order 1147, § 388-15-550, filed 8/26/76; Order 1124, § 388-15-550, filed 6/9/76; Order 1088, § 388-15-550, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-15-580 Support services. [Order 1238, § 388-15-580, filed 8/31/77.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-15-010 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-020 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-110 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-120 Adult protective services. (1) **Authority.** The authority for adult protective services is:

(a) 42 U.S.C. 1397 for adults in need of protection;

(b) 42 U.S.C. 3058, for programs for prevention of elder abuse, neglect, and exploitation;

(c) Chapter 74.34 RCW for frail elders and vulnerable adults;

and

(d) Chapter 26.44 RCW for adult dependent and developmentally disabled persons.

(2) **Goals.** The department shall:

(a) Limit adult protective services goals to those specified under WAC 388-15-010 (1)(c), (d), and (e) and 388-15-010(2); and

(b) Help prevent, correct, improve, or remedy situations of abuse, abandonment, exploitation, or neglect by providing adult protective services to eligible clients as defined under chapter 26.44 RCW and RCW 74.34.020.

(3) **Definitions.** The department shall use the following definitions when intervening to protect frail elderly and vulnerable adults:

(a) **"Abandonment"** means action or inaction by a person or entity with a duty of care for a frail elder or vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care (RCW 74.34.020);

(b) **"Abuse"** means a nonaccidental act of physical or mental mistreatment or injury, or sexual mistreatment, which harms a person through action or inaction by another individual (RCW 74.34.020);

(c) **"Adult protective services evaluation"** is the term used to describe the action taken to determine if further investigation is necessary when a report of self-neglect is received;

(d) **"Basic necessities of life"** means food, water, shelter, clothing, and medically necessary health care, including but not limited to health-related treatment or activities, hygiene, oxygen, and medication;

(e) **"Consent"** means express written consent granted after the person has been fully informed of the nature of the services to be offered and that the receipt of services is voluntary (RCW 74.34.020);

(f) **"Exploitation"** means the illegal or improper use of a frail elder or vulnerable adult or that person's income or resources, including trust funds, for another person's profit or advantage (RCW 74.34.020);

(g) **"Frail elder or vulnerable adult"** shall have the same meaning as the definition in RCW 74.34.020. Frail elder and vulnerable adults include a person:

(i) Sixty years of age and older who has the functional, mental, and physical inability to care for himself or herself;

(ii) Found incapacitated under chapter 11.88 RCW;

(iii) Who has a developmental disability under chapter 71.A.10 RCW;

(iv) Admitted to any long-term care facility that is licensed or required to be licensed under chapter 18.20, 18.51, 72.36, or 70.128 RCW; or

(v) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 7.127 RCW;

(h) **"Neglect"** means a pattern of conduct or inaction by a person or entity with a duty of care for a frail elder or vulnerable adult that results in the deprivation of care necessary to maintain the vulnerable person's physical or mental health (RCW 74.34.020); this may include **"self-neglect"** which means the failure to provide for oneself the goods or services necessary to avoid physical harm, emotional harm, or medical harm. This definition excludes a person who is competent to make a voluntary decision to live his or her life in a manner which may threaten his or her safety or well-being;

(i) **"Mental mistreatment"** means any nonaccidental act of mental or emotional pain or distress or both through action or inaction by another individual. Examples include, but are not limited to intimidation, coercion, ridiculing, harassment, treating an adult like a child, isolating an adult from family, friends, or regular activity, use of silence to control behavior, and yelling and swearing which result in mental distress;

(j) **"Person or entity with a duty of care"** includes, but is not limited to, the following:

(i) A guardian appointed under chapter 11.88 RCW; or

(ii) A person or entity providing the basic necessities of life to frail elder or vulnerable adults where:

(A) The person or entity is employed by or on behalf of the frail elder or vulnerable adult; or

(B) The person or entity voluntarily agrees to provide, or has been providing, the basic necessities of life to the frail elder or vulnerable adult on a continuing basis;

(k) **"Physical abuse"** means any nonaccidental infliction of bodily injury or physical mistreatment. Examples include, but are not limited to striking (with or without an object), slapping, pinching, choking, kicking, shoving, or inappropriate use of drugs or physical restraints;

(l) **"Sexual mistreatment"** means any form of nonconsensual sexual contact. Sexual mistreatment includes, but is not limited to unwanted touching, rape, sodomy, coerced nudity, sexual explicit photographing.

(4) **Eligibility**. Prior to investigating or providing services:

(a) The department shall determine when an adult protective service situation exists.

(b) The department shall conduct investigations without regard to the income of the frail elder or vulnerable adult.

(c) The client shall be the frail elder or vulnerable adult as defined in subsection (3) of this section.

(d) The frail elder or vulnerable adult client shall:

(i) Exhibit evidence of abuse (physical abuse, mental mistreatment, or sexual mistreatment), abandonment, exploitation, or neglect as defined in subsection (3) of this section; and

(ii) Have no other adult available, willing, or able to competently assist.

(e) The department may refuse to investigate reports which do not fit the definition of abuse, neglect, exploitation, abandonment or the definition of frail elder or vulnerable adult found in this chapter.

(5) **Investigation**.

(a) The department shall respond to reports of abuse, neglect, exploitation, or abandonment of frail elder or vulnerable adults. Response to a report may include, but is not limited to, referral to another entity for action; another entity may include, but is not limited to, law enforcement agency, mental health center, department of health, domestic violence program, residential care services, drug or alcohol treatment.

(b) Pursuant to chapter 26.44 RCW the department shall report an incident of abuse or neglect involving an adult dependent or developmentally disabled person who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means or who has been subjected to sexual abuse to the proper law enforcement agency.

(i) In emergency cases where the person's welfare is endangered the department shall notify law enforcement within twenty-four hours after receiving the report.

(ii) In all other cases the department shall notify law enforcement within seventy-two hours after receiving the report.

(6) **Support services**.

(a) The department shall provide services only with the written consent of the client after the client has been fully informed about the services and the client's right to refuse services.

(b) The department shall provide frail elders and vulnerable adults with chore personal care services and placement into a licensed and contracted adult family home or adult residential care facility without regard to income only:

(i) When the services are essential to, and a subordinate part of, the adult protective services plan; and

(ii) For a period not to exceed ninety days during any twelve-month period of time which is specified in WAC 388-15-209(5), 388-15-552(2), or 388-15-562(3).

(c) The department may seek the appointment of a guardian after all other alternatives have been explored and when it is apparent that the client may meet the criteria of incapacity pursuant to chapter 11.88 RCW.

(d) The department may provide assistance to a frail elder or vulnerable adult by filing a protective order as per chapters 10.14, 26.50, and 74.34 RCW, or as otherwise provided by law.

(e) The department may provide other services to protect the vulnerable adult.

[Statutory Authority: RCW 74.08.090, chapters 74.34 and 26.44 RCW and 42 USC 1397 and 3058. 97-21-108, § 388-15-120, filed 10/20/97, effective 11/20/97. Statutory Authority: RCW 74.08.090. 91-01-096 (Order 3116), § 388-15-120, filed 12/18/90, effective 1/18/91; 86-20-017 (Order 2426), § 388-15-120, filed 9/22/86; 85-13-059 (Order 2239), § 388-15-120, filed 6/18/85; 84-17-071 (Order 2141), § 388-15-120, filed 8/15/84; 80-16-025 (Order 1562), § 388-15-120, filed 10/30/80. Statutory Authority: RCW 43.20A.550. 78-04-004 (Order 1276), § 388-15-120, filed 3/2/78; Order 1238, § 388-15-120, filed 8/31/77; Order 1088, § 388-15-120, filed 1/19/76.]

WAC 388-15-134 Child protective services—Notification. (1) **Duty to notify**. The department shall notify the parent or legal custodian of a child when:

(a) The department is investigating a report alleging an act or acts of child abuse or neglect (CA/N); and

(i) Their child is alleged to be the victim; and/or

(ii) The department interviews a child alleged to be the victim of CA/N.

(b) The department takes a child into custody pursuant to a court order issued under RCW 13.34.050;

(c) The department receives custody of a child from law enforcement pursuant to RCW 26.44.050; and

(d) The department files a dependency petition.

(2) **Notification of noncustodial parents**.

(a) The department shall notify noncustodial parents when a child is taken into custody pursuant to RCW 26.44.050 or 13.34.050 and placed into the custody of the department, and

(b) Notification shall also occur when the department files a dependency petition.

(3) **Notification of alleged perpetrator**. The department shall notify the alleged perpetrator of the allegations of child abuse and neglect at the earliest point in the investigation that will not jeopardize the safety and protection of the child or the investigation process.

(4) **Notification contents**. Whenever a child is taken into custody under RCW 13.34.050 or 26.44.050, the notification required by this section shall comply with the requirement of RCW 26.44.120. The notification shall also include:

(a) A description of the department's action; and

(b) The reason or reasons for the department's actions.

(5) **Opportunity to review case information**. The department shall:

(a) Notify the person or persons legally responsible for the child of the address of the office where the case record information will be on file; and

(b) Provide them with the opportunity to read parts of the case record relating to the allegations, provided:

(i) They have requested access to the information, and

(ii) Such access is not otherwise prohibited by law.

(6) **Disclosure of case information**. The department shall not disclose case record information except as permitted under provisions of chapter 388-320 WAC and applicable statutes. The department shall not disclose the name and address of any referent who requests their identity be held in confidence. Even if disclosure is otherwise permissible, the department may refuse disclosure of the name and address of any victim.

(7) **Notification of CPS investigative findings.** Whenever the department completes an investigation of a child abuse or neglect report under chapter 26.44 RCW, the department shall notify the alleged perpetrator of the report and the department's investigative findings, whether founded, unfounded, or inconclusive. The notice shall also advise the person that:

(a) A written response to the report may be provided to the department and that such response will be filed in the record following receipt by the department;

(b) Information in the department's record may be considered in subsequent investigations or proceedings related to child protection or child custody;

(c) There is currently information in the department's record that may be considered in determining that the person is disqualified from being licensed to provide child care, employed by a licensed child care agency, or authorized by the department to care for children; and

(d) A person who has demonstrated a good faith desire to work in a licensed agency may request an informal meeting with the department to have an opportunity to discuss and contest the information currently in the record, pursuant to WAC 388-330-035(1).

(8) **Method of notification.** The notification required by this section shall be made by regular mail to the person's last known address, with a copy of the notice placed in the case file.

(9) **Limits of duty to notify**. The duty of notification created by this section shall be subject to the ability of the department to ascertain the location of the person to be notified. The department shall exercise reasonable, good-faith efforts to ascertain the location of persons entitled to notification under this section.

[Statutory Authority: RCW 74.15.030. 97-13-002, § 388-15-134, filed 6/4/97, effective 7/5/97; 89-07-024 (Order 2773), § 388-15-134, filed 3/8/89. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-15-134, filed 9/10/79; Order 1238, § 388-15-134, filed 8/31/77.]

WAC 388-15-190 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-192 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-196 Home and community services—Minimum qualifications for care providers in home and community settings. To protect the health and welfare of a long-term care service client receiving an AASA administered service, the adult client's care provider shall:

(1) Be eighteen years of age or older;

(2) Complete and submit a criminal history background inquiry form prescribed by the department;

(3) Possess the following minimum standards of knowledge and experience:

(a) General knowledge of acceptable standards of performance, including the necessity to perform dependably, report punctually, maintain flexibility, and to demonstrate kindliness and caring to the client;

(b) Knowledge of when and how to contact the client's representative and the client's case manager.

(4) Have the following required skills:

(a) Adequate skills to read, either directly or through an interpreter, understand and implement the client's service plan;

(b) Adequate communication skills to convey and understand either directly or through an interpreter information required to implement the client's written service plan and verbal instructions;

(c) Adequate skills to maintain provider records of services performed and payments received.

(5) Be able to:

(a) Understand specific directions for providing the care which the individual client requires;

(b) Observe the client for change in health status, including weakness, confusion, and loss of appetite;

(c) Identify problem situations and take appropriate action;

(d) Respond to emergencies without direct supervision;

(e) Perform authorized housework functions competently;

(f) Perform authorized direct personal care functions competently;

(g) Accept the client's individual differences and preferences when performing routine tasks; and

(h) Work independently and perform responsibly within the boundaries of the nonmedical personal care task limits.

(6)(a) Complete the department's fundamentals of caregiving training according to the following schedule:

(i) All in-home personal care providers hired on or after the effective date of this section shall successfully complete the department-designated fundamentals of caregiving training within one hundred twenty days of employment, unless he or she meets the requirements under (iii) or (iv) of this subsection or in subsection (6)(c) or (6)(f);

(ii) All in-home care providers hired prior to November 1, 1996 shall successfully complete the department designated fundamentals of caregiving training prior to October 31, 1997, unless he or she meets the requirements under (iii) or (iv) of this subsection or in subsection (6)(c) or (6)(f);

(iii) Natural, step, or adoptive parents hired as personal care providers for their division of developmental disabilities (DDD) adult children prior to the effective date of this section, will have until September 1, 1998 to complete the caregiving training;

(iv) Natural, step, or adoptive parents hired as personal care providers for their own adult children on or after the effective date of this section will have one hundred eighty days to complete the training requirements.

(b) Complete a minimum of ten hours of continuing education credits per calendar year, on topics relevant to caregiving unless he or she is a parent hired as a personal care provider for their own DDD adult child:

(i) Topics include, but are not limited to:

(A) Residents' rights;

(B) Personal care (such as transfers or skin care);

(C) Dementia;

(D) Mental illness;

(E) Developmental disabilities;

(F) Depression;

(G) Medication assistance;

(H) Communication skills;

(I) Alternatives to restraints; and

(J) Activities for clients.

(ii) Parent providers of their own DDD adult children are exempt from continuing education requirements;

(iii) Other caregivers are required to earn a certificate of completion to meet the requirement for continuing education credit and each hour of completed instruction will count as one hour of continuing education credit; and

(iv) The continuing education requirement begins the calendar year after the year in which the caregiver completes the fundamentals or modified fundamentals of caregiving training.

(c) The following providers are exempt from the fundamentals of caregiving training requirement in subsection (6)(a) of this section if the provider successfully completes the department designated modified fundamentals of caregiving training in accordance with the dates specified in subsection (6)(a) of this section.

(i) A provider who has successfully completed training as a registered or licensed practical nurse, a physical or occupational therapist, a certified nursing assistant, a Medicare-certified home health aide, or who has successfully completed department-approved adult family home training, or department-approved personal care training from an area agency on aging or their subcontractor.

(ii) A provider who has successfully completed the DDD staff training as required by chapter 275-26 WAC is exempt from the fundamentals of caregiving training in subsection (6)(a) of this section as long as the provider continues to work for a DDD-contracted agency. This exemption no longer applies if the provider leaves the DDD-contracted agency.

(iii) Parent hired as a personal care provider for their own DD adult child. This exemption no longer applies if the parent provides services to anyone who is not their own adult child.

(d) The provider shall provide documentation upon request that the provider has met the education and training requirements.

(e) The department shall not continue to authorize reimbursement for services rendered by a care provider who does not meet the educational requirement in subsection (6) of this section.

(f) All in-home personal care providers are exempt from attending the "fundamentals of caregiving" or "modified fundamentals of caregiving" training if they successfully pass the department's challenge test for the class they are required to take. The provider only has one opportunity to successfully pass the challenge test. If the provider does not pass the challenge test then he/she must attend the "fundamentals

of caregiving" or "modified fundamentals of caregiving" training as required.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.39A.005, 74.39A.007, 74.39A.050 and 74.39A.070. 97-16-106, § 388-15-196, filed 8/6/97, effective 9/6/97. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-196, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-196, filed 9/28/95, effective 10/29/95.]

WAC 388-15-202 Long-term care services—Definitions. The department shall use the definition in subsections (1) through (50) of this section for long-term care services. "Long-term care services" means the services administered directly or through contract by the aging and adult services administration of the department, including but not limited to nursing facility care and home and community services.

(1) "Aged person" means a person sixty-five years of age or older.

(2) "Agency provider" means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to a client in the client's own home.

(3) "Application" means a written request for medical assistance or long-term care services submitted to the department by the applicant, the applicant's authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant shall submit the request on a form prescribed by the department.

(4) "Assessment" means an inventory and evaluation of abilities and needs.

(5) "Attendant care" means the chore personal care service provided to a grandfathered client needing full-time care due to the client's need for:

(a) Assistance with personal care; or

(b) Protective supervision due to confusion, forgetfulness, or lack of judgment. Protective supervision does not include responsibilities a legal guardian should assume such as management of property and financial affairs.

(6) "Authorization" means an official approval of a departmental action, for example, a determination of client eligibility for service or payment for a client's long-term care services.

(7) "Available resources" is a term to describe a chore personal care client's assets accessible for use and conversion into money or its equivalent without significant depreciation in the property value.

(8) "Blind person" means a person determined blind as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

(9) "Categorically needy" means the financial status of a person as defined under WAC 388-503-0310.

(10) "Client" means an applicant for service or a person currently receiving services.

(11) "Community residence" means:

(a) The client's "own home" as defined in this section;

(b) Licensed adult family home under department contract;

(c) Licensed boarding home under department contract;

(d) Licensed children's foster home;

(e) Licensed group care facility, as defined in WAC 388-73-014(8); or

(f) Shared living arrangement as defined in this section.

(12) "Community spouse" means a person as described under WAC 388-513-1365 (1)(b).

(13) "Companionship" means the activity of a person in a client's own home to prevent the client's loneliness or to accompany the client outside the home for other than personal care services.

(14) "Contracted program" means services provided by a licensed and contracted home care agency or home health agency.

(15) "COPES" means community options program entry system.

(16) "Department" means the state department of social and health services.

(17) "Direct personal care services" means verbal or physical assistance with tasks involving direct client care which are directly related to the client's handicapping condition. Such assistance is limited to allowable help with the tasks of ambulation, bathing, body care, dressing, eating, personal hygiene, positioning, self-medication, toileting, transfer, as defined under WAC 388-15-202 (38)(a) through (e), (j) through (l), (n), and (o).

(18) "Disabled" means a person determined disabled as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

(19) "Disabling condition" means a condition which prevents a person from self-performance of personal care tasks without assistance.

(20) "Estate recovery" means the department's activity in recouping funds after the client's death which were expended for long-term care services provided to the client during the client's lifetime per WAC 388-15-192.

(21) "Grandfathered client" means a chore personal care services client approved for either:

(a) Attendant care services provided under the chore personal care program when these services began before April 1, 1988; and

(b) Family care services provided under the chore personal care program when these services began before December 14, 1987; and

(c) The client was receiving the same services as of June 30, 1989.

(22) "Home health agency" means a licensed:

(a) Agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence and reimbursed through the use of the client's medical identification card; or

(b) Home health agency, certified or not certified under Medicare, contracted and authorized to provide:

(i) Private duty nursing; or

(ii) Skilled nursing services under an approved Medicaid waiver program.

(23) "Household assistance" means assistance with incidental household tasks provided as an integral, but subordinate part of the personal care furnished directly to a client by and through the long-term care programs as described in this chapter. Household assistance is considered

an integral part of personal care when such assistance is directly related to the client's medical or mental health condition, is reflected in the client's service plan, and is provided only when a client is assessed as needing personal care assistance with one or more direct personal care tasks. Household assistance tasks include travel to medical services, essential shopping, meal preparation, laundry, housework, and wood supply.

(24) "Income" means "income" as defined under WAC 388-500-0005.

(25) "Individual provider" means a person employed by a community options program entry system (COPES) or Medicaid personal care client when the person:

(a) Meets or exceeds the qualifications as defined under WAC 388-15-196;

(b) Has signed an agreement to provide personal care services to a client; and

(c) Has been authorized payment for the services provided in accordance with the client's service plan.

(26) "Individual provider program (IPP)" means a method of chore personal care service delivery where the client employs and supervises the chore personal care service provider.

(27) "Institution" means an establishment which furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. "Institution" includes medical facilities, nursing facilities, and institutions for the mentally retarded, but does not include correctional institutions.

(28) "Institutional eligible client" means a person whose eligibility is determined under WAC 388-513-1315. "Institutionalized client" means the same as defined in WAC 388-513-1365(f).

(29) "Institutional spouse" means a person described under WAC 388-513-1365 (1)(e).

(30) "Medicaid" means the federal aid Title XIX program under which medical care is provided to:

(a) Categorically needy as defined under WAC 388-503-0310; and

(b) Medically needy as defined under WAC 388-503-0320.

(31) "Medical assistance" means the federal aid Title XIX program under which medical care is provided to the categorically needy as defined under WAC 388-503-0310 and 388-503-1105.

(32) "Medical institution" means an institution defined under WAC 388-500-0005.

(33) "Medically necessary" and "medical necessity" mean the same as defined under WAC 388-500-0005.

(34) "Medically oriented tasks" means direct personal care services and household assistance provided as an integral but subordinate part of the personal care and supervision furnished directly to a client.

(35) "Mental health professional" means a person defined under WAC 275-57-020(25).

(36) "Own home" means the client's present or intended place of residence:

(a) In a building the client rents and the rental is not contingent upon the purchase of personal care services as defined in this section; or

(b) In a building the client owns; or

(c) In a relative's established residence; or

(d) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services as defined in this section.

(37) "Personal care aide" means a person meeting the department's qualification and training requirements and providing direct Medicaid personal care services to a client. The personal care aide may be an employee of a contracted agency provider or may be an individual provider employed by the Medicaid personal care client.

(38) "Personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks and household tasks, as listed in subdivisions (a) through (q) of this subsection. Such services may be provided for clients who are functionally unable to perform all or part of such tasks or who are incapable of performing the tasks without specific instructions. Personal care services do not include assistance with tasks performed by a licensed health professional.

(a) "Ambulation" means assisting the client to move around. Ambulation includes supervising the client when walking alone or with the help of a mechanical device such as a walker if guided, assisting with difficult parts of walking such as climbing stairs, supervising the client if client is able to propel a wheelchair if guided, pushing of the wheelchair, and providing constant or standby physical assistance to the client if totally unable to walk alone or with a mechanical device.

(b) "Bathing" means assisting a client to wash. Bathing includes supervising the client able to bathe when guided, assisting the client with difficult tasks such as getting in or out of the tub or washing back, and completely bathing the client if totally unable to wash self.

(c) "Body care" means assisting the client with exercises, skin care including the application of nonprescribed ointments or lotions, changing dry bandages or dressings when professional judgment is not required and pedicure to trim toenails and apply lotion to feet. In adult family homes or in licensed boarding homes contracting with DSHS to provide assisted living services, dressing changes using clean technique and topical ointments must be delegated by a registered nurse in accordance with chapter 246-840 WAC. "Body care" excludes:

(i) Foot care for clients who are diabetic or have poor circulation; or

(ii) Changing bandages or dressings when sterile procedures are required.

(d) "Dressing" means assistance with dressing and undressing. Dressing includes supervising and guiding client when client is dressing and undressing, assisting with difficult tasks such as tying shoes and buttoning, and completely dressing or undressing client when unable to participate in dressing or undressing self.

(e) "Eating" means assistance with eating. Eating includes supervising client when able to feed self if guided, assisting with difficult tasks such as cutting food or buttering bread, and feeding the client when unable to feed self.

(f) "Essential shopping" means assistance with shopping to meet the client's health care or nutritional needs. Limited to brief, occasional trips in the local area to shop for food, medical necessities, and household items required specifical-

ly for the health, maintenance, and well-being of the client. Essential shopping includes assisting when the client can participate in shopping and doing the shopping when the client is unable to participate.

(g) "Housework" means performing or helping the client perform those periodic tasks required to maintain the client in a safe and healthy environment. Activities performed include such things as cleaning the kitchen and bathroom, sweeping, vacuuming, mopping, cleaning the oven, and defrosting the freezer, shoveling snow. Washing inside windows and walls is allowed, but is limited to twice a year. Assistance with housework is limited to those areas of the home which are actually used by the client. This task is not a maid service and does not include yard care.

(h) "Laundry" means washing, drying, ironing, and mending clothes and linens used by the client or helping the client perform these tasks.

(i) "Meal preparation" means assistance with preparing meals. Meal preparation includes planning meals including special diets, assisting clients able to participate in meal preparation, preparing meals for clients unable to participate, and cleaning up after meals. This task may not be authorized to just plan meals or clean up after meals. The client must need assistance with actual meal preparation.

(j) "Personal hygiene" means assistance with care of hair, teeth, dentures, shaving, filing of nails, and other basic personal hygiene and grooming needs. Personal hygiene includes supervising the client when performing the tasks, assisting the client to care for the client's own appearance, and performing grooming tasks for the client when the client is unable to care for own appearance.

(k) "Positioning" means assisting the client to assume a desired position, assistance in turning and positioning to prevent secondary disabilities, such as contractures and balance deficits or exercises to maintain the highest level of functioning which has already been attained and/or to prevent the decline in physical functional level. (Range of motion ordered as part of a physical therapy treatment is not included.)

(l) "Self-medication" means assisting the client to self-administer medications prescribed by attending physician. Self-medication includes reminding the client of when it is time to take prescribed medication, handing the medication container to the client, and opening a container.

(m) "Supervision" means being available to:

(i) Help the client with personal care tasks that cannot be scheduled, such as toileting, ambulation, transfer, positioning, some medication assistance; and

(ii) Provide protective supervision to a client who cannot be left alone because of impaired judgment.

(n) "Toileting" means assistance with bladder or bowel functions. Toileting includes guidance when the client is able to care for own toileting needs, helping client to and from the bathroom, assisting with bedpan routines, using incontinent briefs on client, and lifting client on and off the toilet. Toileting may include performing routine perineal care, colostomy care, or catheter care for the client when client is able to supervise the activities. In adult family homes or in licensed boarding homes contracting with DSHS to provide assisted living services colostomy care and catheterization using clean technique must be delegated by a registered nurse in accordance with chapter 246-840 WAC.

(o) "Transfer" means assistance with getting in and out of a bed or wheelchair or on and off the toilet or in and out of the bathtub. Transfer includes supervising the client when able to transfer if guided, providing steadying, and helping the client when client assists in own transfer. Lifting the client when client is unable to assist in their own transfer requires specialized training.

(p) "Travel to medical services" means accompanying or transporting the client to a physician's office or clinic in the local area to obtain medical diagnosis or treatment.

(q) "Wood supply" means splitting, stacking, or carrying wood for the client when the client uses wood as the sole source of fuel for heating and/or cooking. This task is limited to splitting, stacking, or carrying wood the client has at own home. The department shall not allow payment for a provider to use a chain saw or to fell trees.

(39) "Physician" means a doctor of medicine, osteopathy, or podiatry, as defined under WAC 388-500-0005.

(40) "Plan of care" means a "service plan" as described under WAC 388-15-205.

(41) "Property owned" means any real and personal property and other assets over which the client has any legal title or interest.

(42) "Provider" or "provider of service" means an institution, agency, or person:

(a) Having a signed department agreement to furnish long-term care client services; and

(b) Qualified and eligible to receive department payment.

(43) "Relative" means:

(a) For chore personal care service, a client's spouse, father, mother, son, or daughter;

(b) For Medicaid personal care service:

(i) "Legally responsible relative" means a spouse caring for a spouse or a biological, adoptive, or stepparent caring for a minor child.

(ii) "Nonresponsible relative" means a parent caring for an adult child and an adult child caring for a parent.

(44) "Service plan" means a plan for long-term care service delivery as described under WAC 388-15-205.

(45) "Shared living arrangement" for purposes of Medicaid personal care means an arrangement where:

(a) A nonresponsible relative as defined in (43)(b)(ii) above is the personal care provider and resides in the same residence with common facilities, such as living, cooking, and eating areas; or

(b) A minor child age seventeen or younger lives in the home of a legally responsible relative as defined in (43)(b)(i) above.

(46) "SSI-related" means a person who is aged, blind, or disabled.

(47) "Supervision" means a person available to a long-term care client as defined under WAC 388-15-202 (36)(m).

(48) "Supplemental Security Income (SSI)" means the federal program as described under WAC 388-500-0005.

(49) "Title XIX" is the portion of the federal Social Security Act which authorizes federal funding for medical assistance programs, e.g., nursing facility care, COPES, and Medicaid personal care home and community-based services.

(50) "Transfer of resources" means the same as defined under WAC 388-513-1365 (1)(g).

(51) "Unscheduled tasks" means ambulation, toileting, transfer, positioning, and unscheduled medication assistance as described in this chapter.

[Statutory Authority: RCW 74.09.520. 97-20-066, § 388-15-202, filed 9/25/97, effective 10/1/97. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-202, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-202, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.09.520, 74.39.005, 74.08.043 and 74.08.545. 93-06-042 (Order 3501), § 388-15-202, filed 2/24/93, effective 3/27/93.]

WAC 388-15-340 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-500 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-550 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-580 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-21 WAC
DIVERSITY INITIATIVE

WAC

388-21-005 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-21-005 Diversity initiative. [Statutory Authority: Chapter 49.60 RCW. 93-04-037 (Order 3499), § 388-21-005, filed 1/27/93, effective 2/27/93.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-21-005 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-43 WAC
DEAF AND HARD OF HEARING SERVICES

WAC

388-43-100 Repealed.

388-43-120 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-43-100 TRS advisory committee appointment. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-100, filed 12/30/93, effective 1/30/94.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-43-120 Policies for transition. [Statutory Authority: RCW 43.20A.725. 94-04-037 (Order 3700), § 388-43-120, filed 1/26/94, effective 2/26/94.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-43-100 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-43-120 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-45 WAC
THE STATE-FUNDED FOOD ASSISTANCE PROGRAM FOR LEGAL IMMIGRANTS

WAC

388-45-010 The state-funded food assistance program for legal immigrants.

WAC 388-45-010 The state-funded food assistance program for legal immigrants. (1) Legal immigrants are eligible for the state-funded federal food stamp program for legal immigrants if they:

(a) Meet the alien status requirements of the Food Stamp Act in effect prior to August 22, 1996; and

(b) Are ineligible for federal food stamps due to the immigrant provisions of P.L. 104-193, as amended.

(2) The state program provides the same amount of benefits as the federal food stamp program. Some households may receive both state and federal food stamp. The total benefits for any household cannot exceed the federal food stamp amount for that household size.

[Statutory Authority: RCW 74.04.050, 74.04.057 and 74.08.090. 97-20-124, § 388-45-010, filed 10/1/97, effective 11/1/97.]

Chapter 388-46 WAC
RECIPIENT FRAUD

WAC

388-46-110 Disqualification period for recipients convicted of unlawfully obtaining assistance.

388-46-120 Disqualification period for temporary assistance to needy families (TANF) applicants or recipients convicted of misrepresenting residence to obtain assistance in two or more states.

WAC 388-46-110 Disqualification period for recipients convicted of unlawfully obtaining assistance. (1) An applicant or recipient who has been convicted of unlawful practices in obtaining temporary assistance to needy families (TANF) or general assistance will be disqualified from receiving further TANF or general assistance benefits.

(2) For general assistance, the disqualification will apply only to convictions based on actions which occurred on or after July 23, 1995. For TANF, the disqualification will apply only to convictions based on actions which occurred on or after May 1, 1997.

(3) The length of the disqualification shall be for a period to be determined by the court, but in no event less than six months upon the first conviction and no less than twelve months for a second or subsequent violation.

(4) The disqualification applies only to the person convicted of unlawful practices.

(5) The disqualification period begins on the date the individual is convicted of unlawful practices related to obtaining assistance.

(6) The department shall terminate benefits to a recipient disqualified under this section following notice requirements specified under chapter 388-245 WAC. The department shall deny benefits to an applicant according to chapter 388-215 WAC for the duration of the disqualification period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.290 and Public Law 104-193, Section 103 (a)(1)(1996). 97-10-038, § 388-46-110, filed 4/30/97, effective 5/1/97. Statutory Authority: RCW 74.08.331, 74.08.290 and 1995 c 379. 95-19-003 (Order 3892), § 388-46-110, filed 9/6/95, effective 10/7/95.]

WAC 388-46-120 Disqualification period for temporary assistance to needy families (TANF) applicants or recipients convicted of misrepresenting residence to obtain assistance in two or more states. (1) An applicant or recipient of TANF will be disqualified from receiving further benefits under TANF if the individual is convicted in federal or state court of having made a fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from two or more states.

(2) For the purposes of determining the disqualification of an applicant or recipient under subsection (1) of this section, assistance is defined as receipt of benefits funded by the following:

(a) TANF and any other benefit authorized by Title IV-A of the Social Security Act;

(b) Any benefit authorized by The Food Stamp Act of 1997;

(c) Any benefit authorized by Title XIX, Medicaid; and

(d) Supplemental Security Income benefits authorized by Title XVI.

(3) The disqualification will apply only to convictions based on actions which occur on or after May 1, 1997.

(4) The length of the disqualification is ten years or the period determined by the court under WAC 388-46-110, whichever is longer.

(5) The disqualification applies only to the person convicted of fraud in a federal or state court.

(6) The disqualification period begins on the date the individual is convicted of having made fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from two states.

(7) The provisions of subsections (1) through (6) of this section do not apply to the conviction of an individual when the President of the United States has granted a pardon with respect to the conduct which was the subject of the conviction. The disregard of the provisions because of a pardon is effective the date the pardon is granted and continues for each month thereafter.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.290 and Public Law 104-193, Section 103 (a)(1)(1996). 97-10-038, § 388-46-120, filed 4/30/97, effective 5/1/97.]

Chapter 388-49 WAC
FOOD ASSISTANCE PROGRAMS

WAC

WAC 388-49-020 Definitions. "Able-bodied adults without dependents" means adults eighteen to fifty years of age who do not have any dependents and are mentally and physically able to work.

"Administrative disqualification hearing" means a formal hearing to determine whether or not a person committed an intentional program violation.

"Administrative error overissuance" means any overissuance caused solely by:

(1) Department action or failure to act when the household properly and accurately reported all the household's circumstances to the department; or

(2) Department failure to timely implement an intentional program violation disqualification; or

(3) For households determined categorically eligible under WAC 388-49-180(1), department action or failure to act which resulted in the household's improper eligibility for public assistance, provided a claim can be calculated based on a change in net food stamp income and/or household size.

"Administrative law judge" means an employee of the office of administrative hearings empowered to preside over adjudicative proceedings.

"Aid to families with dependent children (AFDC) program" means the federally funded public assistance program for dependent children and their families authorized under Title IV-A of the Social Security Act.

"Allotment" means the total value of coupons a household is certified to receive during a calendar month.

"Application process" means the filing and completion of an application form, interview or interviews, and verification of certain information.

"Authorized representative" means an adult nonhousehold member sufficiently aware of household circumstances designated, in writing, by the head of the household, spouse, or other responsible household member to act on behalf of the household.

"Beginning months" means the first month the household is eligible for benefits, and the month thereafter.

The first beginning month cannot follow a month in which a household was certified eligible to receive benefits.

"Benefit level" means the total value of food stamps a household is entitled to receive based on household income and circumstances.

"Boarder" means an individual residing with the household, except a person described under WAC 388-49-190 (2)(a), (b), or (c) who is a person:

(1) Paying reasonable compensation to the household for lodging and meals; or

(2) In foster care.

"Budget month" means the first month of the monthly reporting cycle; the month for which the household reports their circumstances.

"Certification period" means definite period of time within which the household has been determined eligible to receive food stamps.

"Child" means someone seventeen years of age or younger, and under parental control.

"Collateral contact" means oral contact in person or by telephone with someone outside of the household to confirm the household's circumstances.

"Commercial boarding home" means an enterprise offering meals and lodging for compensation with the intent of making a profit.

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

"Dependent care deduction" means costs incurred by a household member for care provided by a nonhousehold member when the care is necessary for a household member to seek, accept, or continue employment, or attend training or education preparatory to employment.

"Destitute household" means a household with a migrant or seasonal farmworker with little or no income at the time of application and in need of immediate food assistance.

"Disabled person" means a person who meets one of the following criteria:

(1) Receives Supplemental Security Income (SSI) under Title XVI of the Social Security Act;

(2) Receives disability or blindness payments under Titles I, II, XIV, or XVI of the Social Security Act;

(3) Is a veteran:

(a) With service-connected or nonservice-connected disability rated or paid as total under Title 38 of the United States Code (USC); or

(b) Considered in need of regular aid and attendance, or permanently housebound under Title 38 of the USC.

(4) Is a surviving:

(a) Spouse of a veteran and considered in need of aid and attendance, or permanently housebound; or

(b) Child of a veteran and considered permanently incapable of self-support under Title 38 of the USC;

(5) A surviving spouse or child of a veteran and:

(a) Entitled to compensation for service-connected death or pension benefits for a nonservice-connected death under Title 38 of the USC; and

(b) Has a disability considered permanent under section 221(i) of the Social Security Act.

(6) Receives disability retirement benefits from a federal, state, or local government agency because of a disability considered permanent under section 221(i) of the Social Security Act;

(7) Receives an annuity payment as part of the Railroad Retirement Act of 1974 under:

(a) Section 2 (a)(1)(iv) and is determined eligible to receive Medicare by the Railroad Retirement Board; or

(b) Section 2 (a)(1)(v) and is determined disabled based on the criteria under Title XVI of the Social Security Act.

(8) Is a recipient of disability-related medical assistance under Title XIX of the Social Security Act.

"Documentary evidence" means written confirmation of a household's circumstances.

"Documentation" means the process of recording the source, date, and content of verifying information.

"Elderly person" means a person sixty years of age or older.

"Eligible food" means:

(1) For a homeless food stamp household, meals prepared and served by an authorized homeless meal provider; or

(2) For a blind or a disabled resident, meals prepared and served by a group living arrangement facility.

"Entitlement" means the food stamp benefit a household received including a disqualified household member.

"Equity value" means fair market value less encumbrances.

"Expedited services" means providing food stamps within five calendar days to an eligible household which:

(1) Has liquid resources of one hundred dollars or less; and

(2) Has gross monthly income under one hundred fifty dollars; or

(3) Has combined gross monthly income and liquid resources which are less than the household's current monthly rent or mortgage and either the:

(a) Standard utility allowance as set forth in WAC 388-49-505; or

(b) Limited utility allowance; or

(c) Actual utility costs, whichever is higher; or

(4) Includes all members who are homeless individuals; or

(5) Includes a destitute migrant or seasonal farmworker.

"Fair hearing" means an adjudicative proceeding in which the presiding officer hears and decides an applicant/recipient's appeal from the department's action or decision.

"Fair market value" means the value at which a prudent person might sell the property if the person was not forced to sell.

"Fleeing felon" means a person who is:

(1) Fleeing to avoid prosecution, or custody or confinement after conviction, for a crime, or attempt to commit a crime, that is a felony under the law of the place from which the person is fleeing; or

(2) Violating a condition of probation or parole imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction.

"Food coupon" means any coupon, stamp, type of certificate, authorization card, cash or check issued in lieu of a coupon, or access device, including an electronic benefit transfer card or personal identification number.

"Food coupon authorization (FCA) card" means the document issued by the local or state office to authorize the allotment the household is eligible to receive.

"Food stamp monthly reporting cycle" means the three-month reporting cycle consisting of the budget month, the process month, and the payment month.

"Gross income eligibility standard" means one hundred thirty percent of the federal poverty level for the forty-eight contiguous states.

"Group living arrangement" means a public or private nonprofit residential setting which:

(1) Serves not more than sixteen blind or disabled residents as defined under WAC 388-49-020, **"disabled person"**; and

(2) Is certified by the appropriate state agency under section 1616(e) of the Social Security Act.

"Head of household" means the person designated by the household to be named on the case file, identification card, and FCA card.

"Home visit" means a personal contact at the person's residence by a department employee. The home visit shall be scheduled in advance with the household.

"Homeless individual" means a person lacking a fixed and regular nighttime residence or a person whose primary nighttime residence is a:

(1) Supervised shelter designed to provide temporary accommodations;

(2) Halfway house or similar institution providing temporary residence for persons needing or coming out of institutionalization;

(3) Temporary accommodation in the residence of another person for not more than ninety days; or

(4) Place not designed for, or ordinarily used as, a regular sleeping accommodation for humans.

"Homeless meal provider" means a public or private nonprofit establishment (for example, soup kitchen, temporary shelter, mission, or other charitable organizations) feeding homeless persons, approved by the division of assistance programs (DAP) and authorized by food and consumer service (FCS).

"Household" means the basic client unit in the food stamp program.

"Household disaster" means when food coupons, food purchased with food coupons, or food coupon authorization cards are destroyed by a natural disaster, such as flood, fire, etc.

"Identification card" means the document identifying the bearer as eligible to receive and use food stamps.

"Inadvertent household error overissuance" means any overissuance caused by either:

(1) Misunderstanding or unintended error by a household:

(a) Not determined categorically eligible under WAC 388-49-180(1); or

(b) Determined categorically eligible under WAC 388-49-180(1) if a claim can be calculated based on a change in net food stamp income and/or household size; or

(2) Social Security Administration action or failure to take action which resulted in the household's categorical eligibility, if a claim can be calculated based on a change in net food stamp income and/or household size.

"Ineligible household member" means the member excluded from the food stamp household because of:

(1) Disqualification for intentional program violation;

(2) Failure to apply for or provide a Social Security number;

(3) Failure to comply with work requirements as described under WAC 388-49-360;

(4) Status as an ineligible alien;

(5) Failure to sign the application attesting to the member's citizenship or alien status;

(6) Status as a fleeing felon; or

(7) Felony conviction involving possession, use, or distribution of a controlled substance occurring after August 21, 1996 unless the person is convicted of use or possession of a controlled substance and:

(a) Was determined chemically dependent by a state-certified assessment agency; and

(b) Is participating in or completed a rehabilitation plan consisting of chemical dependency treatment and vocational services; and

(c) Was not previously convicted of a felony for possession or use of a controlled substance within three years of the latest conviction.

"Initial month" means:

(1) The first month for which a household is issued an allotment; or

(2) The first month for which a household is issued an allotment following any period when the household was not certified due to expired eligibility or termination during a certification period; or

(3) For migrant and seasonal farmworker households, the first month for which the household is issued an allotment when applying more than one calendar month after a prior certification ends.

"Institution" means any place of residence (private or public) providing maintenance and meals for two or more persons.

"Institution of higher education" means any institution normally requiring a high school diploma or equivalency certificate for enrollment. This includes any two-year or four-year college. Also included is any course in a trade or vocational school that normally requires a high school diploma or equivalency for admittance to the course.

"Intentional program violation" means intentionally:

(1) Making a false or misleading statement;

(2) Misrepresenting, concealing, or withholding facts; or

(3) Committing any act constituting a violation of the Food Stamp Act, the food stamp program regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt, or possession of food stamp coupons or FCAs.

"Intentional program violation overissuance" means any overissuance caused by an intentional program violation.

"Live-in attendant" means a person residing with a household to provide medical, housekeeping, child care, or other similar personal services.

"Lump sum" means money received in the form of a nonrecurring payment including, but not limited to:

(1) Income tax refunds,

(2) Rebates,

(3) Retroactive payments, and

(4) Insurance settlements.

"Mandatory fees" means those fees charged to all students within a certain curriculum. Transportation, supplies, and textbook expenses are not uniformly charged to all students and are not considered as mandatory fees.

"Migrant farmworker" means a person working in seasonal agricultural employment who is required to be absent overnight from the person's permanent residence.

"Net income eligibility standard" means the federal income poverty level for the forty-eight contiguous states.

"Nonhousehold member" means a person who is not considered a member of the food stamp household such as a:

(1) Roomer;

(2) Live-in attendant;

(3) Ineligible student;

(4) Person who does not purchase and prepare meals with the food stamp household except for persons described under WAC 388-49-190(2); or

(5) Person eighteen through fifty years old without dependents who is no longer eligible for food stamps because of time limits.

"Nonstriker" means any person:

(1) Exempt from work registration the day before the strike for reasons other than their employment;

(2) Unable to work as a result of other striking employees, e.g., truck driver not working because striking newspaper pressmen not printing output;

(3) Not part of the bargaining unit on strike but not wanting to cross picket line due to fear of personal injury or death; or

(4) Unable to work because workplace is closed to employees by employer in order to resist demands of employees, e.g., a lockout.

"Offset" means reduce restored benefits by any overissue (claim) owed by the household to the department.

"Overissuance" means the amount of coupons issued to a household in excess of the amount eligible to receive.

"Overpayment" means the same as "overissuance" and shall be the preferred term used in procedures.

"Payment month" means the third month of the budget cycle; the month in which the food stamp allotment is affected by information reported on the monthly report for the budget month.

"Period of intended use" means the period for which an FCA or food coupon is intended to be used.

"Post secondary education" means a school not requiring a high school diploma or equivalency for enrollment. This includes trade school, vocational schools, business colleges, beauty schools, barber schools, etc.

"Principal wage earner" means the household member with the greatest source of earned income in the two months prior to the month of violation of employment and training and voluntary quit provisions, including members not required to register.

"Process month" means the second month of the monthly reporting cycle; the month in which the monthly report is to be returned by the household to the local office.

"Project area" means the county or similar political subdivision designated by the state as the administrative unit for program operations.

"Prospective budgeting" means the computation of a household's income based on income received or anticipated income the household and department are reasonably certain will be received during the month of issuance.

"Prospective eligibility" means the determination of eligibility based on prospective budgeting rules and other household circumstances anticipated during the month of issuance.

"Qualified alien" means an alien who, at the time the alien applies for or receives food stamps, is:

(1) An alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act,

(2) An alien who is granted asylum under section 208 of such Act,

(3) A refugee who is admitted to the United States under section 207 of such Act,

(4) An alien who is paroled into the United States under section 212 (d)(5) of such Act for a period of at least one year,

(5) An alien whose deportation is being withheld under section 243(h) of such Act,

(6) An alien who is granted conditional entry pursuant to section 203 (a)(7) of such Act as in effect prior to April 1, 1980, or

(7) An alien who or an alien whose child:

(a) Has been battered or subjected to extreme cruelty in the United States by a spouse, parent, or the family of the spouse or parent living in the same household and the U.S. Attorney General determines that there is a substantial connection between such battery or cruelty and the alien's need for benefits;

(b) Has a petition under the Violence Against Women Act for adjustment for immigration status approved or pending with Immigration and Naturalization Service; and

(c) Does not reside in the same household as the individual responsible for the battery or extreme cruelty.

"Quality control review" means a review of a statistically valid sample of cases to determine the accuracy of budgeting, issuance, denial, withdrawal, and termination actions taken by the department.

"Quality control review period" means the twelve-month period from October 1 of each calendar year through September 30 of the following calendar year.

"Recent work history" means being employed and receiving earned income in one of the two months prior to the payment month.

"Recertification" means approval of continuing benefits based on an application submitted prior to the end of the current certification period.

"Resident of an institution" means a person residing in an institution that provides the person with the majority of meals as part of the institution's normal service.

"Retrospective budgeting" means the computation of a household's income for a payment month based on actual income received in the corresponding budget month of the monthly reporting cycle.

"Retrospective eligibility" means the determination of eligibility based on retrospective budgeting rules and other circumstances existing in the budget month.

"Roomer" means a person to whom a household furnishes lodging, but not meals, for compensation.

"Seasonal farmworker" means a person working in seasonal agricultural employment who is not required to be absent overnight from the person's permanent residence.

"Shelter costs" means:

(1) Rent or mortgage payments plus taxes on a dwelling and property;

(2) Insurance on the structure only, unless the costs for insuring the structure and its contents cannot be separated;

(3) Assessments;

(4) Utility costs such as heat and cooking fuel, cooling and electricity, water, garbage, and sewage disposal;

(5) Standard basic telephone allowance;

(6) Initial installation fees for utility services; and

(7) Continuing charges leading to shelter ownership such as loan repayments for the purchase of a mobile home including interest on such payments.

"Shelter for battered women and children" means a public or private nonprofit residential facility serving battered women and children.

"Sibling" means a natural or an adopted brother, sister, half brother, half sister, or stepbrother or stepsister.

"Sponsor" means a person who executed an affidavit of support or similar agreement on behalf of an alien as a condition of the alien's admission into the United States as a permanent resident.

"Sponsored alien" means an alien lawfully admitted for permanent residence who has an affidavit of support or similar agreement executed by a person on behalf of the alien as a condition of the alien's admission into the United States as a permanent resident.

"Spouse" means:

(1) Married under applicable state law; or

(2) Living with another person and holding themselves out to the community as husband and wife by representing themselves as such to relatives, friends, neighbors, or trades people.

"Striker" means any person:

(1) Involved in a strike or concerted stoppage of work by employees including stoppage due to expiration of a collective bargaining agreement; or

(2) Involved in any concerted slowdown or other concerted interruption of operations by employees.

"Student" means any person:

(1) At least eighteen but less than fifty years of age;

(2) Physically and mentally fit for employment; and

(3) Enrolled at least half time in an institution of higher education.

"Systematic alien verification for entitlements (SAVE)" means the immigration and naturalization service (INS) program whereby the department may verify the validity of documents provided by aliens applying for food stamp benefits by obtaining information from a central data file.

"Temporary disability" means a nonpermanent physical illness or injury that incapacitates beyond the initial issuance month.

"Thrifty food plan" means the diet required to feed a family of four as determined by the United States Department of Agriculture. The cost of the diet is the basis for all allotments, taking into account the household size adjustments based on a scale.

"Under parental control" means living with any adult other than the parent. A person is not under parental control when that person is:

(1) Receiving an AFDC grant as the person's own payee; or

(2) Receiving, as the person's own payee, gross income equal to, or exceeding, the AFDC grant payment standard as described under WAC 388-250-1400(2).

"Vehicle" means any device for carrying or conveying persons and objects, including travel by land, water, or air.

"Vendor payment" means money payments not owed or payable directly to a household, but paid to a third party for a household expense, such as:

(1) A payment made in money on behalf of a household whenever another person or organization makes a direct payment to either the household's creditors or a person or organization providing a service to the household; or

(2) Rent or mortgage payments, made to landlords or mortgagees by the department of housing and urban development or by state or local housing authorities.

"Verification" means the use of documentation or third-party information to establish the accuracy of statements on the application. Sources of verification shall be documentary evidence, collateral contacts, or a home visit.

[Statutory Authority: RCW 74.05.510, Public Law 104-193 (1996), sections 115 and 824, and EHB 3901 (1997), section 101 of 55th legislature. 97-16-046, § 388-49-020, filed 7/31/97, effective 8/1/97. Statutory Authority: RCW 74.04.510, P.L. 104-193 and Sections 803, 821 and 824 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 97-06-096, § 388-49-020, filed 3/4/97, effective 4/4/97. Statutory Authority: RCW 74.04.510. 96-23-022, § 388-49-020, filed 11/12/96, effective 1/1/97. Statutory Authority: RCW 74.04.050. 96-06-031 (Order 3947), § 388-49-020, filed 2/29/96, effective 4/1/96; 95-19-013 (Order 3894), § 388-49-020, filed 9/7/95, effective 10/6/95. Statutory Authority: RCW 74.04.050, 74.04.510, 7 CFR 273.9(c) and 7 CFR 273.1(b). 95-06-028 (Order 3840), § 388-49-020, filed 2/22/95, effective 4/1/95. Statutory Authority: RCW 74.04.050, Administrative Notice 94-34 and Public Law 101-624 Section 1725. 94-20-042 (Order 3787), § 388-49-020, filed 9/28/94, effective 10/29/94. Statutory Authority: RCW 74.04.050. 94-16-038 (Order 3757), § 388-49-020, filed 7/27/94, effective 9/1/94. Statutory Authority: RCW 74.04.510 and 7 CFR 271.2. 93-11-041 (Order 3551), § 388-49-020, filed 5/12/93, effective 7/1/93. Statutory Authority: RCW 74.04.050. 92-11-059 (Order 3390), § 388-49-020, filed 5/19/92, effective 6/19/92. Statutory Authority: RCW 74.04.510. 91-16-065 (Order 3224), § 388-49-020, filed 8/1/91, effective 9/1/91; 91-10-096 (Order 3170), § 388-49-020, filed 5/1/91, effective 6/1/91; 90-12-057 (Order 3015), § 388-49-020, filed 5/31/90, effective 7/1/90; 89-18-035 (Order 2854), § 388-49-020, filed 8/29/89, effective 9/29/89; 89-07-001 (Order 2770), § 388-49-020, filed 3/2/89. Statutory Authority: RCW 74.04.050. 88-16-081 (Order 2662), § 388-49-020, filed 8/2/88. Statutory Authority: RCW 74.04.510. 88-08-080 (Order 2618), § 388-49-020, filed 4/6/88. Statutory Authority: RCW 74.04.050. 88-02-031 (Order 2575), § 388-49-020, filed 12/31/87.]

WAC 388-49-160 Certification periods. The department shall certify households:

(1) Receiving assistance to coincide with the assistance review or to the end of the assistance period, whichever is earlier;

(2) Consisting of migrants up to three months;

(3) Without earned income in which all members are disabled or all members are disabled or elderly for up to twelve months;

(4) Without earned income in which all members are elderly for up to twenty-four months;

(5) With little likelihood of change for six months;

(6) Reporting monthly with earned income for up to twelve months;

(7) Reporting monthly with recent work history for up to six months; and

(8) All other households for up to three months.

[Statutory Authority: RCW 74.04.510 and 7 CFR 273.10 (f)(2). 97-09-030, § 388-49-160, filed 4/10/97, effective 5/11/97. Statutory Authority: RCW 74.04.050 and 7 CFR 273.10 (f)(2). 96-14-074 (Order 3987), § 388-49-160, filed 6/28/96, effective 8/1/96. Statutory Authority: RCW 74.04.050 and Waiver to 7 CFR 273.10 (f)(6). 95-06-030 (Order 3841), § 388-49-160, filed 2/22/95, effective 4/1/95. Statutory Authority: RCW 74.04.050. 88-02-031 (Order 2575), § 388-49-160, filed 12/31/87.]

WAC 388-49-190 Household concept. (1) The department shall consider the following as households:

(a) A person living alone;

(b) Persons living together and purchasing or preparing meals together; or

(c) A permanently disabled and elderly person unable to prepare meals provided the:

(i) Person's spouse shall be included in the household; and

(ii) Income of other individuals, except the person's spouse, living with the person does not exceed one hundred sixty-five percent of the poverty level.

(2) The department shall consider the following as households regardless of the purchase and prepare arrangements:

(a) Parents and their natural, adoptive, or stepchildren twenty-one years of age or younger.

(b) Person seventeen years of age or younger under parental control of an adult other than their parent, and the adult who is maintaining the control; or

(c) Spouses who live together.

(3) The department shall consider the following persons living with the household as nonhousehold members who, if otherwise eligible, may qualify as a separate household:

(a) Roomers;

(b) Live-in attendants; or

(c) Persons sharing living quarters with the household who purchase food and prepare meals separately from the household.

(4) The department shall consider the following persons living with the household as ineligible household members:

(a) Persons disqualified for intentional program violation;

(b) Persons disqualified because of noncompliance with work requirements as described under WAC 388-49-360;

(c) Persons who are ineligible aliens;

(d) Persons disqualified for failure to apply for or provide a Social Security number;

(e) Persons who fail to sign the application attesting to their citizenship or alien status;

(f) Fleeing felons; or

(g) Persons convicted of a felony involving possession, use, or distribution of a controlled substance occurring after August 21, 1996 unless the person is convicted of use or possession of a controlled substance and:

(i) Was determined chemically dependent by a state-certified assessment agency; and

(ii) Is participating in or completed a rehabilitation plan consisting of chemical dependency treatment and vocational services; and

(iii) Was not previously convicted of a felony for possession or use of a controlled substance within three years of the latest conviction.

[Statutory Authority: RCW 74.04.510, Public Law 104-193 (1996), section 115, and EHB 3901 (1997), section 101 of 55th legislature. 97-16-045, § 388-49-190, filed 7/31/97, effective 8/1/97. Statutory Authority: RCW 74.04.510 and Public Law 104-193, Section 115 (1996). 97-09-031, § 388-49-190, filed 4/10/97, effective 7/1/97. Statutory Authority: RCW 74.04.510, Public Law 104-193 and Sections 803 and 821 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 96-22-103, § 388-49-190, filed 11/6/96, effective 12/7/96. Statutory Authority: RCW 74.04.050 and 74.04.510. 95-12-001 (Order 3854), § 388-49-190, filed 5/24/95, effective 6/24/95. Statutory Authority: RCW 74.04.050, 74.04.510, P.L. 103-66, Administrative Notice 94-39 and 7 CFR 273.1(b). 95-06-027 (Order 3838), § 388-49-190, filed 2/22/95, effective 4/1/95. Statutory Authority: RCW 74.04.050, P.L. 103-66 and USDA Food and Nutrition Service Administrative Notices 94-01, 94-02 and 94-03. 94-16-039 (Order 3762), § 388-49-190, filed 7/27/94, effective 9/1/94. Statutory Authority: RCW 74.04.510. 91-10-098 (Order 3172), § 388-49-190, filed 5/1/91, effective 6/1/91; 90-14-064 (Order 3033), § 388-49-190, filed 6/29/90, effective 8/1/90; 89-07-001 (Order 2770), § 388-49-190, filed 3/2/89. Statutory Authority: RCW 74.04.050. 88-16-081 (Order 2662), § 388-49-190, filed 8/2/88; 88-02-031 (Order 2575), § 388-49-190, filed 12/31/87.]

WAC 388-49-310 Citizenship and alien status. (1) Eligible household members in the food stamp program must either be U.S. citizens, U.S. nationals, or qualified aliens as specified by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended.

(2) Applicants and recipients who fail to meet the requirements of subsection (1) of this section shall be considered ineligible household members in accordance with the Code of Federal Regulations at 7 CFR 273.1(b) and at 7 CFR 273.4 (b), (c), (d), and (e).

[Statutory Authority: RCW 74.04.510, Sections 5302 and 5306 of the Balanced Budget Act of 1997 and Public Law 104-193. 97-22-042, § 388-49-310, filed 10/31/97, effective 12/1/97. Statutory Authority: RCW 74.04.510 and Section 510 of Public Law 104-208 (1996). 97-12-025, § 388-49-310, filed 5/29/97, effective 6/29/97. Statutory Authority: RCW 74.04.510 and section 402 of HR 3734 (P.L. 104-193) (1996). 97-06-074, § 388-49-310, filed 2/28/97, effective 3/31/97. Statutory Authority: RCW 74.04.050. 92-14-030 (Order 3409), § 388-49-310, filed 6/23/92, effective 7/24/92; 91-11-019 (Order 3177), § 388-49-310, filed 5/7/91, effective 6/1/91. Statutory Authority: RCW 74.04.510. 89-16-106 (Order 2836), § 388-49-310, filed 8/2/89, effective 9/2/89; 89-07-001 (Order 2770), § 388-49-310, filed 3/2/89. Statutory Authority: RCW 74.04.050. 88-16-085 (Order 2666), § 388-49-310, filed 8/2/88; 88-02-031 (Order 2575), § 388-49-310, filed 12/31/87.]

WAC 388-49-355 Work requirements for able-bodied adults without dependents. (1) Except as provided in subsection (4) and (6) of this section, an individual shall not be eligible to participate in the food stamp program for more than three full months in the thirty-six month period beginning January 1, 1997 unless the individual fulfills one of the following requirements:

(a) Works at least twenty hours a week averaged monthly;

(b) Participates in and comply with the requirements of a work program for twenty hours or more per week; or

(c) Participates in a workfare program.

(2) A work program is defined as a program under:

(a) Job Training Partnership Act;

(b) Section 236 of the Trade Act of 1974; or

(c) A state-approved work program.

(3) The department shall exempt an individual from subsection (1) of this section who is:

(a) Under eighteen or over fifty years of age;

(b) Physically or mentally unfit for employment;

(c) A parent or other member of a household with responsibility for a dependent child under eighteen or an incapacitated person;

(d) A pregnant woman;

(e) Living in an exempt area approved by United States Department of Agriculture; or

(f) Otherwise exempt under food stamp employment and training as follows:

(i) Complying with the work requirements of the JOBS program;

(ii) Receiving unemployment compensation;

(iii) A student enrolled at least half time in any institution of higher education.

(iv) A regular participant in a drug addiction or alcoholic treatment and rehabilitation program; or

(v) Employed a minimum of thirty hours per week or receiving weekly earnings which equal the minimum hourly rate multiplied by thirty hours.

(4) An individual who is ineligible for food stamp program benefits because that individual has exhausted the three-month limit in subsection (1) of this section, shall regain eligibility by doing one of the following:

(a) Works eighty hours or more during a thirty-day period;

(b) Participates in and complies with a work program for eighty hours or more during a thirty-day period; or

(c) Participates in and complies with a workfare program.

(5) An individual who regains eligibility under subsection (4) of this section shall remain eligible as long as the individual meets the requirements of subsection (1) of this section.

(6) An individual who regains eligibility in subsection (4) of this section and subsequently loses employment or ceases participation in a work program or in workfare, shall continue to be eligible for an additional three consecutive months provided the individual is otherwise eligible. The consecutive three-month period begins the month following the date the individual first notifies the department the individual no longer meets the requirements of subsection (1) of this section.

(7) An individual shall not receive the additional benefits pursuant to subsection (6) of this section for more than a single three-month period in the thirty-six-month period.

[Statutory Authority: RCW 74.04.510. 97-03-035, § 388-49-355, filed 1/9/97, effective 2/9/97.]

WAC 388-49-360 Work registration and food stamp employment and training (FSE&T) program participation. (1) Unless exempt, the department shall register for work and require participation in the food stamp employment and training (FSE&T) program persons:

(a) Ages sixteen through fifty-nine with dependents;

(b) Ages sixteen and seventeen out of school, not heads-of-households; and

(c) Ages fifty-one through fifty-nine without dependents.

(2) Registration happens at certification and once every twelve months thereafter.

(3) The department shall exempt from work registration and participation in the FSE&T program persons who are:

(a) Sixteen and seventeen years of age who are not heads of households who are:

(i) Attending school; or

(ii) Enrolled in a program under temporary assistance for needy families (TANF), a program under Job Training Partnership Act (JTPA), a program under section 236 of the Trade Act of 1974, or other state or local employment and training programs at least half time;

(b) Physically or mentally unfit for employment;

(c) Responsible for the care of a dependent child under six years of age or of an incapacitated person;

(d) Applying for or receiving unemployment compensation (UC);

(e) Participating in an employment and training program under TANF;

(f) Employed or self-employed thirty hours or more per week, or receiving weekly earnings equal to the federal minimum wage, multiplied by thirty. This shall include migrant and seasonal farmworkers under contract or agreement with an employer;

(g) Enrolled as a student as defined in WAC 388-49-330; or

(h) Regularly participating in a drug addiction or alcoholic treatment and rehabilitation program.

(4) The department shall register for work and exempt from participation in the FSE&T program persons who:

(a) Participate in a refugee assistance program;

(b) Reside in an exempt area;

(c) Reside one hour or more travel distance from available FSE&T services;

(d) Do not have a mailing address or message telephone;

(e) Have a temporary incapacity expected to last sixty or more days; or

(f) Have dependent care needs that exceed the maximum amount payable by the department. The exemption shall continue until:

(i) A suitable program service is available; or

(ii) Circumstances change and monthly dependent care costs no longer exceed the department reimbursement limit.

(5) The department shall accept an applicant's statement concerning the employability of each member of the household unless the information is questionable. The department shall verify any claim for exemption the department determines questionable.

[Statutory Authority: RCW 74.04.510 and Section 6 of HR 3734 (Public Law 104-193) (1996). 97-09-012, § 388-49-360, filed 4/4/97, effective 5/5/97. Statutory Authority: RCW 74.01.510, 74.04.510, 7 CFR 273.7 (b)(1)(i), Public Law 103-66 Section 13922 and Administrative Notice 92-34. 94-22-030 (Order 3803), § 388-49-360, filed 10/26/94, effective 11/26/94. Statutory Authority: RCW 74.04.510. 89-19-025 (Order 2870), § 388-49-360, filed 9/12/89, effective 10/13/89. Statutory Authority: RCW 74.04.050. 88-02-031 (Order 2575), § 388-49-360, filed 12/31/87.]

WAC 388-49-362 Food stamp employment and training program responsibilities. The department shall require persons in the FSE&T program to:

(1) Comply with FSE&T program service requirements;

(2) Report to the department or service provider and participate as required;

(3) Provide information regarding employment status or availability for work as requested;

(4) Report when referred to an employer; and

(5) Accept a bona fide offer of suitable employment.

[Statutory Authority: RCW 74.04.510 and Section 6 of HR 3734 (Public Law 104-193) (1996). 97-09-012, § 388-49-362, filed 4/4/97, effective 5/5/97.]

WAC 388-49-364 Food stamp employment and training program services. (1) The department of social and health services shall administer the FSE&T program and provide FSE&T program services either directly or through a contracted service provider.

(2) Persons required to participate in the FSE&T program may receive one or more of the following services:

(a) Job search activities;

(b) General education development (GED) services; or

(c) English as a second language (ESL) services.

(3) A maximum level of participation shall not exceed one hundred twenty hours in a month. Hours of participation may include a combination of FSE&T services and hours worked for compensation (in cash or in kind).

(4) The department shall provide written information to FSE&T participants regarding:

(a) The FSE&T program;

(b) The grounds for disqualification;

(c) The disqualification penalties; and

(d) The provisions for ending a disqualification.

[Statutory Authority: RCW 74.04.510 and Section 6 of HR 3734 (Public Law 104-193) (1996). 97-09-012, § 388-49-364, filed 4/4/97, effective 5/5/97.]

WAC 388-49-366 Food stamp employment and training good cause. (1) The department shall determine if a person has good cause for refusing or failing to:

(a) Register for work; or

(b) Participate in the FSE&T program.

(2) The department may determine that a person has good cause for reasons including, but not limited to:

(a) Illness of the person;

(b) Illness of another household member requiring the presence of the member;

(c) A household emergency;

(d) The unavailability of transportation; or

(e) Lack of adequate dependent care for children six through twelve years of age.

[Statutory Authority: RCW 74.04.510 and Section 6 of HR 3734 (Public Law 104-193) (1996). 97-09-012, § 388-49-366, filed 4/4/97, effective 5/5/97.]

WAC 388-49-368 Food stamp employment and training disqualifications. (1) If a person refuses or fails to comply with work registration and participate in the FSE&T program without good cause as found in WAC 388-49-366(2), the department shall disqualify the noncompliant person. The department shall treat the disqualified person as an ineligible household member.

(2) Within twenty days of a determination of failure to comply the department shall determine whether good cause exists and, if not, provide notice to the person that contains:

(a) The particular act of noncompliance;

(b) The proposed period of disqualification;

(c) Notification that the person may re-apply at the end of the disqualification period; and

(d) Information describing the action the person may take to end the disqualification.

(3) The disqualification period shall be:

(a) For the first failure to comply, one month and until the failure to comply ceases;

(b) For the second failure to comply, three months and until the failure to comply ceases; and

(c) For the third or subsequent failure to comply, six months and until the failure to comply ceases.

(4) If a person becomes exempt under WAC 388-49-360(4), a disqualification ends when the person:

(a) Has served the one, three, or six month portion of the disqualification penalty; and

(b) Is registered for work.

(5) A person disqualified under TANF, unemployment compensation, or refugee assistance for failure to comply with requirements comparable to FSE&T requirements, is subject to FSE&T disqualification. If a comparable FSE&T program service requirement does not exist, the person shall lose exemption status as referenced under WAC 388-49-360 (3)(a)(ii), (d), (e) and (4)(a) and shall register for work.

(6) At the end of a disqualification period, a person may apply to re-establish eligibility.

(7) Each person has a right to a fair hearing to appeal a denial, reduction, or termination of benefits regarding:

(a) A determination of nonexempt status;

(b) Failure to register for work; or

(c) Noncompliance with FSE&T, or comparable program, participation requirements.

[Statutory Authority: RCW 74.04.510 and Section 6 of HR 3734 (Public Law 104-193) (1996). 97-09-012, § 388-49-368, filed 4/4/97, effective 5/5/97.]

WAC 388-49-369 Food stamp employment and training payments. (1) The department shall pay a person's actual expenses, up to the department limit, that are necessary for the person to participate in the FSE&T program. A person may receive payment for:

(a) Transportation related costs; and

(b) Dependent care costs for each dependent six through twelve years of age.

(2) Dependent care payments:

(a) Shall not be made for a dependent thirteen years of age or older unless the dependent is:

(i) Physically and/or mentally incapable of caring for himself or herself; or

(ii) Under court order.

(b) Shall not be made when any member in the food stamp household provides the dependent care; and

(c) Can not be claimed as an expense and used in calculating the dependent care deduction.

[Statutory Authority: RCW 74.04.510 and Section 6 of HR 3734 (Public Law 104-193) (1996). 97-09-012, § 388-49-369, filed 4/4/97, effective 5/5/97.]

WAC 388-49-380 Voluntary quit. (1) The department shall consider a person ineligible who:

(a) Voluntarily quits his or her most recent job without good cause if:

(i) The employment involved twenty hours or more per week or provided weekly earnings equivalent to the federal minimum wage by twenty hours;

(ii) The quit occurred within sixty days prior to application or any time thereafter; and

(iii) At the time of the voluntary quit, the [person] was required to register for work as provided under WAC 388-49-360 (with exception of subsection (3)(d) and (e) of this section), or the person is nonexempt under WAC 388-49-335; or

(b) Is an employee of the federal, state, or local government who participated in a strike against such government and is dismissed from his or her job because of participation in the strike.

(2) Good cause for voluntarily quitting employment includes the following:

(a) Circumstances included under WAC 388-49-366(2);

(b) The employment is unsuitable as defined under WAC 388-49-370;

(c) Discrimination by an employer based on age, race, sex, color, religious belief, national origin, political belief, marital status, or the presence of any sensory, mental, or physical disability or other reasons in RCW 49.60.180;

(d) Work demands or conditions rendering continued employment unreasonable, such as working without being paid on schedule;

(e) Acceptance by the person of employment or enrollment of at least half time in any recognized school, training program, or institution of higher education including fulfillment of the provisions under WAC 388-49-330, requiring the person to leave employment;

(f) Acceptance by any other household member of employment or enrollment at least half time in any recognized school, training program, or institution of higher education in another county or similar political subdivision requiring the household to move thereby requiring any other member to leave employment;

(g) Resignations by persons under sixty years of age recognized by the employer as retirement;

(h) Acceptance of a bona fide offer of employment of twenty hours or more a week or where the weekly earnings are equivalent to the federal minimum wage multiplied by twenty hours which, because of circumstances beyond the control of the person, subsequently either does not materialize or results in employment of twenty hours or less a week or weekly earnings of less than the federal minimum wage multiplied by twenty hours; and

(i) Leaving a job in connection with patterns of employment where workers frequently move from one employer to another, such as migrant farm labor or construction work.

(3) A household where a person voluntarily quits his or her most recent job shall not be ineligible if the circumstances of the employment involve:

(a) Changes in employment status resulting from reduced hours of employment while working for the same employer;

(b) Termination of a self-employment enterprise; or

(c) Resignation from a job at the demand of an employer.

(4) The person shall have primary responsibility for providing verification of good cause for voluntary quit. If the household and the department are unable to obtain verification, the department shall not deny the household access to the program.

(5) If a quit was without good cause, the person is disqualified:

(a) For the first quit, one month and until the person complies with subsection (7) of this section;

(b) For the second quit, three months and until the person complies with subsection (7) of this section; and

(c) For the third or subsequent quit, six months and until the person complies with subsection (7) of this section.

(6) For persons residing in exempt areas under WAC 388-49-360(4), a disqualification ends when a person:

(a) Has served the one, three, or six month portion of the disqualification penalty; and

(b) Complies with subsection (7)(a) of this section.

(7) The person may re-establish eligibility after the disqualification, if otherwise eligible, and the person:

(a) Secures new employment;

(b) In nonexempt areas, is participating in the food stamp employment and training program;

(c) Is participating in workfare; or

(d) Becomes exempt other than under WAC 388-49-360 (3)(d) and (e).

(8) If a disqualified person moves from the household and joins another household, the department shall consider the person as an ineligible household member of the new household for the remainder of the disqualification period.

[Statutory Authority: RCW 74.04.510 and Section 6 of HR 3734 (Public Law 104-193) (1996). 97-09-012, § 388-49-380, filed 4/4/97, effective 5/5/97. Statutory Authority: RCW 74.01.510, 74.04.510, 7 CFR 273.7 (b)(1)(i), Public Law 103-66 Section 13922 and Administrative Notice 92-34. 94-22-030 (Order 3803), § 388-49-380, filed 10/26/94, effective 11/26/94. Statutory Authority: RCW 74.04.510. 89-19-025 (Order 2870), § 388-49-380, filed 9/12/89, effective 10/13/89. Statutory Authority: RCW 74.04.050. 88-02-031 (Order 2575), § 388-49-380, filed 12/31/87.]

WAC 388-49-385 Food stamp workfare. (1) Workfare is a program available to persons eighteen through fifty years of age without dependents, that gives persons the opportunity to maintain eligibility for food stamp benefits.

(2) Workfare consists of:

(a) For the first month, job search activities or unpaid work with a public or private nonprofit agency; and

(b) Subsequent months, unpaid work with a public or private nonprofit agency.

(3) The department determines the hours that a person must participate in unpaid work with a public or private nonprofit agency.

(4) Workfare hours when added to compensated hours worked may not exceed thirty hours a week.

(5) The department shall pay for a person's actual expenses, up to the department limit, that are necessary for the person to participate in workfare.

[Statutory Authority: RCW 74.04.510 and Section 6 of HR 3734 (Public Law 104-193) (1996). 97-09-012, § 388-49-385, filed 4/4/97, effective 5/5/97.]

WAC 388-49-470 Income—Exclusions. (1) The department shall exclude the following income:

(a) Money withheld from an income source to repay a prior overpayment from that same income source except for money withheld to recoup an intentional noncompliance overpayment from a federal, state, or local means-tested program;

(b) Income specifically excluded by any federal statute from consideration as income in the food stamp program;

(c) The earned income of household members who are:

(i) Seventeen years of age or under; and

(ii) Attending elementary or secondary school at least half time.

(d) Infrequent or irregular income, received during a three-month period by a prospectively budgeted household, that:

(i) Cannot be reasonably anticipated as available; and

(ii) Shall not exceed thirty dollars for all household members.

(e) Loans, including those from private individuals and commercial institutions, other than educational loans where repayment is deferred;

(f) Nonrecurring lump sum payments;

(g) Income used for the cost of producing self-employment income;

(h) Educational assistance financed in whole or in part with Title IV funds or issued by the Bureau of Indian Affairs;

(i) Educational assistance to the extent such assistance is earmarked by the school or actually paid by the student for the following educational expenses:

(i) Tuition;

(ii) Mandatory fees, including rental or purchase of equipment, materials, and supplies related to pursuing the course of study;

(iii) Books;

(iv) Supplies;

(v) Transportation; and

(vi) Miscellaneous personal expenses.

(j) Reimbursements for past or future expenses to the extent the reimbursements do not:

(i) Exceed the actual expense; and

(ii) Represent a gain or benefit to the household.

(k) Any gain or benefit not in money;

(l) Vendor payments as defined in WAC 388-49-020;

(m) Money received and used for the care and maintenance of a third-party beneficiary who is not a household member;

(n) Supplemental payments or allowances made under federal, state, or local laws for the purpose of offsetting increased energy costs;

(o) Support payments owed to a household member, but specified by the support court order or other legally binding written support or alimony agreement to go directly to a third-party beneficiary rather than to the household;

(p) Support payments on behalf of a household member, not required by the support court order or other legally binding written support or alimony agreement and paid directly to a third party rather than to the household;

(q) Payments from the individual and family grant program;

(r) Public assistance payments:

(i) Over and above the regular warrant amount;

(ii) Not normally a part of the regular warrant; and

(iii) Paid directly to a third party on behalf of the household.

(s) From Jobs Training Partnership Act programs:

(i) Allowances; and

(ii) Earnings from on-the-job training by household members under parental control and eighteen years of age and younger.

(t) Cash donations based on need:

(i) Received directly by the household;

(ii) From one or more private, nonprofit, charitable organizations; and

(iii) Not exceeding three hundred dollars in any federal fiscal year quarter.

(u) Earned income credit;

(v) Governmental foster care payments received by households with foster care individuals who are considered to be boarders under WAC 388-49-020(10).

(2) When earnings or amount of work performed by a household member described in subsection (1)(c) of this section, cannot be differentiated from the earnings or work performed by other household members, the department shall:

(a) Prorate the earnings equally among the working members; and

(b) Exclude the household member's pro rata share.

(3) When the intended beneficiaries of a single payment for care and maintenance of a third-party beneficiary include both household members and persons not in the household, the department shall exclude:

(a) Any identifiable portion intended and used for the care and maintenance of the person out of the household; or

(b) The lesser of:

(i) The actual amount used from a single payment for the care of a person outside the household; or

(ii) A pro rata share of the single payment when the single payment does not identify the portion intended for the care of the person outside the household.

[Statutory Authority: RCW 74.04.510 and 7 U.S.C. 2014 (d) and (k). 97-05-002, § 388-49-470, filed 2/5/97, effective 3/8/97. Statutory Authority: RCW 74.04.510 and Section 807 and 808 of H.R. 3734 (Public Law 104-193). 96-22-100, § 388-49-470, filed 11/6/96, effective 12/7/96. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (c)(16). 94-22-029 (Order 3802), § 388-49-470, filed 10/26/94, effective 1/1/95. Statutory Authority: RCW 74.04.510, P.L. 103-66 (8-10-93) and 7 CFR 273.11(k). 94-16-074 (Order 3766), § 388-49-470, filed 7/29/94, effective 9/1/94. Statutory Authority: RCW 74.04.510 and 1992 § 479B. 93-17-032 (Order 3614), § 388-49-470, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (b)(5), (c)(2), and (c)(6). 92-22-051 (Order 3475), § 388-49-470, filed 10/28/92, effective 12/1/92. Statutory Authority: RCW 74.04.510 and Public Law 102-237. 92-11-063 (Order 3392), § 388-49-470, filed 5/19/92, effective 6/19/92. Statutory Authority: RCW 74.04.510. 92-03-119 (Order 3316), § 388-49-470, filed 1/21/92, effective 2/21/92; 91-06-004 (Order 3141), § 388- 49-470, filed 2/21/91, effective 3/24/91; 90-15-028 (Order 3040), § 388-49-470, filed 7/13/90, effective 8/13/90; 89-24-040 (Order 2911), § 388-49-470, filed 12/1/89, effective 1/1/90; 89-11-101 (Order 2800), § 388-49-470, filed 5/24/89; 88-21-096 (Order 2716), § 388-49-470, filed 10/19/88; 88-08-079 (Order 2617), §

388-49-470, filed 4/6/88. Statutory Authority: RCW 74.04.050. 88-02-031 (Order 2575), § 388-49-470, filed 12/31/87.]

WAC 388-49-505 Utility allowances. (1) The department shall:

(a) Establish the following utility allowances for use in calculating shelter costs:

(i) A standard utility allowance for households incurring any separate utility charges for heating or cooling costs;

(ii) A limited utility allowance for households, without heating or cooling costs, incurring any separate utility charges other than telephone costs; and

(iii) A telephone allowance for households incurring separate charges for phone service and not claiming the standard or limited utility allowance.

(b) Obtain food and consumer service approval of the methodology used to establish utility allowances.

(2) The standard utility allowance shall be two hundred twenty-three dollars.

(3) The limited utility allowance shall be one hundred sixty-four dollars.

(4) The telephone allowance shall be twenty-nine dollars.

[Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (2)(6)(vi) requires the state review and adjust the utility allowances each year. 97-18-086, § 388-49-505, filed 9/3/97, effective 10/1/97. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6)(v) and (vi). 96-22-101, § 388-49-505, filed 11/6/96, effective 12/7/96. Statutory Authority: RCW 74.04.050 and 7 CFR 273.9 (a), (d)(6)(v) and (vi), (5), (7) and (8). 95-21-052 (Order 3907), § 388-49-505, filed 10/11/95, effective 11/11/95. Statutory Authority: RCW 74.04.050 and 7 CFR 273.9 (d)(6)(vi). 95-11-121 (Order 3853), § 388-49-505, filed 5/24/95, effective 7/1/95. Statutory Authority: RCW 74.04.050 and 7 CFR 273.9 (d)(6)(v) and (vi). 94-17-174 (Order 3776), § 388-49-505, filed 8/24/94, effective 10/1/94. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6)(vi) and Letter of Approval from Food and Nutrition Services. 93-18-024 (Order 3626), § 388-49-505, filed 8/25/93, effective 10/1/93. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9(a). 92-22-055 (Order 3473), § 388-49-505, filed 10/28/92, effective 11/28/92. Statutory Authority: RCW 74.04.510. 91-08-013 (Order 3154), § 388-49-505, filed 3/26/91, effective 4/26/91; 89-23-083 (Order 2901), § 388-49-505, filed 11/17/89, effective 12/18/89; 88-23-085 (Order 2726), § 388-49-505, filed 11/18/88. Statutory Authority: RCW 74.04.050. 88- 04-042 (Order 2593), § 388-49-505, filed 1/28/88.]

WAC 388-49-640 Overissuances. (1) The department shall establish claims and take collection action against households and household members for administrative error, inadvertent household error, or intentional program violation resulting in overissuances except as provided in subsections (3), (10), and (11) of this section.

(2) The department shall establish an overissuance claim against any household:

(a) Receiving more food stamp benefits than it was entitled to receive; or

(b) Containing an adult member who was an adult member of another household receiving more benefits than it was entitled to receive.

(3) The department shall not establish an administrative error claim or an inadvertent household error claim if an overissuance occurred because:

(a) The department failed to ensure the household:

(i) Signed the application form;

(ii) Completed a current work registration form; or

(iii) Was certified in the correct project area.

(b) The household transacted an expired food coupon authorization (FCA) unless the household had altered the FCA.

(4) The department shall hold all persons who were adult members of the household at the time of the overissuance jointly and severally liable for the overissuance.

(a) The department shall establish an overissuance claim and pursue collection action against any or all of these persons.

(b) If the household composition changes, the department may establish an overissuance claim and pursue collection action against any household containing a person who was an adult member of the household receiving the overissuance.

(5) The department shall not collect more than the amount of the overissuance.

(6) The department shall not establish an:

(a) Administrative error overissuance unless the department has:

(i) Discovered the overissuance within twelve months of its occurrence; and

(ii) Calculated the overissuance and mailed the household a demand letter within twenty-four months of the overissuance discovery date.

(b) Inadvertent household error overissuance unless the department has:

(i) Discovered the overissuance within twenty-four months of its occurrence; and

(ii) Calculated the overissuance and mailed the household a demand letter within twenty-four months of the overissuance discovery date.

(c) Intentional program violation overissuance unless the department has:

(i) Discovered the overissuance within seventy-two months of its occurrence; and

(ii) Calculated the overissuance and mailed the household a demand letter within twenty-four months of the overissuance discovery date.

(7) Except as provided in subsection (9) of this section, the department shall determine the overissuance amount to be the difference between:

(a) The allotment actually authorized; and

(b) The allotment that should have been authorized.

(8) When determining the monthly allotment the household should have been authorized, the department shall:

(a) Count the actual income received by the household;

(b) Not apply the twenty percent earned income deduction to earned income which the household failed, without good cause, to report in a timely manner.

(9) The amount of the household's and/or household member's liability for an overissuance shall be the difference between:

(a) The amount of the overissuance; and

(b) Any lost benefits not previously restored or used as an offset.

(10) The department shall initiate collection action on all inadvertent household or administrative error claims unless:

(a) The claim is collected through offset;

(b) The administrative error claim is less than one hundred dollars;

(c) The inadvertent household error claim is less than thirty-five dollars;

(d) The department cannot locate the liable household; or

(e) The department determines collection action will prejudice an inadvertent household error claim case referred for possible prosecution or administrative disqualification.

(11) The department shall initiate collection action against the liable household whose member is found to have committed an intentional program violation unless:

(a) The household has repaid the overissuance;

(b) The department cannot locate the household; or

(c) The department determines collection action will prejudice the case against a household member referred for prosecution.

(12) The department shall initiate collection action by providing the household a demand letter.

(13) A household or household member may repay an overissuance by:

(a) A lump sum;

(b) Regular installments under a payment schedule agreed to by the household or household member and the department; and/or

(c) Allotment reduction.

(14) The department shall ensure a negotiated monthly installment amount is not less than the amount which could be recovered through allotment reduction when a currently participating household is liable for an inadvertent household error or an intentional program violation.

(15) A household member and/or the department may request the payment schedule be renegotiated.

(16) When allotment reduction is the method of collection, the department shall reduce a currently participating household's allotment to repay an:

(a) Inadvertent household error overissuance by the greater of:

(i) Ten percent of the household's monthly allotment; or

(ii) Ten dollars per month.

(b) Intentional program violation overissuance by the greater of:

(i) Twenty percent of the household's monthly entitlement; or

(ii) Ten dollars per month.

(c) Administrative error overissuance by the amount agreed to by the household.

(17) The department shall reduce the allotment to repay an inadvertent household error or an intentional program violation claim when:

(a) A household is liable for an inadvertent household error claim and fails to notify the department of their chosen repayment agreement or request a fair hearing and continued benefits within twenty days after receipt of the demand letter; or

(b) A household is liable for an intentional program violation claim and fails to inform the department of their chosen repayment agreement within ten days after receiving the demand letter; or

(c) After notification of failure to make payment according to a negotiated repayment schedule, the household member fails to:

(i) Make the overdue payments; or

(ii) Request renegotiation of the payment schedule.

(18) The department shall suspend collection action when:

(a) Collection action has not been initiated as provided in subsection (10) of this section;

(b) A liable household member cannot be located; or

(c) The cost of further collection action is likely to exceed the amount that can be recovered.

(19) The department may accept offers of compromise for overissuances when:

(a) The department has already established the account receivable for the overissuance and taken steps to recover the overissuance; and

(b) The amount offered approximates the net amount expected to be collected prior to the expiration of the collection period allowed by statute.

(20) The department shall write-off amounts from its account receivable records and release any applicable liens prior to the expiration of the collection period allowed by statute when there is:

(a) No further possibility of collection;

(b) An account receivable balance after payment of an accepted offer of compromise; or

(c) An account receivable balance after a claim has been in suspense for three consecutive years, as provided in subsection (19) of this section.

(21) The department may initiate collection action to satisfy a food stamp overissuance which occurred in another state when the department:

(a) Determines that the originating state does not intend to pursue collection in Washington state; and

(b) Receives the following from the originating state:

(i) Documentation of the overissuance computation;

(ii) Overissuance notice prepared for the client; and

(iii) Proof of service that the client received the overissuance notice.

[Statutory Authority: RCW 74.04.510. 97-04-024, § 388-49-640, filed 1/28/97, effective 2/28/97. Statutory Authority: RCW 74.04.050. 95-19-013 (Order 3894), § 388-49-640, filed 9/7/95, effective 10/6/95. Statutory Authority: RCW 74.04.510 and 7 CFR 273.18(1). 94-23-131 (Order 3810), § 388-49-640, filed 11/23/94, effective 1/1/95. Statutory Authority: RCW 74.04.510. 92-12-043 (Order 3396), § 388-49-640, filed 5/29/92, effective 7/1/92; 91-22-047 (Order 3278), § 388-49-640, filed 10/31/91, effective 12/1/91; 88-08-039 (Order 2610), § 388-49-640, filed 4/1/88. Statutory Authority: RCW 74.04.050. 88-02-031 (Order 2575), § 388-49-640, filed 12/31/87.]

WAC 388-49-670 Intentional program violations—Disqualification penalties. (1) The department shall disqualify the person or persons committing an intentional program violation as defined in WAC 388-49-020.

(2) The department shall apply the following disqualification penalties to a person committing an intentional program violation for offenses not related to those described in subsection (3) of this section:

(a) If the intentional program violation occurred in whole or in part after the household was notified of the following penalties:

(i) Twelve months for the first violation;

(ii) Twenty-four months for the second violation;

(iii) Permanently for the third violation.

(b) If the violation ended before the household was notified of the penalties in subsection (2)(a) of this section:

(i) Six months for the first violation;

(ii) Twelve months for the second violation;

(iii) Permanently for the third violation.

(3) The department shall apply disqualification penalties against a person for the following activities:

(a) A two-year disqualification penalty for a first conviction by a federal, state, or local court of the trading or receiving of food coupons for a controlled substance, as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802);

(b) A ten-year disqualification penalty for a person found to have made a fraudulent statement or misrepresented information respecting identity or residence in order to receive multiple coupon benefits simultaneously; or

(c) A permanent disqualification for:

(i) The second conviction by a federal, state, or local court of the trading or receiving of food coupons for a controlled substance as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802);

(ii) The first conviction by a federal, state, or local court of the trading or receiving of food coupons for firearms, ammunition, or explosives; or

(iii) The first conviction by a federal, state, or local court for knowingly buying, selling, trading, or presenting for redemption food coupons of five hundred dollars or more in violation of section 15 (b) and (c) of the Food Stamp Act of 1977, as amended.

(4) The department shall consider multiple violations as only one disqualification when the violations occur before the department notified the household of the penalties, as described in subsection (2) and (3) of this section.

(5) When a court of law convicts a person of an offense which qualifies as an intentional program violation, the department shall:

(i) Recommend that a disqualification penalty, as provided in subsection (2) or (3) of this section, be imposed in addition to any civil or criminal intentional program violation penalties;

(ii) Impose a disqualification period as specified in subsection (2) or (3) of this section if the court fails to address disqualification or specify a disqualification period;

(iii) Initiate the disqualification period for the currently eligible person or persons within forty-five days of the date the:

(A) Disqualification is ordered if the court does not specify a date; or

(B) Court finds such person or persons guilty if the court specifies a disqualification date; and

(iv) Not initiate or continue an intentional program violation disqualification period contrary to a court order.

(6) Before the disqualification is implemented, the department shall provide written notice informing the disqualified person of the disqualification and effective date.

(7) The department shall provide written notice to the remaining household member or members, if any:

(a) Of the allotment the household will receive during the period of disqualification; or

(b) That the household must re-apply because the certification period has expired.

(8) The department shall recognize an intentional program violation determined in another state or political jurisdiction.

[Statutory Authority: RCW 74.04.510. 97-04-023, § 388-49-670, filed 1/28/97, effective 2/28/97; 96-06-042 (Order 3948), § 388-49-670, filed 3/1/96, effective 4/1/96. Statutory Authority: RCW 74.04.050. 95-19-013 (Order 3894), § 388-49-670, filed 9/7/95, effective 10/6/95. Statutory Authority: RCW 74.04.510 and P.L. 103-66 section 13942. 94-16-043 (Order 3758), § 388-49-670, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 74.04.510. 89-12-034 (Order 2803), § 388-49-670, filed 6/1/89. Statutory Authority: RCW 74.04.050. 88-02-031 (Order 2575), § 388-49-670, filed 12/31/87.]

Chapter 388-52 WAC
SERVICES INVOLVING OTHER AGENCIES

WAC

388-52-150 through 388-52-172 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-52-150 Vocational rehabilitation services. [Order 975, § 388-52-150, filed 10/11/74; Order 542, § 388-52-150, filed 3/31/71, effective 5/1/71; Order 465, § 388-52-150, filed 6/23/70; Regulation 20.24, filed 1/24/64.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-52-155 Vocational rehabilitation services—Training expenses. [Order 975, § 388-52-155, filed 10/11/74; Order 542, § 388-52-155, filed 3/31/71, effective 5/1/71.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-52-160 Comprehensive employment and training program—Definitions. [Order 975, § 388-52-160, filed 10/11/74.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-52-163 Comprehensive employment and training program—Services provided. [Order 975, § 388-52-163, filed 10/11/74.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-52-166 Comprehensive employment and training program—Participation of recipient. [Statutory Authority: RCW 74.08.090. 81-10-011 (Order 1643), § 388-52-166, filed 4/27/81; 79-03-013 (Order 1368), § 388-52-166, filed 2/15/79; Order 975, § 388-52-166, filed 10/11/74.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-52-169 Treatment of recipient's income from CETA. [Order 975, § 388-52-169, filed 10/11/74.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-52-172 Release of information to prime sponsors of CETA program. [Order 975, § 388-52-172, filed 10/11/74.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-52-150 through 388-52-172 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-55 WAC
REFUGEE ASSISTANCE

WAC

388-55-030 Treatment of income and resources.

WAC 388-55-030 Treatment of income and resources. (1) The income and resources of RCA/RMA clients shall be treated according to the rules in chapters 388-216 WAC and 388-218 WAC, except that RCA/RMA clients do not qualify for:

(a) The fifty percent gross earned income disregard allowed under WAC 388-218-1440. Instead, the first ninety dollars of an RCA/RMA client's monthly gross earned income shall be disregarded;

(b) The three thousand dollar savings account exemption allowed to recipients under WAC 388-216-2650;

(c) The exemption for a motor vehicle used to transport a physically disabled household member under WAC 388-216-2500; and

(d) The five thousand dollar vehicle equity value exemption under WAC 388-216-2650. Instead, the equity value exemption for a used and useful vehicle owned by an RCA/RMA client is one thousand five hundred dollars.

(2) The department shall not consider resources which are unavailable, including property remaining in other countries, in determining eligibility for RCA/RMA.

(3) The income of a refugee dependent child shall be treated as specified in WAC 388-218-1410.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-128, § 388-55-030, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 43.20A.550 and 45 CFR 400 Subparts E, F and G. 96-05-009 (Order 3944), § 388-55-030, filed 2/9/96, effective 3/11/96. Statutory Authority: RCW 43.20A.550. 83-13-069 (Order 1969), § 388-55-030, filed 6/16/83.]

Chapter 388-61 WAC
FAMILY VIOLENCE

WAC

388-61-001 What does the Family Violence Amendment mean for TANF recipients?

WAC 388-61-001 What does the Family Violence Amendment mean for TANF recipients? The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), also known as the Welfare Reform Act, gave every state the option to have a program to address issues of family violence for temporary assistance for needy families (TANF) recipients.

(1) For TANF, it is family violence when a recipient, or family member or household member has been subjected by another family member or household member as defined in RCW 26.50.010 (1) to one of the following:

(a) Physical acts that resulted in, or threatened to result in, physical injury;

(b) Sexual abuse;

(c) Sexual activity involving a dependent child;

(d) Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities;

(e) Threats of or attempts at, physical sexual abuse;

(f) Mental abuse;

(g) Neglect or deprivation of medical care, or

(h) Stalking.

(2) DSHS shall:

(a) Screen and identify TANF recipients for a history of family violence;

(b) Notify TANF recipients about the Family Violence Amendment both verbally and in writing;

(c) Maintain confidentiality as stated in RCW 74.04.060;

(d) Refer individuals needing counseling to supportive services;

(e) Waive WorkFirst requirements in cases where the requirements would make it more difficult to escape family violence, unfairly penalize victims of family violence or place victims at further risk of family violence. Requirements to be waived may include:

(i) Time limits for TANF recipients, for as long as necessary (after fifty-two months of receiving TANF);

(ii) Cooperation with the division of child support.

(f) Develop specialized work activities for clients meeting the definition of family violence in instances where participation in work activities would place the recipients at further risk of family violence.

[Statutory Authority: RCW 74.04.050, 74.08.090 and 74.04.057. 97-20-124, § 388-61-001, filed 10/1/97, effective 11/1/97.]

Chapter 388-70 WAC
CHILD WELFARE SERVICES—FOSTER CARE—ADOPTION SERVICES—SERVICES TO UNMARRIED PARENTS

WAC

388-70-064 Repealed.

388-70-160 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-70-064 Payment for foster care to relative. [Statutory Authority: RCW 74.08.090. 82-24-068 (Order 1915), § 388-70-064, filed 12/1/82; 80-06-069 (Order 1504), § 388-70-064, filed 5/22/80; Order 913, § 388-70-064, filed 3/1/74.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-70-160 Guardianship of estate of child. [Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-160, filed 9/1/78; Order 965, § 388-70-160, filed 8/29/74; Order 913, § 388-70-160, filed 3/1/74; Regulation 70.160, filed 3/22/60.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-70-064 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-160 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-71 WAC
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

WAC

388-71-005 through 388-71-055 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-71-005 Duty to provide. [Order 1081, § 388-71-005, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-010 Definitions. [Order 1081, § 388-71-010, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-015 Conditions for placement. [Order 1081, § 388-71-015, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-020 Condition under which compact applies. [Order 1081, § 388-71-020, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-025 Exemptions. [Order 1081, § 388-71-025, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-030 Child leaving Washington state. [Order 1081, § 388-71-030, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-035 Child entering Washington state. [Order 1081, § 388-71-035, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-040 Procedures for change in placement status. [Order 1081, § 388-71-040, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-045 Retention of jurisdiction. [Order 1081, § 388-71-045, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-050 Financial responsibility. [Order 1081, § 388-71-050, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

388-71-055 Penalty for illegal placement. [Order 1081, § 388-71-055, filed 12/24/75.] Repealed by 98-01-149, filed 12/19/97, effective 1/19/98. Statutory Authority: RCW 74.08.090.

WAC 388-71-005 through 388-71-055 Repealed.
See Disposition Table at beginning of this chapter.

Chapter 388-73 WAC

CHILD CARE AGENCIES—MINIMUM LICENSING/ CERTIFICATION REQUIREMENTS

WAC

388-73-400 Repealed.
388-73-402 Repealed.
388-73-403 Repealed.
388-73-404 Repealed.
388-73-406 Repealed.
388-73-408 Repealed.
388-73-409 Repealed.
388-73-410 Repealed.
388-73-412 Repealed.
388-73-414 Repealed.
388-73-430 Repealed.
388-73-432 Repealed.
388-73-434 Repealed.
388-73-436 Repealed.
388-73-438 Repealed.
388-73-440 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-73-400 Day care providers. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-400, filed 7/9/92, effective 8/9/92; 78-10-006 (Order 1336), § 388-73-400, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-402 Maximum hours—Rest periods. [Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-402, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-402, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-403 Operating hours—Staff on premises. [Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-403, filed 12/2/86.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-404 Ill children. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-404, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-406 Nap and sleep equipment. [Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-406, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-406, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-408 Evening and nighttime care. [Statutory Authority: RCW 74.15.030. 80-13-019 (Order 1540), § 388-73-408, filed 9/9/80; 78-10-006 (Order 1336), § 388-73-408, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-409 Off-grounds trips. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-409, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-409, filed 12/2/86.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-410 Information to parents—Day care facilities. [Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-410, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-410, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-412 Toddlers and preschool children. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-412, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-414 Attendance—Mini-day care centers. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-414, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-414, filed 12/2/86.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-430 Capacity—Limitations on ages and numbers—Mini-day care centers. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-430, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-432 Staffing—Mini-day care program. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-432, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-434 Qualifications of licensee—Mini-day care. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-434, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-436 Qualifications of child care staff—Mini-day care. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-436, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-438 Program and equipment—Mini-day care. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), §

388-73-438, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-73-440 Play areas—Mini-day care. [Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-440, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-440, filed 9/8/78.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-73-400 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-402 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-403 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-404 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-406 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-408 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-409 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-410 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-412 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-414 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-430 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-432 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-434 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-436 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-438 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-73-440 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-76 WAC
ADULT FAMILY HOMES MINIMUM LICENSING REQUIREMENTS

WAC

WAC 388-76-9970 Purpose. The purpose of WAC 388-76-9970 through 388-76-9980 is to satisfy the legislative requirements of section 402, chapter 392, Laws of 1997.

[Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9970, filed 9/3/97, effective 9/4/97.]

WAC 388-76-9972 Definitions. For purposes of WAC 388-76-9970 through 388-76-9980, the following definitions shall apply:

"Accommodation" means a determination by the department to accept an application for a new adult family home license, based on a case-by-case review of requests.

"Long distance" means a distance of thirty miles or more, or requiring thirty minutes or more of travel time between existing licensed residential long-term care facilities.

"Moratorium" means a temporary stoppage of the acceptance of new adult family home applications received during the dates specified in WAC 388-76-9974. The moratorium is limited because accommodations may be granted by the department to allow for the application for new licenses, in individual cases in which the department finds that a need exists.

"Need" means the necessity for long-term care services by persons enrolled in Medicaid whose care requirements have been assessed to be most appropriately served in a residential long-term care setting. To meet this definition, the department must find that a need exists for one of the following:

(1) Services for persons who reside in a geographical area which has a lack of available providers; a need will be found by the department based on consultation with case managers and on a review of the availability of existing residential facilities; or

(2) Services for persons whose requirements are distinctive, and require special expertise by care providers; a need will be found by the department based on consultation with case managers or specialized departmental staff, such as staff serving persons with developmental disabilities or with mental health disabilities; or

(3) Services for persons of particular ethnic groups whose cultural lifestyle can only be maintained by care providers with knowledge of their culture; a need will be found by the department based on consultation with case managers or specialized departmental staff, such as staff serving persons with developmental disabilities, or persons with mental health disabilities; or

(4) Services for persons who would be isolated from family and friends if they relocated across a long distance in order to receive residential services; a need will be found by

the department based on a review of the proximity of existing residential facilities.

[Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9972, filed 9/3/97, effective 9/4/97.]

WAC 388-76-9974 Effective date of the moratorium. The moratorium shall be effective beginning at 8:00 a.m., September 4, 1997, and extend through 5:00 p.m., December 12, 1997, or until such time as the secretary removes the moratorium. After the moratorium is lifted by the secretary, WAC 388-76-9970 through 388-76-9980 will no longer be effective.

[Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9974, filed 9/3/97, effective 9/4/97.]

WAC 388-76-9976 Process for requesting an individual accommodation. (1) Before submitting an application for adult family home licensure, a person must request an individual accommodation to the moratorium by writing a letter to the director of residential care services, aging and adult services administration, at the following address:

Aging and Adult Services Administration
Director, Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

(2) Any requests for individual accommodations that do not contain all of the requirements listed in subsection (3) of this section, will be returned to the individual making the request without action.

(3) The letter requesting an individual accommodation shall contain all of the following:

(a) A statement that the letter is a request for an individual accommodation to the moratorium on the licensure of new adult family homes; and

(b) A statement of which type of need, as defined in WAC 388-76-9972, the adult family home proposes to address; and

(c) A statement that the applicant will contract with the state to provide service to a client or clients who have been determined to be Medicaid eligible; and

(d) A photocopy of one of the following:

(i) For persons who do not currently have an adult family home license: The certificate of attendance at an adult family home orientation. The certificate of attendance can be obtained by attending an orientation session sponsored by a local adult family home area office. Information about the orientations may be obtained by calling the phone numbers listed in subsection (6) of this section; or

(ii) For persons who currently operate a licensed home and are requesting consideration of an additional license, and therefore do not need to attend orientation: A current adult family home license.

(4) The director of residential care services, or the director's designee, shall evaluate the need for the home, based on the definition of need in WAC 388-76-9974. The department shall respond in writing, within fifteen working days, with a decision to grant or deny the request for the individual accommodation. Individuals who receive a letter granting their request for accommodation may then apply for an adult family home license.

(5) The letter requesting the accommodation should not be accompanied by an adult family home application. Any applications or accompanying checks sent with letters will be returned to the applicant without action.

(6) The adult family home area offices are:

Southeast Washington
Phone: 360/493-2546
Address: Residential Care Services/
Adult Family Home Area Office
PO Box 45600
Olympia, WA 98504-5600
Counties: Clark, Cowlitz, Klickitat, Lewis, Pacific, Skamania, Thurston, Wahkiakum.

King County
Phone: 206/587-4285
Address: Residential Care Services/
Adult Family Home Area Office
1737 Airport Way S, Suite 160
Seattle, WA 98134
County: King (excluding north King County zip codes).

Northwest Washington
Phone: 360/653-0591
Address: Residential Care Services/
Adult Family Home Area Office
PO Box 3504
Arlington, WA 98036
Counties: Island, San Juan, Skagit, Snohomish, Whatcom (and including north King County zip codes).

Northeast Washington
Phone: 509/456-3911
Address: Residential Care Services/
Adult Family Home Area Office
316 W. Boone, Suite 170
Spokane, WA 99201-2351
Counties: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, Yakima.

Pierce County and the Olympic Peninsula
Phone: 253/597-4160
Address: Residential Care Services/
Adult Family Home Area Office
1949 S. State Street
Tacoma, WA 98405-2850
Counties: Clallam, Grays Harbor, Jefferson, Kitsap, Mason, Pierce.

[Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9976, filed 9/3/97, effective 9/4/97.]

WAC 388-76-9978 Applications that will be processed during the moratorium. (1) Applications received under any one of the following conditions shall be processed according to the usual departmental licensure process:

(a) Applications postmarked on or before September 3, 1997, to:

Aging and Adult Services Administration
Residential Care Services

PO Box 45600
Olympia, WA 98504-5600; or

(b) Applications hand delivered no later than 5:00 p.m., September 3, 1997, to:

Aging and Adult Services Administration
Residential Care Services/Adult Family Home Licensing
Building A, 600 Woodland Square Loop
Lacey, WA 98503

With the delivery confirmed by a receipt from aging and adult services staff; or

(c) Applications received with an attached letter from the director of residential care services, or the director's designee, stating that an individual accommodation has been granted; or

(d) Applications for licensed homes that are relocating. Applicants who are planning to relocate shall make a notation on the first page of their application, indicating that they have a current license and plan to relocate. This does not include applications for licenses for homes where the license is being transferred from one individual or entity to another individual or entity.

(2) All other applications shall be returned to the applicant without action.

[Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9978, filed 9/3/97, effective 9/4/97.]

WAC 388-76-9980 Notification of the end of the moratorium. Persons currently holding an adult family home license, and persons on the department's interested parties mailing list will be notified of the date that the moratorium is no longer in effect, as determined by the secretary.

[Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9980, filed 9/3/97, effective 9/4/97.]

Chapter 388-78 WAC
SUPPORT SERVICES FOR ASSESSMENT AND EMPLOYMENT AND TRAINING PROGRAMS IN THE FAMILY INDEPENDENCE PROGRAM

WAC

388-78-005 through 388-78-220 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-78-005 General provisions. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-005, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-010 Definitions. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-010, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-015 Supportive social services. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-015, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-020 Self-sufficiency plan. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-020, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-100 FIP employment and training requirements. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-100, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-120 Grievance procedure and administrative reviews and appeals. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-120, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-205 FIP child care. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-205, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-210 Standards for child care providers. [Statutory Authority: Chapter 74.21 RCW. 89-08-050 (Order 2781), § 388-78-210, filed 3/31/89; 88-12-088 (Order 2628), § 388-78-210, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-215 Payment standards for child care services. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-215, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-78-220 Child day care co-payments. [Statutory Authority: Chapter 74.21 RCW. 88-12-088 (Order 2628), § 388-78-220, filed 6/1/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-78-005 through 388-78-220 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-86 WAC
MEDICAL CARE—SERVICES PROVIDED

WAC

388-86-050 Repealed.
388-86-051 Repealed.
388-86-075 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-86-050 Inpatient hospital care. [Statutory Authority: RCW 74.08.090. 90-01-053 (Order 2916), § 388-86-050, filed 12/15/89, effective 1/15/90; 88-15-010 (Order 2649), § 388-86-050, filed 7/8/88; 88-04-048 (Order 2594), § 388-86-050, filed 1/29/88; 86-14-099 (Order 2397), § 388-86-050, filed 7/2/86; 86-02-031 (Order 2321), § 388-86-050, filed 12/27/85; 85-13-061 (Order 2241), § 388-86-050, filed 6/18/85; 84-20-100 (Order 2157), § 388-86-050, filed 10/3/84; 83-17-073 (Order 2011), § 388-86-050, filed 8/19/83; 83-05-050 (Order 1949), § 388-86-050, filed 2/16/83; 81-16-033 (Order 1685), § 388-86-050, filed 7/29/81; 81-10-015 (Order 1647), § 388-86-050, filed 4/27/81; 80-13-020 (Order 1542), § 388-86-050, filed 9/9/80; 79-10-095 (Order 1439), § 388-86-050, filed 9/25/79; 79-06-030 (Order 1395), § 388-86-050, filed 5/16/79; 79-01-002 (Order 1359), § 388-86-050, filed 12/8/78; 78-06-087 (Order 1301), § 388-86-050, filed 6/2/78; 78-02-024 (Order 1265), § 388-86-050, filed 1/13/78; Order 1233, § 388-86-050, filed 8/31/77; Order 1172, § 388-86-050, filed 11/24/76; Order 1061, § 388-86-

050, filed 10/8/75; Order 952, § 388-86-050, filed 7/16/74; Order 911, § 388-86-050, filed 3/1/74; Order 858, § 388-86-050, filed 9/27/73; Order 844, § 388-86-050, filed 8/9/73; Order 836, § 388-86-050, filed 7/26/73; Order 762, § 388-86-050, filed 1/2/73; Order 713, § 388-86-050, filed 9/14/72; Order 680, § 388-86-050, filed 5/10/72; Order 615, § 388-86-050, filed 10/7/71; Order 566, § 388-86-050, filed 5/19/71; Order 549, § 388-86-050, filed 3/31/71, effective 5/1/71; Order 519, § 388-86-050, filed 2/24/71; Order 501, § 388-86-050, filed 12/9/70; Order 484, § 388-86-050, filed 10/13/70; Order 474, § 388-86-050, filed 8/19/70; Order 435, § 388-86-050, filed 3/31/70; Order 419, § 388-86-050, filed 12/31/69; Order 385, § 388-86-050, filed 8/27/69; Order 335, § 388-86-050, filed 2/3/69; Order 264 (part), § 388-86-050, filed 11/24/67.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-86-051 Selective contracting program. [Statutory Authority: RCW 74.08.090. 88-04-048 (Order 2594), § 388-86-051, filed 1/29/88.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-86-075 Outpatient and emergency care. [Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-86-075, filed 10/25/95, effective 10/28/95; 88-15-010 (Order 2649), § 388-86-075, filed 7/8/88; 83-03-016 (Order 1937), § 388-86-075, filed 1/12/83; 81-16-033 (Order 1685), § 388-86-075, filed 7/29/81; 81-10-015 (Order 1647), § 388-86-075, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-075, filed 10/9/80; 79-06-034 (Order 1402), § 388-86-075, filed 5/16/79; Order 1196, § 388-86-075, filed 3/3/77; Order 1112, § 388-86-075, filed 4/15/76; Order 696, § 388-86-075, filed 6/29/72; Order 566, § 388-86-075, filed 5/19/71; Order 264 (part), § 388-86-075, filed 11/24/67.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-86-050 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-86-051 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-86-075 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-87 WAC
MEDICAL CARE—PAYMENT

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-87-013 Conditions of payment—Hospital care. [Statutory Authority: RCW 74.08.090. 88-04-048 (Order 2594), § 388-87-013, filed 1/29/88; 83-03-016 (Order 1937), § 388-87-013, filed 1/12/83; 81-16-032 (Order 1684), § 388-87-013, filed 7/29/81; 81-10-016 (Order 1648), § 388-87-013, filed 4/27/81; 80-13-020 (Order 1542), § 388-87-013, filed 9/9/80; 78-02-024 (Order 1265), § 388-87-013, filed 1/13/78; Order 1015, § 388-87-013, filed 3/27/75.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-87-030 Responsibility of physician—Patient admitted to hospital. [Statutory Authority: RCW 74.08.090. 81-16-032 (Order 1684), § 388-87-030, filed 7/29/81; 81-10-016 (Order 1648), § 388-87-030, filed 4/27/81; 80-13-020 (Order 1542), § 388-87-030, filed 9/9/80; Order 1233, § 388-87-030, filed 8/31/77; Order 911, § 388-87-030, filed 3/1/74; Order 879, § 388-87-030, filed 11/29/73; Order 837, § 388-87-030, filed 7/26/73; Order 386, § 388-87-030, filed 8/27/69; Order 336, § 388-87-030, filed 2/3/69; Order 304, § 388-87-030, filed 9/6/68; Order 264 (part), § 388-87-030, filed 11/24/67.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-87-032 Advanced registered nurse practitioners services (ARNP)—Payment. [Statutory Authority: RCW 74.08.090. 92-11-003 (Order 3384), § 388-87-032, filed 5/8/92, effective 6/8/92.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-87-070 Payment—Hospital inpatient services. [Statutory Authority: RCW 74.08.090. 93-01-035 (Order 3487), § 388-87-070, filed 12/9/92, effective 1/9/93; 91-21-123 (Order 3268), § 388-87-070, filed 10/23/91, effective 11/23/91; 91-10-025 (Order 3161), § 388-87-070, filed 4/23/91, effective 5/24/91; 90-01-053 (Order 2916), § 388-87-070, filed 12/15/89, effective 1/15/90; 88-04-048 (Order 2594), § 388-87-070, filed 1/29/88. Statutory Authority: 1987 c 406. 87-19-091 (Order 2539), § 388-87-070, filed 9/17/87. Statutory Authority: RCW 74.08.090. 85-23-034 (Order 2307), § 388-87-070, filed 11/15/85; 85-17-033 (Order 2266), § 388-87-070, filed 8/15/85; 85-03-073 (Order 2195), § 388-87-070, filed 1/17/85; 84-21-078 (Order 2162), § 388-87-070, filed 10/18/84; 84-11-070 (Order 2099), § 388-87-070, filed 5/22/84; 83-17-096 (Order 2015), § 388-87-070, filed 8/23/83; 83-08-022 (Order 1951), § 388-87-070, filed 3/30/83; 83-03-016 (Order 1937), § 388-87-070, filed 1/12/83; 82-18-066 (Order 1873), § 388-87-070, filed 9/1/82; 82-01-001 (Order 1725), § 388-87-070, filed 12/3/81; 81-16-032 (Order 1684), § 388-87-070, filed 7/29/81; 81-10-016 (Order 1648), § 388-87-070, filed 4/27/81; 80-15-034 (Order 1554), § 388-87-070, filed 10/9/80; 79-01-002 (Order 1359), § 388-87-070, filed 12/8/78; 78-02-024 (Order 1265), § 388-87-070, filed 1/13/78; Order 1112, § 388-87-070, filed 4/15/76; Order 681, § 388-87-070, filed 5/10/72; Order 615, § 388-87-070, filed 10/7/71; Order 582, § 388-87-070, filed 7/20/71; Order 550, § 388-87-070, filed 3/31/71, effective 5/1/71; Order 386, § 388-87-070, filed 8/27/69; Order 336, § 388-87-070, filed 2/3/69; Order 304, § 388-87-070, filed 9/6/68; Order 264 (part), § 388-87-070, filed 11/24/67.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-87-072 Payment—Hospital outpatient services. [Statutory Authority: RCW 74.08.090. 95-04-033 (Order 3826), § 388-87-072, filed 1/24/95, effective 2/1/95; 91-21-123 (Order 3268), § 388-87-072, filed 10/23/91, effective 11/23/91; 91-10-025 (Order 3161), § 388-87-072, filed 4/23/91, effective 5/24/91; 85-17-033 (Order 2266), § 388-87-072, filed 8/15/85.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-87-115 Payment—Organ transplantation. [Statutory Authority: RCW 74.08.090. 90-23-070 (Order 3095), § 388-87-115, filed 11/20/90, effective 12/21/90; 87-12-050 (Order 2495), § 388-87-115, filed 6/1/87.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-87-013 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-020 Subrogation. (1) For the purpose of this section, "liable third party" means:

(a) The tort-feasor or insurer of the tort-feasor, or both; and

(b) Any person who is liable, under any contract or insurance purchased by the client or by any other person, to provide coverage for the illness or injuries for which the assistance or residential care is paid or provided by the department.

(2) As a condition of medical care eligibility a client shall assign to the state any right the client may have to receive payment from any liable third party. Except as provided in subsection (3) of this section, to the extent that payment has been made under medical care programs under chapter 74.09 RCW for health care items or services furnished to an eligible client, the state shall have been subrogated to the client's rights to payment by any other party which has a legal or contractual liability to pay for those health care items or services.

(3) To the extent authorized by a contract executed under RCW 74.09.522, a managed health care plan has the rights and remedies of the department as provided in RCW 43.20B.060 and 70.09.180.

(4) The department shall not be responsible to pay for medical care for a client whose personal injuries are occasioned by the negligence or wrongdoing of another: *Provided, however,* That the secretary of the department or the secretary's designee may furnish the medical care required as a result of an injury to the client if the client is otherwise eligible for medical care and no other liable third party has been identified at the time the claim is filed, and the department shall thereby be subrogated to the rights of recovery therefore to the extent of the cost of medical care furnished by the department.

(5) The department may pursue its right to recover the value of medical care provided to an eligible client from any liable third party as a subrogee, assignee, or by enforcement of its public assistance lien as provided under RCW 43.20B.040 through 43.20B.070.

(6) Recovery pursuant to the subrogation rights, assignment, or enforcement of the lien granted to the department shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement. No settlement or judgment of a lien created under RCW 43.20B.060 shall be discharged or compromised without written consent of the secretary of the department or the secretary's designee. The department shall only consider compromise or discharge of a medical care lien as authorized by federal regulation at 42 CFR 433.139.

(7) The doctrine of equitable subrogation shall not apply to defeat, reduce, or prorate recovery by the department as to its assignment, lien, or subrogation rights.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 97-04-005, § 388-87-020, filed 1/24/97, effective 2/24/97. Statutory Authority: SSB 5419(6) and RCW 74.08.090. 95-20-031 (Order 3900), § 388-87-020, filed 9/27/95, effective 10/28/95; Order 264 (part), § 388-87-020, filed 11/24/67.]

WAC 388-87-030 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-032 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-070 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-072 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-115 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-96 WAC
NURSING HOME ACCOUNTING AND REIMBURSEMENT SYSTEM

WAC

WAC 388-96-010 Terms. Unless the context indicates otherwise, the following definitions apply in this chapter.

"Accounting" means activities providing information, usually quantitative and often expressed in monetary units, for:

(1) Decision-making;

(2) Planning;

(3) Evaluating performance;

(4) Controlling resources and operations; and

(5) External financial reporting to investors, creditors, regulatory authorities, and the public.

"Accrual method of accounting" means a method of accounting in which revenues are reported in the period when earned, regardless of when collected, and expenses are reported in the period in which incurred, regardless of when paid.

"Administration and management" means activities used to maintain, control, and evaluate the efforts and resources of an organization for the accomplishment of the objectives and policies of that organization.

"Allowable costs" - See WAC 388-96-501.

"Ancillary care" means services that are required by the individual, comprehensive plan of care provided by qualified therapists or by support personnel under their supervision.

"Arm's-length transaction" means a transaction resulting from good-faith bargaining between a buyer and seller who have adverse bargaining positions in the marketplace. The following are not arms's-length transactions:

(1) The sale or exchange of nursing home facilities between two or more parties in which all parties subsequently continue to own one or more of the facilities involved in the transaction; and

(2) Sale of a nursing home facility that is subsequently leased back to the seller within five years of the date of sale.

"Assets" means economic resources and certain deferred charges of the contractor, recognized and measured according to generally accepted accounting principles.

"Bad debts" means amounts considered to be uncollectible from accounts and notes receivable.

"Beds" means, unless otherwise specified, the number of set-up beds in the nursing home, not to exceed the number of licensed beds.

"Beneficial owner" means any person who:

(1) Directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares:

(a) Voting power which includes the power to vote, or to direct the voting of such ownership interest; and/or

(b) Investment power which includes the power to dispose, or to direct the disposition of such ownership interest;

(2) Directly or indirectly, creates or uses a trust, proxy, power of attorney, pooling arrangement, or any other contract, arrangement, or device with the purpose or effect of divesting himself or herself of beneficial ownership of an ownership interest, or preventing the vesting of such beneficial ownership as part of a plan or scheme to evade the reporting requirements of this chapter;

(3) Subject to subsection (2) of **"beneficial owner,"** has the right to acquire beneficial ownership of such ownership interest within sixty days, including but not limited to any right to acquire:

(a) Through the exercise of any option, warrant, or right;

(b) Through the conversion of an ownership interest;

(c) Pursuant to the power to revoke a trust, discretionary account, or similar arrangement; or

(d) Pursuant to the automatic termination of a trust, discretionary account, or similar arrangement;

Except that, any person who acquires an ownership interest or power specified in (a), (b), or (c) of subsection (3) of **"beneficial owner"** with the purpose or effect of changing or influencing the control of the contractor, or in connection with or as a participant in any transaction having such purpose or effect, immediately upon such acquisition shall be deemed to be the beneficial owner of the ownership interest which may be acquired through the exercise or conversion of such ownership interest or power; or

(4) In the ordinary course of business, is a pledgee of ownership interest under a written pledge agreement, shall not be deemed the beneficial owner of such pledged ownership interest until the pledgee:

(a) Takes all formal steps necessary required to declare a default; and

(b) Determines the power to vote or to direct the vote or to dispose or to direct the disposition of such pledged ownership interest will be exercised; provided that, the pledge agreement:

(i) Is bona fide and was not entered into with the purpose nor with the effect of changing or influencing the control of the contractor, nor in connection with any transaction having such purpose or effect, including persons meeting the conditions set forth in subsection (2) of this definition; and

(ii) Prior to default, does not grant the pledgee the power to:

(A) Vote or direct the vote of the pledged ownership interest; or

(B) Dispose or direct the disposition of the pledged ownership interest, other than the grant of such power or powers pursuant to a pledge agreement under which credit is extended and in which the pledgee is a broker or dealer.

"Capitalization" means the recording of an expenditure as an asset.

"Capitalized lease" means a lease required to be recorded as an asset and associated liability in accordance with generally accepted accounting principles.

"Cash method of accounting" means a method of accounting in which revenues are recorded when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for those expenditures and assets.

"Change of ownership" means a substitution of the individual operator or operating entity contracting with the department to deliver care services to medical care recipients in a nursing facility and ultimately responsible for the daily operational decisions of the nursing facility.

(1) Events which constitute a change of ownership include, but are not limited to, the following:

(a) The form of legal organization of the contractor is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) Ownership of the nursing home business enterprise is transferred by the contractor to another party, regardless of whether ownership of some or all of the real property and/or personal property assets of the facility is also transferred;

(c) If the contractor is a partnership, any event that dissolves the partnership;

(d) If the contractor is a corporation, and the corporation is dissolved, merges with another corporation which is the survivor, or consolidates with one or more other corporations to form a new corporation;

(e) If the operator is a corporation and, whether by a single transaction or multiple transactions within any continuous twenty-four-month period, fifty percent or more of the stock is transferred to one or more:

(i) New or former stockholders; or

(ii) Present stockholders each having held less than five percent of the stock before the initial transaction; or

(f) Any other event or combination of events which results in a substitution or substitution of control of the individual operator or the operating entity contracting with the department to deliver care services.

(2) Ownership does not change when the following, without more, occur:

(a) A party contracts with the contractor to manage the nursing facility enterprise as the contractor's agent, i.e.,

subject to the contractor's general approval of daily operating and management decisions; or

(b) The real property or personal property assets of the nursing facility change ownership or are leased, or a lease of them is terminated, without a substitution of individual operator or operating entity and without a substitution of control of the operating entity contracting with the department to deliver care services.

"Charity allowance" means a reduction in charges made by the contractor because of the indigence or medical indigence of a patient.

"Contract" means a contract between the department and a contractor for the delivery of nursing facility services to medical care recipients.

"Contractor" means an entity that contracts with the department to deliver services to medical care recipients in a nursing facility. The entity is responsible for operational decisions.

"Courtesy allowances" means reductions in charges in the form of an allowance to physicians, clergy, and others, for services received from the contractor. Employee fringe benefits are not considered courtesy allowances.

"CSO" means the local community services office of the department.

"Department" means the department of social and health services (DSHS) and employees.

"Depreciation" means the systematic distribution of the cost or other base of tangible assets, less salvage, over the estimated useful life of the assets.

"Donated asset" means an asset the contractor acquired without making any payment for the asset either in cash, property, or services. An asset is not a donated asset if the contractor:

(1) Made even a nominal payment in acquiring the asset; or

(2) Used donated funds to purchase the asset.

"Entity" means an individual, partnership, corporation, or any other association of individuals capable of entering enforceable contracts.

"Equity capital" means total tangible and other assets which are necessary, ordinary, and related to patient care from the most recent provider cost report minus related total long-term debt from the most recent provider cost report plus working capital as defined in this section.

"Exceptional care recipient" means a medical care recipient determined by the department to require exceptionally heavy care.

"Facility" means a nursing home or facility licensed in accordance with chapter 18.51 RCW, or that portion of a hospital licensed in accordance with chapter 70.41 RCW which operates as a nursing home.

"Fair market value" means:

(1) Prior to January 1, 1985, the price for which an asset would have been purchased on the date of acquisition in an arm's-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell; or

(2) Beginning January 1, 1985, the replacement cost of an asset, less observed physical depreciation, on the date the fair market value is determined.

"Financial statements" means statements prepared and presented according to generally accepted accounting principles and the provisions of chapter 74.46 RCW and this chapter including, but not limited to:

(1) Balance sheet;

(2) Statement of operations;

(3) Statement of changes in financial position; and

(4) Related notes.

"Fiscal year" means the operating or business year of a contractor. All contractors report on the basis of a twelve-month fiscal year, but provision is made in this chapter for reports covering abbreviated fiscal periods. As determined by context or otherwise, **"fiscal year"** may also refer to a state fiscal year extending from July 1 through June 30 of the following year and comprising the first or second half of a state fiscal biennium.

"Gain on sale" means the actual total sales price of all tangible and intangible nursing home assets including, but not limited to, land, building, equipment, supplies, goodwill, and beds authorized by certificate of need, minus the net book value of such assets immediately prior to the time of sale.

"Generally accepted accounting principles (GAAP)" means accounting principles approved by the financial accounting standards Board (FASB).

"Generally accepted auditing standards (GAAS)" means auditing standards approved by the American institute of certified public accountants (AICPA).

"Goodwill" means the excess of the price paid for:

(1) A business over the fair market value of all other identifiable, tangible, and intangible assets acquired; and

(2) An asset over the fair market value of the asset.

"Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies.

"Imprest fund" means a fund which is regularly replenished in exactly the amount expended from it.

"Intangible asset" is an asset that lacks physical substance but possesses economic value.

"Interest" means the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user.

"Joint facility costs" means any costs representing expenses incurred which benefit more than one facility, or one facility and any other entity.

"Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not pursuant to a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee shall not be considered modification of a lease term.

"Medical care program" means medical assistance provided under RCW 74.09.500 or authorized state medical care services.

"Medical care recipient" means an individual determined eligible by the department for the services provided in chapter 74.09 RCW.

"Multiservice facility" means a facility at which two or more types of health or related care are delivered, e.g., a hospital and nursing facility, or a boarding home and nursing facility.

"Net book value" means the historical cost of an asset less accumulated depreciation.

"Net invested funds" means the net book value of tangible fixed assets, excluding assets associated with central or home offices or otherwise not on the nursing facility premises, employed by a contractor to provide services under the medical care program, including land, buildings, and equipment as recognized and measured in conformity with generally accepted accounting principles and not in excess of any lids or reimbursement limits set forth in this chapter, plus an allowance for working capital as provided in this chapter.

"Nonadministrative wages and benefits" means wages, benefits, and corresponding payroll taxes paid for nonadministrative personnel, not to include administrator, assistant administrator, or administrator-in-training.

"Nonallowable costs" means the same as **"unallowable costs."**

"Nonrestricted funds" means funds which are not restricted to a specific use by the donor, e.g., general operating funds.

"Nursing facility" means a home, place, or institution, licensed under chapter 18.51 or 70.41 RCW, where nursing care services are delivered.

"Operating lease" means a lease under which rental or lease expenses are included in current expenses in accordance with generally accepted accounting principles.

"Owner" means a sole proprietor, general or limited partner, or beneficial interest holder of five percent or more of a corporation's outstanding stock.

"Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form the beneficial ownership takes.

"Patient day" or **"resident day"** means a calendar day of care provided to a nursing facility resident that will include the day of admission and exclude the day of discharge; except that, when admission and discharge occur on the same day, one day of care shall be deemed to exist. A patient is admitted for purposes of this definition when the patient is assigned a bed and a patient medical record is opened. A **"client day"** or **"recipient day"** means a calendar day of care provided to a medical care recipient determined eligible by the department for services provided under chapter 74.09 RCW, subject to the same conditions regarding admission and discharge applicable to a patient day or resident day of care.

"Per diem (per patient day or per resident day) costs" means total allowable costs for a fiscal period divided by total patient or resident days for the same period.

"Professionally designated real estate appraiser" means an individual:

(1) Regularly engaged in the business of providing real estate valuation services for a fee;

(2) Qualified by a nationally recognized real estate appraisal educational organization on the basis of extensive practical appraisal experience, including:

(a) Writing of real estate valuation reports;

(b) Passing of written examinations on valuation practice and theory; and

(c) Subscribing and adhering to the standards of professional practice required by the organization.

"Prospective daily payment rate" means the rate assigned by the department to a contractor for providing service to medical care recipients. The rate is used to compute the maximum participation of the department in the contractor's costs.

"Qualified therapist":

(1) An activities specialist having specialized education, training, or at least one year's experience in organizing and conducting structured or group activities;

(2) An audiologist eligible for a certificate of clinical competence in audiology or having the equivalent education and clinical experience;

(3) A mental health professional as defined by chapter 71.05 RCW;

(4) A mental retardation professional who is either a qualified therapist or a therapist approved by the department who has specialized training or one year's experience in treating or working with the mentally retarded or developmentally disabled;

(5) A social worker graduated from a school of social work;

(6) A speech pathologist eligible for a certificate of clinical competence in speech pathology or having the equivalent education and clinical experience;

(7) A physical therapist as defined by chapter 18.74 RCW;

(8) An occupational therapist licensed under chapter 18.59 RCW and chapter 246-847 WAC; or

(9) A respiratory care practitioner certified under chapter 18.89 RCW.

"Rebased rate" or **"cost rebased rate"** means a facility-specific rate assigned to a nursing facility for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year.

"Recipient" means a medical care recipient.

"Records" means data supporting all financial statements and cost reports including, but not limited to:

(1) All general and subsidiary ledgers;

(2) Books of original entry;

(3) Invoices;

(4) Schedules;

(5) Summaries; and

(6) Transaction documentation, however maintained.

"Regression analysis" means a statistical technique through which one can analyze the relationship between a dependent or criterion variable and a set of independent or predictor variables.

"Related care" includes:

(1) The director of nursing services;

(2) Activities and social services programs;

(3) Medical and medical records specialists; and

(4) Consultation provided by:
(a) Medical directors;
(b) Pharmacists;
(c) Occupational therapists;
(d) Physical therapists;
(e) Speech therapists;
(f) Other therapists; and
(g) Mental health professionals as defined in law and regulation.

"Related organization" means an entity under common ownership and/or control, or which has control of or is controlled by, the contractor. Common ownership exists if an entity has a five percent or greater beneficial ownership interest in the contractor and any other entity. Control exists if an entity has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution, whether or not the power is legally enforceable and however exercisable or exercised.

"Relative" includes:
(1) Spouse;
(2) Natural parent, child, or sibling;
(3) Adopted child or adoptive parent;
(4) Stepparent, stepchild, stepbrother, stepsister;
(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law;
(6) Grandparent or grandchild; and
(7) Uncle, aunt, nephew, niece, or cousin.

"Restricted fund" means a fund for which the use of the principal and/or income is restricted by agreement with or direction of the donor to a specific purpose, in contrast to a fund over which the contractor has complete control. Restricted funds generally fall into three categories:
(1) Funds restricted by the donor to specific operating purposes;
(2) Funds restricted by the donor for additions to property, plant, and equipment; and
(3) Endowment funds.

"Secretary" means the secretary of the department of social and health services (DSHS).

"Start-up costs" means the one-time preopening costs incurred from the time preparation begins on a newly constructed or purchased building until the first patient is admitted. Start-up costs include:
(1) Administrative and nursing salaries;
(2) Utility costs;
(3) Taxes;
(4) Insurance;
(5) Repairs and maintenance; and
(6) Training costs.

Start-up costs do not include expenditures for capital assets.

"Title XIX" means the 1965 amendments to the Social Security Act, P.L. 89-07, as amended.

"Unallowable costs" means costs which do not meet every test of an allowable cost.

"Uniform chart of accounts" means a list of account titles identified by code numbers established by the department for contractors to use in reporting costs.

"Vendor number" means a number assigned to each contractor delivering care services to medical care recipients.

"Working capital" means total current assets necessary, ordinary, and related to patient care from the most recent cost report minus total current liabilities necessary, ordinary, and related to patient care from the most recent cost report.

[Statutory Authority: RCW 74.46.800. 97-17-040, § 388-96-010, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-010, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-010, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-010, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-010, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-010, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-010, filed 12/23/87. Statutory Authority: RCW 74.09.120 and 74.46.800. 85-13-060 (Order 2240), § 388-96-010, filed 6/18/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-010, filed 12/4/84. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-010, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-010, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-010, filed 10/13/82; 81-22-081 (Order 1712), § 388-96-010, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-010, filed 2/25/81. Statutory Authority: RCW 74.09.120. 80-09-083 (Order 1527), § 388-96-010, filed 7/22/80; 79-04-061 (Order 1381), § 388-96-010, filed 3/28/79. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-010, filed 6/1/78; Order 1262, § 388-96-010, filed 12/30/77.]

WAC 388-96-224 Final settlement. (1) If an audit is conducted, the department shall issue a final settlement report to the contractor after completion of the audit process, including exhaustion or termination of any administrative review and appeal of audit findings or determinations requested by the contractor, but not including judicial review as may be available to and commenced by the contractor.

(2) The department shall prepare a final settlement by cost center and shall fully substantiate disallowed costs, refunds, underpayments, or adjustments to the cost report and financial statements, reports, and schedules submitted by the contractor. The department shall take into account all authorized shifting, cost savings, and upper limits to rates on a cost center basis. For the final settlement report, the department shall compare:

(a) The prospective rate the contractor was paid for the facility in question during the report period, weighted by the number of allowable resident days reported for the period each rate was in effect to

(b) The contractor's audited allowable costs for the reporting period; or

(c) For nonaudited reporting periods, the contractor's desk reviewed allowable costs for the reporting period.

(3) A contractor shall have twenty-eight days after receipt of a final settlement report to contest such report pursuant to WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight-day period, the department shall not review a final settlement report. Any administrative review of a final settlement shall be limited to calculation of the settlement or the application of settlement principles and rules, or both, and shall not examine or reexamine rate or audit issues.

(4) The department shall reopen a final settlement if it is necessary to make adjustments based upon findings resulting from an audit performed pursuant to RCW

74.46.105. The department may also reopen a final settlement to recover an industrial insurance dividend or premium discount under RCW 51.16.035 in proportion to a contractor's medical care recipients, pursuant to RCW 74.46.180(5).

[Statutory Authority: RCW 74.46.150, [74.46.]160, [74.46.]170 and [74.46.]800. 97-17-040, § 388-96-224, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-224, filed 9/12/95, effective 10/13/95. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-224, filed 12/23/87. Statutory Authority: RCW 74.09.120 and 74.46.800. 85-13-060 (Order 2240), § 388-96-224, filed 6/18/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-224, filed 9/16/83.]

WAC 388-96-505 Offset of miscellaneous revenues. (1) The contractor shall reduce allowable costs whenever the item, service, or activity covered by such costs generates revenue or financial benefits (e.g., purchase discounts, refunds of allowable costs or rebates) other than through the contractor's normal billing for care services; except, the department shall not deduct from the allowable costs of a nonprofit facility unrestricted grants, gifts, and endowments, and interest therefrom.

(2) The contractor shall reduce allowable costs for hold-bed revenue in the property, administrative, and operational cost areas only. In the property cost area, the amount of reduction will be determined by dividing a facility's allowable property costs by total patient days and multiplying the result by total hold-room days. In the administrative cost area, the amount of the bed hold revenue shall be determined by dividing a facility's allowable administrative costs by total patient days and multiplying the result by total hold-room days. In the operational cost area, the amount of reduction will be determined by dividing allowable operational costs minus dietary and laundry costs by the total patient days and multiplying the result by total hold-room days.

(3) Where goods or services are sold, the amount of the reduction shall be the actual cost relating to the item, service, or activity. In the absence of adequate documentation of cost, it shall be the full amount of the revenue received. Where financial benefits such as purchase discounts, refunds of allowable costs or rebates are received, the amount of the reduction shall be the amount of the discount or rebate. Financial benefits such as purchase discounts, refunds of allowable costs and rebates, including industrial insurance rebates, shall be offset against allowable costs in the year the contractor actually receives the benefits.

(4) Only allowable costs shall be recovered under this section. Costs allocable to activities or services not included in nursing facility services (e.g., costs of vending machines and services specified in chapter 388-86 WAC not included in nursing facility services) are nonallowable costs.

[Statutory Authority: RCW 74.46.200 and 74.46.800. 97-17-040, § 388-96-505, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-505, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-505, filed 7/23/92, effective 8/23/92. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-505, filed 12/23/87. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-505, filed 12/4/84; 82-21-025 (Order 1892), § 388-96-505, filed 10/13/82. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-505, filed 2/25/81. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-505, filed 6/1/78; Order 1262, § 388-96-505, filed 12/30/77.]

WAC 388-96-534 Joint cost allocation disclosure (JCAD). (1) The contractor shall disclose to the department:

(a) The nature and purpose of all costs representing allocations of joint facility costs; and

(b) The methodology of the allocation utilized.

(2) The contractor shall demonstrate in such disclosure:

(a) The services involved are necessary and nonduplicative; and

(b) Costs are allocated in accordance with benefits received from the resources represented by those costs.

(3) The contractor shall make such disclosure not later than September 30th for the following year; except, a new contractor shall submit the first year's disclosure together with the submissions required by WAC 388-96-026. Within this section, the meaning of the:

(a) "Effective date" is the date the department will recognize allocation per an approved JCAD; and

(b) "Implementation date" is the date the facility will begin or began incurring joint facility costs.

(4) The department shall determine the acceptability of the JCAD methodology not later than December 31 of each year for all JCADs received by September 30th.

(a) The effective date of an acceptable JCAD that was received by September 30th is January 1st.

(b) The effective date of an acceptable JCAD that was received after September 30th shall be ninety days from the date the JCAD was received by the department.

(5) The contractor shall submit to the department for approval an amendment or revision to an approved JCAD methodology at least thirty days prior to the implementation date of the amendment or revision. For amendments or revisions received less than thirty days before the implementation date, the effective date of approval will be thirty days from the date the JCAD is received by the department.

(6) When a contractor, who is not currently incurring joint facility costs, begins to incur joint facility costs during the calendar year, the contractor shall provide the information required in subsections (1) and (2) of this section at least ninety days prior to the implementation date. If the JCAD is not received ninety days before the implementation date, the effective date of the approval will be ninety days from the date the JCAD is received by the department.

(7) Joint facility costs not disclosed, allocated, and reported in conformity with this section are nonallowable costs. Joint facility costs incurred before the effective dates of subsections (4), (5), and (6) of this section are unallowable. Costs disclosed, allocated, and reported in conformity with a department-approved JCAD methodology must undergo review and be determined allowable costs for the purposes of rate setting and audit.

[Statutory Authority: RCW 74.46.270. 97-17-040, § 388-96-534, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-534, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-534, filed 5/26/94, effective 6/26/94. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-534, filed 12/23/87. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-534, filed 9/16/83; 80-09-083 (Order 1527), § 388-96-534, filed 7/22/80.]

WAC 388-96-553 Capitalization. The following costs shall be capitalized:

(1) Expenditures for depreciable assets with historical cost in excess of seven hundred fifty dollars per unit and a useful life of more than one year from the date of purchase;

(2) Expenditures and costs for depreciable assets with historical cost of seven hundred fifty dollars or less per unit if either:

(a) The depreciable asset was acquired in a group purchase where the total cost exceeded seven hundred fifty dollars; or

(b) The depreciable asset was part of the initial equipment or stock of the nursing home; and

(3) Expenditures for any change, including repairs with a cost in excess of seven hundred fifty dollars that increases the useful life of the depreciable asset by two years or more.

[Statutory Authority: RCW 74.46.310, [74.46.]320 and [74.46.]330. 97-17-040, § 388-96-553, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-553, filed 9/16/83; 83-05-007 (Order 1944), § 388-96-553, filed 2/4/83; 82-11-065 (Order 1808), § 388-96-553, filed 5/14/82. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-553, filed 2/25/81; Order 1262, § 388-96-553, filed 12/30/77.]

WAC 388-96-554 Expensing. The following costs shall be expensed:

(1) Expenditures for depreciable assets with historical cost of seven hundred fifty dollars or less per unit or a useful life of one year or less from the date of purchase.

(2) Subsection (1) of this section shall not apply if:

(a) The depreciable asset was acquired in a group purchase where the total cost exceeded seven hundred fifty dollars; or

(b) The depreciable asset was part of the initial equipment or stock of the nursing home.

(3) Expenditures for and costs of building and other real property items, components and improvements, whether for leased or owner-operated facilities, of seven hundred and fifty dollars or less.

(4) Expenditures for and costs of repairs necessary to maintain the useful life of equipment, including furniture and furnishings, and real property items, components or improvements which do not increase the useful life of the asset by two years or more. If a repair is to the interior or exterior of the structure, the term "asset" shall refer to the structure.

(5) Remaining undepreciated cost of equipment, including furniture or furnishings or real property items, components, or improvements which are retired and not replaced, provided such cost shall be offset by any proceeds or compensations received for such assets, and such cost shall be expensed only if the contractor has made a reasonable effort to recover at least the outstanding book value of such assets. If a retired asset is replaced, WAC 388-96-572(3) shall apply and the replacement or renewal shall be capitalized if required by WAC 388-96-553.

[Statutory Authority: RCW 74.46.310, [74.46.]320 and [74.46.]330. 97-17-040, § 388-96-554, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-554, filed 9/16/83; 83-05-007 (Order 1944), § 388-96-554, filed 2/4/83.]

WAC 388-96-559 Cost basis of land and depreciation base. (1) For all partial or whole rate periods after December 31, 1984 unless otherwise provided or limited by this chapter or by this section, chapter 388-96 WAC or chapter 74.46 RCW, the total depreciation base of depreciable assets and the cost basis of land shall be the lowest of:

(a) The contractor's appraisal, if any;

(b) The department's appraisal obtained through the department of general administration of the state of Washington, if any; or

(c) The historical purchase cost of the contractor, or lessor if the assets are leased by the contractor, in acquiring ownership of the asset in an arm's-length transaction, and preparing the asset for use, less goodwill, and less accumulated depreciation, if applicable, incurred during periods the assets have been used in or as a facility by any and all contractors. Such accumulated depreciation is to be measured in accordance with subsection (5) of this section and WAC 388-96-561, 388-96-565, and 388-96-567. Where the straight-line or sum-of-the-years digits method of depreciation is used the contractor:

(i) May deduct salvage values from historical costs for each cloth based item, e.g., mattresses, linen, and draperies; and

(ii) Shall deduct salvage values from historical costs of at least:

(A) Five percent of the historical value for each noncloth item included in moveable equipment; and

(B) Twenty-five percent of the historical value for each vehicle.

(2) Unless otherwise provided or limited by this chapter or by chapter 74.46 RCW, the department shall, in determining the total depreciation base of a depreciable real or personal asset owned or leased by the contractor, deduct depreciation relating to all periods subsequent to the more recent of:

(a) The date such asset was first used in the medical care program; or

(b) The most recent date such asset was acquired in an arm's-length purchase transaction which the department is required to recognize for Medicaid cost reimbursement purposes.

No depreciation shall be deducted for periods such asset was not used in the medical care program or was not used to provide nursing care.

(3) The department may have the fair market value of the asset at the time of purchase established by appraisal through the department of general administration of the state of Washington if:

(a) The department challenges the historical cost of an asset; or

(b) The contractor cannot or will not provide the historical cost of a leased asset and the department is unable to determine such historical cost from its own records or from any other source.

The contractor may allocate or reallocate values among land, building, improvements, and equipment in accordance with the department's appraisal.

If an appraisal is conducted, the depreciation base of the asset and cost basis of land will not exceed the fair market value of the asset. An appraisal conducted by or through the department of general administration shall be final unless the appraisal is shown to be arbitrary and capricious.

(4) If the land and depreciable assets of a newly constructed nursing facility were never used in or as a

nursing facility before being purchased from the builder, the cost basis and the depreciation base shall be the lesser of:

(a) Documented actual cost of the builder; or

(b) The approved amount of the certificate of need issued to the builder.

When the builder is unable or unwilling to document its costs, the cost basis and the depreciation base shall be the approved amount of the certificate of need.

(5) For leased assets, the department may examine documentation in its files or otherwise obtainable from any source to determine:

(a) The lessor's purchase acquisition date; or

(b) The lessor's historical cost at the time of the last arm's-length purchase transaction.

If the department is unable to determine the lessor's acquisition date by review of its records or other records, the department, in determining fair market value as of such date, may use the construction date of the facility, as found in the state fire marshal's records or other records, as the lessor's purchase acquisition date of leased assets.

(6) For all rate periods past or future, where depreciable assets or land are acquired from a related organization, the contractor's depreciation base and land cost basis shall not exceed the base and basis the related organization had or would have had under a contract with the department.

(7) If a contractor cannot or will not provide the lessor's purchase acquisition cost of assets leased by the contractor and the department is unable to determine historical purchase cost from another source, the appraised asset value of land, building, or equipment, determined by or through the department of general administration shall be adjusted, if necessary, by the department using the *Marshall and Swift Valuation Guide* to reflect the value at the lessor's acquisition date. If an appraisal has been prepared for leased assets and the assets subsequently sell in the first arm's-length transaction since January 1, 1980, under subsection (9) of this section, the *Marshall and Swift Valuation Guide* will be used to adjust, if necessary, the asset value determined by the appraisal to the sale date. If the assets are located in a city for which the *Marshall and Swift Valuation Guide* publishes a specific index, or if the assets are located in a county containing that city, the city-specific index shall be used to adjust the appraised value of the asset. If the assets are located in a city or county for which a specific index is not calculated, the *Western District Index* calculated by Marshall and Swift shall be used.

(8) For new or replacement building construction or for substantial building additions requiring the acquisition of land and which commenced to operate on or after July 1, 1997, the department shall determine allowable land costs of the additional land acquired for the new or replacement construction or for substantial building additions to be the lesser of:

(a) The contractor's or lessor's actual cost per square foot; or

(b) The square foot land value as established by an appraisal that meets the latest publication of the *Uniform Standards of Professional Appraisal Practice (USPAP)* and the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA). The department shall obtain a USPAP appraisal that meets FIRREA first from:

(i) An arms'-length lender that has accepted the ordered appraisal; or

(ii) If the department is unable to obtain from the arms'-length lender a lender-approved appraisal meeting USPAP and FIRREA standards or if the contractor or lessor is unable or unwilling to provide or cause to be provided a lender-approved appraisal meeting USPAP and FIRREA standards, then:

(A) The department shall order such an appraisal; and

(B) The contractor shall immediately reimburse the department for the costs incurred in obtaining the USPAP and FIRREA appraisal.

(9) Except as provided for in subsection (8) of this section, for all rates effective on or after January 1, 1985, if depreciable assets or land are acquired by purchase which were used in the medical care program on or after January 1, 1980, the depreciation base or cost basis of such assets shall not exceed the net book value existing at the time of such acquisition or which would have existed had the assets continued in use under the previous Medicaid contract with the department; except that depreciation shall not be accumulated for periods during which such assets were not used in the medical care program or were not in use in or as a nursing care facility.

(10)(a) Subsection (9) of this section shall not apply to the most recent arm's-length purchase acquisition if it occurs ten years or more after the previous arm's-length transfer of ownership nor shall subsection (9) of this section apply to the first arm's-length purchase acquisition of assets occurring on or after January 1, 1980, for facilities participating in the Medicaid program before January 1, 1980. The depreciation base or cost basis for such acquisitions shall not exceed the lesser of the fair market value as of the date of purchase of the assets determined by an appraisal conducted by or through the department of general administration or the owner's acquisition cost of each asset, land, building, or equipment. An appraisal conducted by or through the department of general administration shall be final unless the appraisal is shown to be arbitrary and capricious. Should a contractor request a revaluation of an asset, the contractor must document ten years have passed since the most recent arm's-length transfer of ownership. As mandated by Section 2314 of the Deficit Reduction Act of 1984 (P.L. 98-369) and state statutory amendments, and under RCW 74.46.840, for all partial or whole rate periods after July 17, 1984, this subsection is inoperative for any transfer of ownership of any asset, including land and all depreciable or nondepreciable assets, occurring on or after July 18, 1984, leaving subsection (9) of this section to apply without exception to acquisitions occurring on or after July 18, 1984, except as provided in subsections (10)(b) and (11) of this section.

(b) For all rates after July 17, 1984, subsection (8)(a) shall apply, however, to transfers of ownership of assets:

(i) Occurring before January 1, 1985, if the costs of such assets have never been reimbursed under Medicaid cost reimbursement on an owner-operated basis or as a related party lease; or

(ii) Under written and enforceable purchase and sale agreements dated before July 18, 1984, which are documented and submitted to the department before January 1, 1988.

(c) For purposes of Medicaid cost reimbursement under this chapter, an otherwise enforceable agreement to purchase

a nursing home dated before July 18, 1984, shall be considered enforceable even though the agreement contains:

(i) No legal description of the real property involved; or

(ii) An inaccurate legal description, notwithstanding the statute of frauds or any other provision of law.

(11)(a) In the case of land or depreciable assets leased by the same contractor since January 1, 1980, in an arm's-length lease, and purchased by the lessee/contractor, the lessee/contractor shall have the option to have the:

(i) Provisions of subsection (10) of this section apply to the purchase; or

(ii) Reimbursement for property and return on investment continue to be calculated under the provisions contained in RCW 74.46.530 (1)(e) and (f) and WAC 388-96-754(5). Reimbursement shall be based upon provisions of the lease in existence on the date of the purchase.

(b) The lessee/contractor may select the option in subsection (11)(a)(ii) of this section only when the purchase date meets one of the following criteria. The purchase date is:

(i) After the lessor has declared bankruptcy or has defaulted in any loan or mortgage held against the leased property;

(ii) Within one year of the lease expiration or renewal date contained in the lease;

(iii) After a rate setting for the facility in which the reimbursement rate set, under this chapter and under chapter 74.46 RCW, no longer is equal to or greater than the actual cost of the lease; or

(iv) Within one year of any purchase option in existence on January 1, 1988.

(12) For purposes of establishing the property and return on investment component rates, the value of leased equipment, if unknown by the contractor, may be estimated by the department using previous department of general administration appraisals as a data base. The estimated value may be adjusted using the *Marshall and Swift Valuation Guide* to reflect the value of the asset at the lessor's purchase acquisition date.

[Statutory Authority: RCW 74.46.360. 97-17-040, § 388-96-559, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-559, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-559, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-559, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.46.800. 88-16-079 (Order 2660), § 388-96-559, filed 8/2/88; 86-10-055 (Order 2372), § 388-96-559, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-559, filed 8/19/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-559, filed 12/4/84; 81-22-081 (Order 1712), § 388-96-559, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-559, filed 2/25/81; Order 1262, § 388-96-559, filed 12/30/77.]

WAC 388-96-565 Lives. (1) Except for new buildings, major remodels and major repair projects as defined in subsection (3) of this section, the contractor shall use lives reflecting the estimated actual useful life of assets, for example, land improvements, buildings, equipment, leasehold improvements, and other assets. Lives shall not be shorter than guideline lives published by the American Hospital Association in computing allowable depreciation. In cases of newly constructed buildings containing newly licensed nursing home beds, the shortest lives shall be the most recently published lives for construction classes as defined and described in the *Marshall Valuation Service* published by the Marshall Swift Publication Company.

(2) The contractor shall measure lives from the date on which the assets were first used in the medical care program or from the date of the most recent arm's-length acquisition by purchase of the asset, whichever is more recent. The contractor shall extend lives to reflect periods, if any, during which assets were not used to provide nursing care or were not used in the medical care program.

(3) Effective July 1, 1997, for depreciable assets acquired on or after July 1, 1997 including new facilities, major remodels, and major repair projects that begin operating on or after July 1, 1997, the department shall use the most current edition of *Estimated Useful Lives of Depreciable Hospital Assets* published by the American Hospital Publishing, Inc., to determine the useful life of depreciable assets, new building, major remodels, and major repair projects; *provided that*, the shortest life that may be used for new buildings is thirty years. New building, major remodels, and major repair projects are those projects that meet or exceed the expenditure minimum established by the department of health pursuant to chapter 70.38 RCW.

(4) Contractors shall depreciate building improvements other than major remodels and major repairs defined in subsection (3) of this section over the remaining useful life of the building, as modified by the improvement, but not less than fifteen years.

(5) Improvements to leased property which are the responsibility of the contractor under the terms of the lease shall be depreciated over the useful life of the improvement in accordance with American Hospital Association guidelines.

(6) A contractor may change the estimate of an asset's useful life to a longer life for purposes of depreciation.

[Statutory Authority: RCW 74.46.310, [74.46.]320 and [74.46.]330. 97-17-040, § 388-96-565, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-565, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-565, filed 12/21/88. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-565, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-565, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-565, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-565, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-565, filed 2/25/81; Order 1262, § 388-96-565, filed 12/30/77.]

WAC 388-96-585 Unallowable costs. (1) The department shall not allow costs if not documented, necessary, ordinary, and related to the provision of care services to authorized patients.

(2) The department shall include, but not limit unallowable costs to the following:

(a) Costs of items or services not covered by the medical care program. Costs of nonprogram items or services even if indirectly reimbursed by the department as the result of an authorized reduction in patient contribution;

(b) Costs of services and items covered by the Medicaid program but not included in the Medicaid nursing facility daily payment rate. Items and services covered by the Medicaid nursing facility daily payment rate are listed in chapters 388-86 and 388-97 WAC;

(c) Costs associated with a capital expenditure subject to Section 1122 approval (Part 100, Title 42 C.F.R.) if the department found the capital expenditure inconsistent with applicable standards, criteria, or plans. If the contractor did not give the department timely notice of a proposed capital expenditure, all associated costs shall be nonallowable as of the date the costs are determined not to be reimbursable under applicable federal regulations;

(d) Costs associated with a construction or acquisition project requiring certificate of need approval or exemption from the requirements for certificate of need for the replacement of existing nursing home beds pursuant to RCW 70.38.115 (13)(a) if such approval or exemption was not obtained;

(e) Costs of outside activities (e.g., costs allocable to the use of a vehicle for personal purposes or related to the part of a facility leased out for office space);

(f) Salaries or other compensation of owners, officers, directors, stockholders, and others associated with the contractor or home office, except compensation paid for service related to patient care;

(g) Costs in excess of limits or violating principles set forth in this chapter;

(h) Costs resulting from transactions or the application of accounting methods circumventing the principles of the prospective cost-related reimbursement system;

(i) Costs applicable to services, facilities, and supplies furnished by a related organization in excess of the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere;

(j) Bad debts. Beginning July 1, 1983, the department shall allow bad debts of Title XIX recipients only if:

(i) The debt is related to covered services;

(ii) It arises from the recipient's required contribution toward the cost of care;

(iii) The provider can establish reasonable collection efforts were made;

(iv) The debt was actually uncollectible when claimed as worthless; and

(v) Sound business judgment established there was no likelihood of recovery at any time in the future.

Reasonable collection efforts shall consist of three documented attempts by the contractor to obtain payment. Such documentation shall demonstrate the effort devoted to collect the bad debts of Title XIX recipients is at the same level as the effort normally devoted by the contractor to collect the bad debts of non-Title XIX patients. Should a contractor collect on a bad debt, in whole or in part, after filing a cost report, reimbursement for the debt by the department shall be refunded to the department to the extent of recovery. The department shall compensate a contractor for bad debts of Title XIX recipients at final settlement through the final settlement process only.

(k) Charity and courtesy allowances;

(l) Cash, assessments, or other contributions, excluding dues, to charitable organizations, professional organizations, trade associations, or political parties, and costs incurred to improve community or public relations. Any portion of trade association dues attributable to legal and consultant fees and costs in connection with lawsuits or other legal action against the department shall be unallowable;

(m) Vending machine expenses;

(n) Expenses for barber or beautician services not included in routine care;

(o) Funeral and burial expenses;

(p) Costs of gift shop operations and inventory;

(q) Personal items such as cosmetics, smoking materials, newspapers and magazines, and clothing, except items used in patient activity programs where clothing is a part of routine care;

(r) Fund-raising expenses, except expenses directly related to the patient activity program;

(s) Penalties and fines;

(t) Expenses related to telephones, televisions, radios, and similar appliances in patients' private accommodations;

(u) Federal, state, and other income taxes;

(v) Costs of special care services except where authorized by the department;

(w) Expenses of any employee benefit not in fact made available to all employees on an equal or fair basis, e.g., key-man insurance, other insurance, or retirement plans;

(x) Expenses of profit-sharing plans;

(y) Expenses related to the purchase and/or use of private or commercial airplanes which are in excess of what a prudent contractor would expend for the ordinary and economic provision of such a transportation need related to patient care;

(z) Personal expenses and allowances of owners or relatives;

(aa) All expenses for membership in professional organizations and all expenses of maintaining professional licenses, e.g., nursing home administrator's license;

(bb) Costs related to agreements not to compete;

(cc) Goodwill and amortization of goodwill;

(dd) Expense related to vehicles which are in excess of what a prudent contractor would expend for the ordinary and economic provision of transportation needs related to patient care;

(ee) Legal and consultant fees in connection with a fair hearing against the department relating to those issues where:

(i) A final administrative decision is rendered in favor of the department or where otherwise the determination of the department stands at the termination of administrative review; or

(ii) In connection with a fair hearing, a final administrative decision has not been rendered; or

(iii) In connection with a fair hearing, related costs are not reported as unallowable and identified by fair hearing docket number in the period they are incurred if no final administrative decision has been rendered at the end of the report period; or

(iv) In connection with a fair hearing, related costs are not reported as allowable, identified by docket number, and prorated by the number of issues decided favorably to a contractor in the period a final administrative decision is rendered.

(ff) Legal and consultant fees in connection with a lawsuit against the department, including suits which are appeals of administrative decisions;

(gg) Lease acquisition costs, bed rights and other intangible assets not related to patient care;

(hh) Interest charges assessed by the state of Washington for failure to make timely refund of overpayments and

interest expenses incurred for loans obtained to make such refunds;

(ii) Beginning January 1, 1985, lease costs, including operating and capital leases, except for office equipment operating lease costs;

(jj) Beginning January 1, 1985, interest costs;

(kk) Travel expenses outside the states of Idaho, Oregon, and Washington, and the Province of British Columbia. However, travel to or from the home or central office of a chain organization operating a nursing home will be allowed whether inside or outside these areas if such travel is necessary, ordinary, and related to patient care;

(ll) Board of director fees for services in excess of one hundred dollars per board member, per meeting, not to exceed twelve meetings per year;

(mm) Moving expenses of employees in the absence of a demonstrated, good-faith effort to recruit within the states of Idaho, Oregon, and Washington, and the Province of British Columbia;

(nn) For rates effective after June 30, 1993, depreciation expense in excess of four thousand dollars per year for each passenger car or other vehicles primarily used for the administrator, facility staff, or central office staff;

(oo) Any costs associated with the use of temporary health care personnel from any nursing pool not registered with the director of the department of health at the time of such pool personnel use;

(pp) Costs of payroll taxes associated with compensation in excess of allowable compensation for owners, relatives, and administrative personnel;

(qq) Department-imposed postsurvey charges incurred by the facility as a result of subsequent inspections which occur beyond the first postsurvey visit during the certification survey calendar year;

(rr) For all partial or whole rate periods after July 17, 1984, costs of assets, including all depreciable assets and land, which cannot be reimbursed under the provisions of the Deficit Reduction Act of 1984 (DEFRA) and state statutes and regulations implementing DEFRA;

(ss) Effective for July 1, 1991, and all following rates, compensation paid for any purchased nursing care services, including registered nurse, licensed practical nurse, and nurse assistant services, obtained through service contract arrangement in excess of the amount of compensations which would have been paid for such hours of nursing care services had they been paid at the combined regular and overtime average hourly wage, including related taxes and benefits, for in-house nursing care staff of like classification of registered nurse, licensed practical nurse, or nursing assistant at the same nursing facility, as reported on the facility's filed cost report for the most recent cost report period;

(tt) Outside consultation expenses required pursuant to WAC 388-97-275;

(uu) Fees associated with filing a bankruptcy petition under chapters VII, XI, and XIII, pursuant to the Bankruptcy Reform Act of 1978, Public Law 95-598;

(vv) All advertising or promotional costs of any kind, except reasonable costs of classified advertising in trade journals, local newspapers, or similar publications for employment of necessary staff;

(ww) Costs reported by the contractor for a prior period to the extent such costs, due to statutory exemption, will not be incurred by the contractor in the period to be covered by the rate.

[Statutory Authority: RCW 74.46.190, [74.46.]460 and [74.46.]800. 97-17-040, § 388-96-585, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-585, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-585, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-585, filed 5/26/94, effective 6/26/94; 93-17-033 (Order 3615), § 388-96-585, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-585, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-585, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 74.09.120 and 74.46.800. 90-09-061 (Order 2970), § 388-96-585, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.46.800. 89-17-030 (Order 2847), § 388-96-585, filed 8/8/89, effective 9/8/89. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-585, filed 12/21/88. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-585, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-585, filed 5/7/86, effective 7/1/86; 84-12-039 (Order 2105), § 388-96-585, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-585, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-585, filed 10/13/82; 82-11-065 (Order 1808), § 388-96-585, filed 5/14/82; 81-22-081 (Order 1712), § 388-96-585, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-585, filed 2/25/81. Statutory Authority: RCW 74.09.120. 79-04-102 (Order 1387), § 388-96-585, filed 4/4/79. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-585, filed 6/1/78; Order 1262, § 388-96-585, filed 12/30/77.]

WAC 388-96-709 Prospective rate revisions—Reduction in licensed beds. (1) The department will revise a contractor's prospective rate when the contractor reduces the number of its licensed beds and:

(a) Notifies the department in writing thirty days before the licensed bed reduction; and

(b) Supplies a copy of the new bed license and documentation of the number of beds sold, exchanged or otherwise placed out of service, along with the name of the contractor that received the beds, if any; and

(c) Requests a rate revision.

(2) The revised prospective rate shall comply with all the provisions of rate setting contained in this chapter including all lids and maximums unless otherwise specified in this section and shall remain in effect until an adjustment can be made for economic trends and conditions as authorized by chapter 74.46 RCW and this chapter.

(3) The revised prospective rate shall be effective the first of a month determined by where in the month the effective date of the licensed bed reduction occurs or the date the contractor complied with subsections 1(a), (b), and (c) of this section as follows:

(a) If the contractor complied with subsection (1)(a), (b), and (c) of this section and the effective date of the reduction falls:

(i) Between the first and the fifteenth of the month, then the revised prospective rate is effective the first of the month in which the reduction occurs; or

(ii) Between the sixteenth and the end of the month, then the revised prospective rate is effective the first of the month following the month in which the reduction occurs; or

(b) When the contractor fails to comply with subsection 1(a) of this section, then the date the department receives from the contractor the documentation that is required by

subsection (1)(b) and (c) of this section shall become the effective date of the reduction for the purpose of applying subsection (3)(a)(i) and (ii) of this section.

(4) For all prospective Medicaid payment rates from July 1, 1995 through June 30, 1998, the department shall revise a nursing facility's prospective rate to reflect a reduction in licensed beds as follows:

(a) The department shall use the reduced total number of licensed beds to determine occupancy used to calculate the nursing services, food, administrative and operational rate components per WAC 388-96-719. If actual occupancy from the 1994 cost report was:

(i) At or over ninety percent before the reduction and remains at or above ninety percent, there will be no change to the components;

(ii) Less than ninety percent before the reduction and changes to at or above ninety percent, then recompute the components using actual 1994 resident days;

(iii) Less than ninety percent before the reduction and remains below ninety percent, then recompute the components using the change in resident days from the 1994 cost report resulting from the reduced number of licensed beds used to calculate the ninety percent.

(b) To determine occupancy used to calculate the property and return on investment (ROI) components per WAC 388-96-719, the department shall use the facility's anticipated resident occupancy level subsequent to the decrease in licensed bed capacity as long as the occupancy for the reduced number of beds is at or above ninety percent. Subject to the provisions of chapter 388-96 WAC and chapter 74.46 RCW, in no case shall the department use less than ninety percent occupancy of the facility's reduced licensed bed capacity.

[Statutory Authority: RCW 74.46.510. 97-17-040, § 388-96-709, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-709, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-709, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-709, filed 5/26/93, effective 6/26/93.]

WAC 388-96-719 Method of rate determination. (1) Effective July 1, 1995 through June 30, 1998, nursing facility Medicaid payment rates shall be rebased or adjusted for economic trends and conditions annually and prospectively, on a per resident day basis, in accordance with the principles and methods set forth in chapter 74.46 RCW and this chapter, to take effect July 1st of each year. Unless the operator qualifies as a "new contractor" under the provisions of this chapter, a nursing facility's rate for July 1, 1995 must be established upon its own calendar year cost report data for 1994 covering at least six months.

(2) July 1, 1995 component rates in the nursing services, food, administrative and operational cost centers shall be cost-rebased utilizing desk-reviewed and adjusted costs reported for calendar year 1994, for all nursing facilities submitting at least six months of cost data. Such component rates for July 1, 1995 shall also be adjusted upward or downward for economic trends and conditions as provided in RCW 74.46.420 and in this section. Component rates in property and return on investment (ROI) shall be reset annually as provided in chapter 74.46 RCW and in this chapter.

(3) July 1, 1995 component rates in the nursing services, food, administrative and operational cost centers shall be adjusted by the change in the Implicit Price Deflator for Personal Consumption Expenditures Index ("IPD index"). The period used to measure the IPD increase or decrease to be applied to these July 1, 1995 rate components shall be calendar year 1994.

(4) July 1, 1996 component rates in the nursing services, food, administrative and operational cost centers shall not be cost-rebased, but shall be the component rates in these cost centers assigned to each nursing facility in effect on June 30, 1996, adjusted downward or upward for economic trends and conditions by the change in the nursing home input price index without capital costs published by the Health Care Financial Administration of the United States Department of Health and Human Services (HCFA index). The period to be used to measure the HCFA index increase or decrease to be applied to these June 30, 1996 component rates for July 1, 1996 rate setting shall be calendar year 1994.

(5) July 1, 1997 component rates in the nursing services, food, administrative and operational cost centers shall not be cost-rebased, but shall be the component rates in these cost centers assigned to each nursing facility in effect on June 30, 1997, adjusted downward or upward for economic trends and conditions by the change in the nursing home input price index without capital costs published by the Health Care Financing Administration of the United States Department of Health and Human Services (HCFA index), multiplied by a factor of 1.25. The period to be used to measure the HCFA index increase or decrease to be applied to these June 30, 1997 component rates for July 1, 1997 rate setting shall be calendar year 1996.

(6) The 1994 change in the IPD index to be applied to July 1, 1995 component rates in the nursing services, food, administrative and operational costs centers, as provided in subsection (3) of this section, shall be calculated by:

(a) Consulting the latest quarterly IPD index available to the department no later than February 28, 1995 to determine, as nearly as possible, applicable expenditure levels as of December 31, 1994;

(b) Subtracting from expenditure levels taken from the quarterly IPD index described in subsection (6)(a) of this section expenditure levels taken from the IPD index for the quarter occurring one year prior to it; and

(c) Dividing the difference by the level of expenditures from the quarterly IPD index occurring one year prior to the quarterly IPD index described in subsection (6)(a) of this section.

(7) In applying the change in the IPD index to establish July 1, 1995 component rates in the nursing services, food, administrative and operational cost centers for a contractor having at least six months, but less than twelve months, of cost report data from calendar year 1994, the department shall prorate the downward or upward adjustment by a factor obtained by dividing the contractor's actual calendar days from 1994 cost report data by two, adding three hundred sixty-five, and dividing the resulting figure by five hundred forty-eight.

(8) The change in the HCFA index to be applied to each nursing facility's June 30, 1996 and June 30, 1997 compo-

nent rates in nursing services, food, administrative and operational cost centers, as provided in subsections (4) and (5) of this section, shall be calculated by:

(a) Consulting the latest quarterly HCFA index available to the department no later than February 28 following the applicable calendar year to be used to measure the change to determine, as nearly as possible, the applicable price levels as of December 31 of the applicable calendar year;

(b) Subtracting from the price levels taken from the quarterly HCFA index described in subsection (8)(a) of this section the price levels taken from the HCFA index for the quarter occurring one year prior to it; and

(c) Dividing the difference by the price levels from the quarterly HCFA index occurring one year prior to the quarterly HCFA index described in subsection (8)(a).

(9) If either the Implicit Price Deflator for Personal Consumption Expenditures (IDP) index or the Health Care Financing Administration (HCFA) index specified in this section ceases to be available, the department shall select and use in its place or their place one or more measures of change utilizing the same or comparable time periods specified in this section.

(10) For July 1, 1995, July 1, 1996, and July 1, 1997, the department shall establish the per resident day nursing services, food, administrative and operations prospective component rates and limits using resident days at the higher of ninety percent occupancy or actual facility occupancy computed by dividing the actual number of resident days by the product of the number of licensed beds and calendar days in the 1994 cost report period; except that, new facilities as defined in WAC 388-96-026 (1)(a) commencing operation between January 1, 1994 and June 30, 1994 that had their occupancy for nursing services, food, administrative and operational component rates based on the higher of ninety percent or actual occupancy level shall have these component rates revised effective May 1, 1997 based on eighty-five percent occupancy.

(11) For July 1, 1995, July 1, 1996, and July 1, 1997, the department shall compute per resident day property and return on investment prospective component rates using resident days at the higher of ninety percent occupancy or actual facility occupancy computed by dividing the actual number of resident days by the product of the number of licensed beds and calendar days in the prior calendar year cost report period.

(12) If a nursing facility has full-time residents other than those receiving nursing facility care:

(a) The facility may request in writing, and

(b) The department may grant in writing an exception to include the resident days for the nonnursing facility care residents in the occupancy calculations of subsections (10) and (11) of this section. Exceptions granted shall be revocable effective ninety days after written notice of revocation is received from the department. The department shall not grant an exception unless the contractor submits with the annual cost report a certified statement of occupancy including all residents of the facility and their status or level of care.

[Statutory Authority: RCW 74.46.430. 97-17-040, § 388-96-719, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-719, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-719, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-719, filed 9/14/93, effective 10/15/93; 90-09-061 (Order 2970), § 388-96-719, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-719, filed 12/23/87. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-719, filed 8/19/85. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-719, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-719, filed 9/16/83; 82-17-071 (Order 1867), § 388-96-719, filed 8/18/82; 82-12-068 (Order 1820), § 388-96-719, filed 6/2/82; 82-04-073 (Order 1756), § 388-96-719, filed 2/3/82; 81-15-049 (Order 1669), § 388-96-719, filed 7/15/81; 80-06-122 (Order 1510), § 388-96-719, filed 5/30/80, effective 7/1/80; 79-12-085 (Order 1461), § 388-96-719, filed 11/30/79; 78-11-043 (Order 1353), § 388-96-719, filed 10/20/78. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-719, filed 6/1/78. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-719, filed 1/9/78.]

WAC 388-96-735 Administrative cost area rate. (1) The administrative cost center shall include for cost reporting purposes all administrative, oversight, and management costs, whether incurred at the facility or allocated in accordance with a department-approved joint cost allocation methodology.

(2) For July 1, 1995 rate setting only, the department shall determine peer group median cost plus limits for the administrative cost center in accordance with this section.

(a) The department shall divide into two peer groups nursing facilities located in the state of Washington providing services to Medicaid residents. These two peer groups shall be:

(i) Those nursing facilities located within a Metropolitan Statistical Area (MSA) as defined and determined by the United States Office of Management and Budget or other applicable federal office (MSA facilities); and

(ii) Those not located within such an area (non-MSA facilities).

(b) Prior to any adjustment for economic trends and conditions under WAC 388-96-719, the facilities in each peer group shall be arrayed from lowest to highest by magnitude of per resident day adjusted administrative cost from the 1994 cost report year, regardless of whether any such adjustments are contested by the nursing facility. All available cost reports from the 1994 cost report year having at least six months of cost report data shall be used, including all closing cost reports covering at least six months. The department shall include costs current-funded by means of rate add-ons, granted under the authority of WAC 388-96-777 and commencing in the 1994 cost report year in costs arrayed. The department shall exclude costs current-funded by rate add-ons granted under the authority of WAC 388-96-777 and commencing January 1 through June 30, 1995 from costs arrayed.

(c) The median or fiftieth percentile nursing facility administrative cost for each peer group shall then be determined. In the event there are an even number of facilities within a peer group, the adjusted administrative cost of the lowest cost facility in the upper half shall be used as the median cost for that peer group. Facilities at the fiftieth percentile in each peer group and those immediately above and below it shall be subject to field audit in the administrative cost area prior to issuing new July 1 rates.

(3) For July 1, 1995 rate setting only, administrative component rates for facilities within each peer group shall be set at the lower of:

(a) The facility's adjusted per patient day administrative cost from the 1994 report period, reduced or increased by the change in the IPD Index as authorized by WAC 388-96-719; or

(b) The median nursing facility administrative cost for the facility's peer group using the 1994 calendar year report data plus ten percent of that cost, reduced or increased by the change in the IPD Index as authorized by WAC 388-96-719.

(4) Rate add-ons made to current fund administrative costs, pursuant to WAC 388-96-777 and commencing in the 1994 cost report year, shall be reflected in July 1, 1995 prospective rates only by their inclusion in the costs arrayed. A facility shall not receive, based on the calculation or consideration of any such 1994 report year adjustment, a July 1, 1995 administrative rate higher than that provided in subsection (3) of this section.

(5) For all rate setting beginning July 1, 1995 and following, the department shall add administrative rate add-ons, granted under authority of WAC 388-96-533 and 388-96-777 to a facility's administrative rate, but only up to the facility's peer group median cost plus ten percent limit as follows:

(a) For July 1, 1995, add-ons commencing in the preceding six months;

(b) For July 1, 1996, add-ons commencing in the preceding eighteen months; and

(c) For July 1, 1997, add-ons commencing in the preceding thirty months.

(6) Subsequent to issuing July 1, 1995 rates, the department shall recalculate the median costs of each peer group based on the most recent adjusted administrative cost report information in departmental records as of October 31, 1995. For any facility which would have received a higher or lower July 1, 1995 administrative component rate based upon the recalculation of that facility's peer group median costs, the department shall reissue that facility's administrative rate reflecting the recalculation, retroactive to July 1, 1995.

(7) For both the initial calculation of peer group median costs and the recalculation based on adjusted administrative cost information as of October 31, 1995 the department shall use adjusted information regardless of whether the adjustments may be contested or the subject of pending administrative or judicial review. Median costs, once calculated utilizing October 31, 1995 adjusted cost information, shall not be adjusted to reflect subsequent administrative or judicial rulings, whether final or not.

(8) For rates effective July 1, 1996, a nursing facility's noncost-rebased administrative component rate shall be that facility's administrative component rate existing on June 30, 1996, reduced or inflated as authorized by RCW 74.46.420 and WAC 388-96-719. The July 1, 1996, administrative component rate used to calculate the return on investment (ROI) component rate shall be the inflated prospective administrative component rate as of June 30, 1996, excluding any rate increases granted from January 1, 1996 to June 30, 1996 pursuant to RCW 74.46.460 and WAC 388-96-777.

(9) For rates effective July 1, 1997, a nursing facility's noncost-rebased administrative component rate shall be that facility's administrative component rate existing on June 30, 1997, reduced or inflated as authorized by RCW 74.46.420 and WAC 388-96-719. The July 1, 1997, administrative component rate used to calculate the return on investment (ROI) component rate shall be the inflated prospective administrative component rate as of June 30, 1997, excluding any rate increases granted from January 1, 1997 to June 30, 1997 pursuant to RCW 74.46.460 and WAC 388-96-777.

[Statutory Authority: RCW 74.46.800. 97-17-040, § 388-96-735, filed 8/14/97, effective 9/14/97; 96-15-056, § 388-96-735, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-735, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-735, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-735, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-735, filed 12/4/84; 83-19-047 (Order 2025), § 388-96-735, filed 9/16/83; 82-11-065 (Order 1808), § 388-96-735, filed 5/14/82; 81-15-049 (Order 1669), § 388-96-735, filed 7/15/81; 80-06-122 (Order 1510), § 388-96-735, filed 5/30/80, effective 7/1/80; 79-12-085 (Order 1461), § 388-96-735, filed 11/30/79; 78-02-013 (Order 1264), § 388-96-735, filed 1/9/78.]

WAC 388-96-745 Property cost area reimbursement rate. (1) The department shall determine the property cost area component rate for each facility annually, to be effective July 1, 1995, 1996, and 1997 in accordance with this section and any other applicable provisions of this chapter. For July 1, 1995, July 1, 1996, and July 1, 1997 rates, funding granted under the authority of WAC 388-96-776 shall be annualized and subsumed in each of these July 1 prospective rates.

(2) The department shall divide the allowable prior period depreciation costs subject to the provisions of this chapter, adjusted for any capitalized addition or replacements approved by the department, plus

(a) The retained savings from the property cost center as provided in WAC 388-96-228, by

(b) The greater of:

(i) Total resident days for the facility in the calendar year cost report period ending six months prior to each July 1, property component rate commencement date; or

(ii) Resident days for the facility as calculated on eighty-five or ninety percent facility occupancy, as applicable in accordance with the provisions of this chapter and chapter 74.46 RCW.

(3) Allowable depreciation costs are defined as the costs of depreciation of tangible assets meeting the criteria specified in WAC 388-96-557, regardless of whether owned or leased by the contractor. The department shall not reimburse depreciation of leased office equipment.

(4) If a capitalized addition or retirement of an asset will result in an increased licensed bed capacity during the calendar year following the capitalized addition or replacement, the department shall use the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity as long as the occupancy for the increased number of beds is at or above ninety percent. Subject to the provisions of chapter 388-96 WAC and chapter 74.46 RCW, in no case shall the department use less than ninety percent occupancy of the facility's increased licensed bed capacity. If a capitalized addition, replacement,

or retirement results in a decreased licensed bed capacity, WAC 388-96-709 will apply.

(5) When a facility is constructed, remodeled, or expanded after obtaining a certificate of need or exemption from the requirements for certificate of need for the replacement of existing nursing home beds pursuant to RCW 70.38.115 (13)(a), the department shall determine actual and allocated allowable land cost and building construction cost. Reimbursement for such allowable costs, determined pursuant to the provisions of this chapter, shall not exceed the maximums set forth in this subsection and in subsections (4) and (6) of this section. The department shall determine construction class and types through examination of building plans submitted to the department and/or on-site inspections. The department shall use definitions and criteria contained in the *Marshall and Swift Valuation Service* published by the Marshall and Swift Publication Company. Buildings of excellent quality construction shall be considered to be of good quality, without adjustment, for the purpose of applying these maximums.

(6) Construction costs shall be final labor, material, and service costs to the owner or owners and shall include:

(a) Architect's fees;

(b) Engineers' fees (including plans, plan check and building permit, and survey to establish building lines and grades);

(c) Interest on building funds during period of construction and processing fee or service charge;

(d) Sales tax on labor and materials;

(e) Site preparation (including excavation for foundation and backfill);

(f) Utilities from structure to lot line;

(g) Contractors' overhead and profit (including job supervision, workmen's compensation, fire and liability insurance, unemployment insurance, etc.);

(h) Allocations of costs which increase the net book value of the project for purposes of Medicaid reimbursement;

(i) Other items included by the *Marshall and Swift Valuation Service* when deriving the calculator method costs.

(7) The department shall allow such construction costs, at the lower of actual costs or the maximums derived from the sum of the basic construction cost limit plus the common use area limit which corresponds to the type, class and number of total nursing home beds for the new construction, remodel or expansion. The maximum limits shall be calculated using the most current cost criteria contained in the Marshall and Swift Valuation Service and shall be adjusted forward to the midpoint date between award of the construction contract and completion of construction.

(8) When some or all of a nursing home's common-use areas are situated in a basement, the department shall exclude some or all of the per-bed allowance for common-use areas to derive the construction cost lid for the facility. The amount excluded will be equal to the ratio of basement common-use areas to all common-use areas in the facility times the common-use area limits determined in accordance with subsection (7) of this section. In lieu of the excluded amount, the department shall add an amount calculated using the calculator method guidelines for basements in nursing homes published in the Marshall and Swift Valuation Service.

(9) Subject to provisions regarding allowable land contained in this chapter, allowable costs for land shall be the lesser of:

(a) Actual cost per square foot, including allocations;

(b) The average per square foot land value of the ten nearest urban or rural nursing facilities at the time of purchase of the land in question. The average land value sample shall reflect either all urban or all rural facilities depending upon the classification of urban or rural for the facility in question. The values used to derive the average shall be the assessed land values which have been calculated for the purpose of county tax assessments; or

(c) For new or replacement building construction or for substantial building additions requiring the acquisition of land which commenced to operate on or after July 1, 1997, WAC 388-96-559(8) shall apply.

(10) If allowable costs for construction or land are determined to be less than actual costs pursuant to subsection (3), (4), and (5) of this section, the department may increase the amount if the owner or contractor is able to show unusual or unique circumstances having substantially impacted the costs of construction or land. Actual costs shall be allowed to the extent they resulted from such circumstances up to a maximum of ten percent above levels determined under subsections (3), (4), and (5) of this section for construction or land. An adjustment under this subsection shall be granted only if requested by the contractor. The contractor shall submit documentation of the unusual circumstances and an analysis of their financial impact with the request.

[Statutory Authority: RCW 74.46.800 and 74.46.530. 97-17-040, § 388-96-745, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-745, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-745, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-745, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-745, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-745, filed 7/23/92, effective 8/23/92. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-745, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-745, filed 12/23/87. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-745, filed 4/20/87. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-745, filed 12/4/84.]

WAC 388-96-754 A contractor's return on investment. (1) The department shall establish for each Medicaid nursing facility a return on investment (ROI) component rate composed of a financing allowance and a variable return allowance. The department shall determine a facility's ROI rate annually in accordance with this section, to be effective July 1, 1995, July 1, 1996, and July 1, 1997.

(2) The department shall rebase a nursing facility's financing allowance annually and shall determine the financing allowance by:

(a) Multiplying the net invested funds of each facility by ten percent and dividing by the greater of:

(i) A nursing facility's total resident days from the most recent cost report period, to which the provisions of WAC 388-96-719 and RCW 74.46.420 shall apply; or

(ii) Resident days calculated on eighty-five percent or ninety percent resident occupancy at the facility, as deter-

mined by the provisions of this chapter. Resident day calculations from the most recent cost report shall correspond to the following:

(A) If the nursing facility cost report covers twelve months, annual resident days from the contractor's most recent twelve month cost report period; or

(B) If the nursing facility cost report covers less than twelve months but more than six months, annualized resident days and working capital costs based upon data in the cost report.

(b) If a capitalized addition or replacement results in an increased licensed bed capacity during the calendar year following the capitalized addition or replacement, the department shall multiply the net invested funds of each facility by ten percent and divide by the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity as long as the occupancy for the increased number of beds is at or above ninety percent. Subject to the provisions of chapter 388-96 WAC and chapter 74.46 RCW, in no case shall the department use less than ninety percent occupancy of the facility's increased licensed bed capacity.

If a capitalized addition or retirement of an asset results in a decreased licensed bed capacity, WAC 388-96-709 will apply.

(c) For July 1, 1995 rate setting, the working capital portion of net invested funds at a nursing facility shall be five percent of the sum of a contractor's costs from the cost report year used to establish the contractor's prospective component rates in the nursing services, food, administrative, and operational cost centers that have been adjusted for economic trends and conditions under authority of WAC 388-96-719 and RCW 74.46.420 and five percent of allowable property cost.

(d) For July 1, 1996 rate setting, the working capital portion of net invested funds shall be five percent of the sum of the July 1, 1996 prospective component rates, excluding any rate increases granted from January 1, 1996 to June 30, 1996 pursuant to RCW 74.46.460, WAC 388-96-774 and 388-96-777, for the nursing services, food, administrative, and operational cost centers multiplied by resident days as defined in subsection (2)(a)(ii)(A)and (B), or if a capitalized addition or replacement, subsection (2)(b) of this section from calendar year 1995, adjusted for economic trends and conditions granted under authority of WAC 388-96-719 plus the desk reviewed property costs from the cost report for calendar year 1995;

(e) For July 1, 1997 rate setting, the working capital portion of net invested funds shall be five percent of the sum of the July 1, 1997 prospective component rates, excluding any rate increases granted from January 1, 1997 to June 30, 1997 pursuant to RCW 74.46.460, WAC 388-96-774 and 388-96-777, for the nursing services, food, administrative and operational cost centers multiplied by resident days as defined in subsection (2)(a)(ii)(A)and (B) and (b) of this section from calendar year 1996, adjusted for economic trends and conditions granted under authority of WAC 388-96-719 plus the desk reviewed property costs from the cost report for calendar year 1996;

(f) For July 1, 1995, July 1, 1996, and July 1, 1997 rate setting, in computing the portion of net invested funds representing the net book value of tangible fixed assets, the same assets, depreciation bases, lives, and methods referred to in this chapter, including owned and leased assets, shall be used, except the capitalized cost of land upon which a facility is located and other such contiguous land which is reasonable and necessary for use in the regular course of providing resident care shall also be included. As such, subject to provisions contained in this chapter, capitalized cost of leased land, regardless of the type of lease, shall be the lessor's historical capitalized cost. Subject to provisions contained in this chapter, for land purchases before July 18, 1984 (the enactment date of the Deficit Reduction Act of 1984 (DEFRA)), capitalized cost of land shall be the buyer's capitalized cost. For all partial or whole rate periods after July 17, 1984, if the land is purchased on or after July 18, 1984, capitalized cost of land shall be that of the owner of record on July 17, 1984, or buyer's capitalized cost, whichever is lower. In the case of leased facilities where the net invested funds are unknown or the contractor is unable or unwilling to provide necessary information to determine net invested funds, the department may determine an amount to be used for net invested funds based upon an appraisal conducted by the department of general administration per this chapter; and

(g) A contractor shall retain that portion of ROI rate payments at settlement representing the contractor's financing allowance only to the extent reported net invested funds, upon which the financing allowance is based, are substantiated by the department.

(3) The department shall determine the variable return allowance according to the following procedure:

(a) For July 1, 1995 rate setting only, the department shall, without utilizing the MSA and Non-MSA peer groups used to calculate other Medicaid component rates, rank all facilities in numerical order from highest to lowest based upon the combined average resident day allowable costs, as adjusted by desk review and audit, for the nursing services, food, administrative, and operational cost centers taken from the 1994 cost report period. The department shall use adjusted costs taken from 1994 cost reports having at least six months of data, shall not include adjustments for economic trends and conditions granted under authority of WAC 388-96-719 and RCW 74.46.420, and shall include costs current-funded under authority of WAC 388-96-774 and 388-96-777 and commencing in the 1994 cost report year. The adjusted costs of each facility shall be calculated based upon a minimum facility occupancy of ninety percent. In the case of a new contractor, nursing services, food, administrative, and operational cost levels actually used to set the initial rate shall be used for the purpose of ranking the new contractor.

(b) The department shall compute the variable return allowance by multiplying the sum of the July 1, 1995 nursing services, food, administrative and operational rate components for each nursing facility by the appropriate percentage which shall not be less than one percent nor greater than four percent. The department shall divide the facilities ranked according to subsection (3)(a) of this section into four groups, from highest to lowest, with an equal number of facilities in each group or nearly equal as is possible. The department shall assign facilities in the highest quarter a percentage of one, in the second highest quarter a percentage of two, in the third highest quarter a percentage of three, and in the lowest quarter a percentage of four. The

per patient day variable return allowance in the initial rate of a new contractor shall be the same as that in the rate of the preceding contractor, if any.

(c) The percentages so determined and assigned to each facility for July 1, 1995 rate setting, shall continue to be assigned without modification for July 1, 1996 and July 1, 1997 rate setting. Neither the break points separating the four groups nor facility ranking shall be adjusted to reflect future rate add-ons granted to contractors for any purpose under WAC 388-96-774 and 388-96-777. These principles shall apply, as well, to new contractors as defined in WAC 388-96-026 (1)(a) and (b).

(d) For an initial rate established for a nursing facility on or after July 1, 1995 under WAC 388-96-710(1), the variable return allowance shall be computed as provided in subsection (3)(b) of this section, using the identical variable return percentage breakpoints calculated for July 1, 1995 rate setting. The variable return breakpoints shall not be modified based upon the consideration of any rate adjustment, nor shall the variable return breakpoints be adjusted for economic trends and conditions. The percentage so determined and assigned for the initial rate shall continue until the facility's return on investment component rate can be rebased from cost report data of the new contractor covering at least six months from the prior calendar year.

(e) For a new contractor's nursing facility rate rebased as of July 1, 1996 determined under WAC 388-96-710, the variable return allowance shall be computed as provided in subsection (3)(b) of this section, using the identical variable return breakpoints calculated for July 1, 1995 rate setting. The variable return breakpoints shall not be modified based upon the consideration of any rate adjustment, nor shall the variable return breakpoints be adjusted for economic trends and conditions. The percentage so determined and assigned for the rebased rate at this time shall continue without modification for July 1, 1997 rate setting.

(f) For a new contractor's nursing facility rate rebased as of July 1, 1997 determined under WAC 388-96-710, the variable return allowance shall be computed as provided in subsection (3)(b) of this section, using the identical variable return breakpoints calculated for July 1, 1995 rate setting. The variable return breakpoints shall not be modified based upon consideration of any rate adjustment, nor shall the variable return breakpoints be adjusted for economic trends and conditions. The percentage so determined and assigned for the rebased rate at this time shall continue without modification until June 30, 1998.

(4) The sum of the financing allowance and the variable return allowance shall be the return on investment rate for each facility and shall be a component of the prospective rate for each facility.

(5) If a facility is leased by a contractor as of January 1, 1980, in an arm's-length agreement, which continues to be leased under the same lease agreement as defined in this chapter, and for which the annualized lease payment, plus any interest and depreciation expenses of contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total patient days, minus the property cost center determined according to this chapter, is more than the return on investment allowance determined according to this section, the following shall apply:

(a) The financing allowance shall be recomputed substituting the fair market value of the assets, as of January 1, 1982, determined by department of general administration appraisal less accumulated depreciation on the lessor's assets since January 1, 1982, for the net book value of the assets in determining net invested funds for the facility. Said appraisal shall be final unless shown to be arbitrary and capricious.

(b) The sum of the financing allowance computed under this subsection and the variable return allowance shall be compared to the annualized lease payment, plus any interest and depreciation expenses of contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total patient days, minus the property cost center rate determined according to this chapter. The lesser of the two amounts shall be called the alternate return on investment allowances.

(c) The return on investment allowance determined in accordance with subsections (1), (2), (3), and (4) of this section or the alternate return on investment allowance, whichever is greater, shall be the return on investment allowance for the facility and shall be a component of the prospective rate of the facility.

(d) In the case of a facility leased by the contractor as of January 1, 1980, in an arm's-length agreement, if the lease is renewed or extended pursuant to a provision of the lease agreement existing on January 1, 1980, the treatment provided in subsection (5)(a) of this section shall be applied except that in the case of renewals or extensions made on or subsequent to April 1, 1985, per a provision of the lease agreement existing on January 1, 1980, reimbursement for the annualized lease payment shall be no greater than the reimbursement for the annualized lease payment for the last year prior to the renewal or extension of the lease.

(6) The information from the two prior reporting periods used to set the two prospective return on investment rates in effect during the settlement year is subject to field audit. If the financing allowances which can be documented and calculated at audit of the prior periods are different than the prospective financing allowances previously determined by desk-reviewed, reported information, and other relevant information, the prospective financing allowances shall be adjusted to the audited level at final settlement of the year the rates were in effect, except the adjustments shall reflect a minimum bed occupancy level of eighty-five percent. Any adjustments to the financing allowances pursuant to this subsection shall be for settlement purposes only. However, the variable return allowances shall be the prospective allowances determined by desk-reviewed, reported information, and other relevant information and shall not be adjusted to reflect prior-period audit findings.

[Statutory Authority: RCW 74.46.530. 97-17-040, § 388-96-754, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-754, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-754, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-754, filed 9/14/93, effective 10/15/93; 91-22-025 (Order 3270), § 388-96-754, filed 10/29/91, effective 11/29/91; 90-09-061 (Order 2970), § 388-96-754, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-754, filed 12/21/88. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-754, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-754, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-754, filed 8/19/85.

Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-754, filed 12/4/84.]

WAC 388-96-774 Add-ons to the prospective rate—Staffing. (1) The department shall determine each contractor's reimbursement rates prospectively at least once each calendar year, to be effective July 1st.

(a) The department may grant a rate add-on to a nursing service (NS) or operational (OP) prospective reimbursement rate; *provided* that, for the current fiscal year, the total amount of the current legislative appropriation, if any, to fund the Medicaid share of such rate add-on has not been exceeded. The NS and OP rate add-ons shall be for:

(i) Variations in the distribution of patient classifications for the total resident population or changes in patient characteristics for the total resident population from the Medicaid cost report for the period on which the current rate was set; or

(ii) Changes in staffing levels at a facility required by the department as evidenced by a written directive from the director of nursing home services, aging and adult services administration.

(b) The department shall not grant and the contractor shall not use rate add-ons for:

(i) Compensation increases for existing, newly hired or promoted staff;

(ii) The use of temporary employment services providing direct patient care;

(iii) Any purpose if the nursing facility has a pending bankruptcy; *unless*, it is under chapter 11 and the nursing facility can provide a written evaluation from the trustee in bankruptcy stating the reorganization will be approved and implemented;

(iv) Correction of survey citations; or

(v) Staffing increases to resolve complaints.

(c) The department shall not grant a rate add-on to a cost center if that cost center is at or above the median cost limit for the facility's peer group reduced or increased under WAC 388-96-719.

(2) Per state fiscal year, the contractor may submit no more than two requests under this section. If a request has been previously submitted and denied because it was not complete, then it will not count as a request for this subsection; *provided*, the resubmitted request is complete and exactly the same as the previous request, e.g., type of request, positions and full-time equivalencies.

(3) Contractors requesting a rate add-on shall submit a written request to the office of rates management, aging and adult services administration, separate from all other requests and inquiries of the department, e.g., WAC 388-96-904 (1) and (5). The written request shall only be submitted after the hire date of the new staff and shall include the following:

(a) A financial analysis showing:

(i) The increased cost; and

(ii) An estimate of the rate increase, computed according to allowable methods, necessary to fund the cost.

(b) A written justification for granting the rate increase;

(c) A certification and supporting documentation showing the changes in staffing have commenced;

(d) Two proofs of hire, e.g., payroll document, W-4, and appointment letter;

(e) A written narrative describing the contractor's efforts to provide alternative solutions prior to submitting a request under this section; and

(f) A written plan specifying:

(i) Additional staff to be added;

(ii) Changes in all patient characteristics requiring the additional staff; and

(iii) The predicted improvements in patient care services that will result.

(4) Contractors receiving rate add-ons per this section shall submit quarterly reports. The quarterly reports shall cover the first day the rate add-on is effective and show how the additional rate funds and hours were utilized. The contractor shall submit quarterly reports as long as it receives the rate add-on. If the contractor does not use the funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

(5) In reviewing a request made under subsection (3) of this section, the department shall consider but is not limited to one or more of the following:

(a) Whether additional staff requested by a contractor is necessary to meet patient care needs;

(b) Comparisons of staffing patterns of nursing facilities from either the latest statewide metropolitan statistical area (MSA) peer group or non-MSA peer group to which the nursing facility belongs and calculated on a per patient day basis. The department shall use the latest MSA and non-MSA designations received from the office of management and budget or the appropriate federal agency;

(c) The physical layout of the facility;

(d) Nursing service planning and management for maximum efficiency;

(e) Historic trends in underspending of a facility's nursing services and operational component rates;

(f) Numbers, positions, and scheduling of existing staff;

(g) Increases in acuity (debility) levels of all residents in the facility;

(h) Survey, complaint resolution reports, and quality assurance data; and

(i) The facility's ability to fund its staffing request through the facility's existing total Medicaid reimbursement rate.

(6) The department may also adjust rates to cover costs associated with placing a nursing home in receivership for costs not covered by the rate of the former contractor, including:

(a) Compensation of the receiver;

(b) Reasonable expenses of receivership and transition of control; and

(c) Costs incurred by the receiver in carrying out court instructions or rectifying deficiencies found.

(7) The department shall not grant a rate add-on effective earlier than sixty days prior to receipt of the initial written request by the office of rates management subject to the requirements of subsection (3) of this section, the department shall grant a rate add-on for an approved request as follows:

(a) If the request is received between the first day and fifteenth day of the month, then the rate will be effective on the first day of that month; or

(b) If the request is received between the sixteenth day and the last day of the month, the rate will be effective on the first day of the following month.

(8) If the initial written request is incomplete, the department will notify the contractor of the documentation and information required. The contractor must submit the requested information within fifteen days from the date the contractor receives the notice to provide the information. If the contractor fails to complete the rate add-on request by providing all the requested documentation and information within the fifteen days from the date of receipt of notification, the department will deny the request for failure to complete.

(9) If, after the denial for failure to complete the request, the contractor submits a written request for the same need, the date of receipt for the purposes of applying subsection (7) will depend upon whether the subsequent request for the same need is complete, i.e., the department does not have to request additional documentation and information in order to make a determination. If a subsequent request for funding of the same need is:

(a) Complete, then the date of the initial incomplete request may be used when applying subsection (7) of this section; or

(b) Incomplete, then the date of the subsequent request must be used when applying subsection (7) of this section.

(10) The department shall respond, in writing, not later than sixty days after receipt of a complete request.

[Statutory Authority: RCW 74.46.460. 97-17-040, § 388-96-774, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-774, filed 7/16/96, effective 8/16/96; 94-12-043 and 94-14-016 (Order 3737 and 3737A), § 388-96-774, filed 5/26/94 and 6/23/94, effective 6/26/94 and 7/24/94; 93-17-033 (Order 3615), § 388-96-774, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-774, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.09.120 and 74.46.800. 90-09-061 (Order 2970), § 388-96-774, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-774, filed 12/21/88. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-774, filed 12/23/87. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-774, filed 4/20/87. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-774, filed 8/19/85.]

WAC 388-96-776 Add-ons to the prospective rate—Capital improvements. (1) The department shall grant an add-on to a prospective rate for any capitalized additions or replacements made as a condition for licensure or certification; *provided*, the net rate effect is ten cents per patient day or greater.

(2) The department shall grant an add-on to a prospective rate for capitalized improvements done under RCW 74.46.465; *provided*, the legislature specifically appropriates funds for capital improvements for the biennium in which the request is made and the net rate effect is ten cents per patient day or greater. Physical plant capital improvements include, but are not limited to, capitalized additions, replacements or renovations made as a result of an approved certificate of need or exemption from the requirements for certificate of need for the replacement of existing nursing home beds pursuant to RCW 70.38.115 (13)(a) or capitalized additions or renovations for the removal of physical plant waivers.

(3) Rate add-ons granted pursuant to subsection (1), (2) or (16) of this section shall be limited in total amount each fiscal year to the total current legislative appropriation, if any, specifically made to fund the Medicaid share of such rate add-ons for the fiscal year.

(4) When physical plant improvements made under subsection (1) or (2) are completed in phases, the department shall not grant a rate add-on for any addition, replacement or improvement until each phase is completed and fully utilized for which it was intended. The department shall limit rate add-on to only the actual cost of the depreciable tangible assets meeting the criteria of WAC 388-96-557 and as applicable to that specific completed and fully utilized phase.

(5) When the construction class of any portion of a newly constructed building will improve as the result of any addition, replacement or improvement occurring in a later, but not yet completed and fully utilized phase of the project, the most appropriate construction class, as applicable to that completed and fully utilized phase, will be assigned for purposes of calculating the rate add-on. The department shall not revise the rate add-on retroactively after completion of the portion of the project that provides the improved construction class. Rather, the department shall calculate a new rate add-on when the improved construction class phase is completed and fully utilized and the rate add-on will be effective in accordance with subsection (9) of this section using the date the class was improved.

(6) The department shall not add on construction fees as defined in WAC 388-96-745(6) and other capitalized allowable fees and costs as related to the completion of all phases of the project to the rate until all phases of the entire project are completed and fully utilized for the purpose it was made. At that time, the department shall add on these fees and costs to the rate, effective no earlier than the earliest date a rate add-on was established specifically for any phase of this project. If the fees and costs are incurred in a later phase of the project, the add-on to the rate will be effective on the same date as the rate add-on for the actual cost of the tangible assets for that phase.

(7) The contractor requesting an adjustment under subsection (1) or (2) shall submit a written request to the office of rates management separate from all other requests and inquiries of the department, e.g., WAC 388-96-904 (1) and (5). A complete written request shall include the following:

(a) A copy of documentation requiring completion of the addition or replacements to maintain licensure or certification for adjustments requested under subsection (1) of this section;

(b) A copy of the new bed license, whether the number of licensed beds increases or decreases, if applicable;

(c) All documentation, e.g., copies of paid invoices showing actual final cost of assets and/or service, e.g., labor purchased as part of the capitalized addition or replacements;

(d) Certification showing the completion date of the capitalized additions or replacements and the date the assets were placed in service per WAC 388-96-559(2);

(e) A properly completed depreciation schedule for the capitalized additions or replacement as provided in this chapter;

(f) A written justification for granting the rate increase; and

(g) For capitalized additions or replacements requiring certificate of need approval, a copy of the approval and description of the project.

(8) The department's criteria used to evaluate the request may include, but is not limited to:

(a) The remaining functional life of the facility and the length of time since the facility's last significant improvement;

(b) The amount and scope of the renovation or remodel to the facility and whether the facility will be better able to serve the needs of its residents;

(c) Whether the improvement improves the quality of living conditions of the residents;

(d) Whether the improvement might eliminate life safety, building code, or construction standard waivers;

(e) Prior survey results; and

(f) A review of the copy of the approval and description of the project.

(9) The department shall not grant a rate add-on effective earlier than sixty days prior to the receipt of the initial written request by the office of rates management and not earlier than the date the physical plant improvements are completed and fully utilized. The department shall grant a rate add-on for an approved request as follows:

(a) If the physical plant improvements are completed and fully utilized during the period from the first day to the fifteenth day of the month, then the rate will be effective on the first day of that month; or

(b) If the physical plant improvements are completed and fully utilized during the period from the sixteenth day and the last day of the month, the rate will be effective on the first day of the following month.

(10) If the initial written request is incomplete, the department will notify the contractor of the documentation and information required. The contractor shall submit the requested information within fifteen days from the date the contractor receives the notice to provide the information. If the contractor fails to complete the add-on request by providing all the requested documentation and information within the fifteen days from the date of receipt of notification, the department shall deny the request for failure to complete.

(11) If, after the denial for failure to complete, the contractor submits a written request for the same project, the date of receipt for the purpose of applying subsection (9) will depend upon whether the subsequent request for the same project is complete, i.e., the department does not have to request additional documentation and information in order to make a determination. If a subsequent request for funding of the same project is:

(a) Complete, then the date of the first request may be used when applying subsection (9); or

(b) Incomplete, then the date of the subsequent request must be used when applying subsection (9) even though the physical plant improvements may be completed and fully utilized prior to that date.

(12) The department shall respond, in writing, not later than sixty days after receipt of a complete request.

(13) If the contractor does not use the funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

(14) When any physical plant improvements made under subsection (1) or (2) results in a change in licensed beds, any rate add-on granted will be subject to the provisions regarding the number of licensed beds, patient days, occupancy, etc., included in this chapter.

(15) All rate components to fund the Medicaid share of nursing facility new construction or refurbishing projects costing in excess of one million two hundred thousand dollars, or projects requiring state or federal certificate of need approval, shall be based upon a minimum facility occupancy of eighty-five percent for the nursing services, food, administrative, operational and property cost centers, and the return on investment (ROI) rate component, during the initial rate period in which the adjustment is granted. These same component rates shall be based upon a minimum facility occupancy of ninety percent for all rate periods after the initial rate period.

(16) If a rate add-on granted under the authority of this section for a capitalized addition or replacement results in an increase in property taxes, the department may grant an additional rate add-on to fund the Medicaid share of any increase in property taxes. A rate add-on granted under this subsection shall be effective the first day of the month the tax increase is effective.

[Statutory Authority: RCW 74.46.465. 97-17-040, § 388-96-776, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-776, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-776, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-776, filed 5/26/94, effective 6/26/94.]

Chapter 388-110 WAC

CONTRACTED RESIDENTIAL CARE SERVICES: ASSISTED LIVING SERVICES, ENHANCED ADULT RESIDENTIAL CARE, AND ADULT RESIDENTIAL CARE

WAC

WAC 388-110-110 Caregiver education and training requirements. (1) The contractor shall ensure that:

(a) All caregivers hired on or after July 1, 1996 successfully complete the department designated fundamentals of caregiving training within one hundred twenty days of employment, unless he or she meets the requirements in subsection (2) below;

(b) All caregivers hired prior to July 1, 1996 successfully complete the department designated fundamentals of caregiving training prior to March 1, 1997, unless he or she meets the requirements in subsection (2) below; and

(c) All caregivers complete a minimum of ten hours of continuing education credits per calendar year, on topics relevant to caregiving:

(i) Topics include but are not limited to residents' rights, personal care, dementia, mental illness, developmental disabilities, depression, medication assistance, communica-

tion skills, alternatives to restraints, and activities for residents;

(ii) Caregivers must receive a certificate of completion to meet the requirement for continuing education credit and each hour of completed instruction will count as one hour of continuing education credit; and

(iii) The continuing education requirement begins the calendar year after the year in which the caregiver completes the fundamentals or modified fundamentals of caregiving training.

(2) A caregiver who has successfully completed training as a registered or licensed practical nurse, a physical or occupational therapist, a nursing assistant certified, a home health aide from a Medicare-certified home health agency or who has successfully completed a department approved adult family home training, or department approved personal care training from an area agency on aging or its subcontractor, is exempt from the fundamentals of caregiving training in subsection (1) above if the caregiver successfully completes the department designated modified fundamentals of caregiving training in accordance with the dates specified in subsection (1) above.

(3) Caregivers are exempt from attending the fundamentals of caregiving or modified fundamentals of caregiving trainings if they successfully pass the department's challenge test for the class they are required to take. The caregiver has only one opportunity to take the challenge test. If the caregiver does not successfully pass the challenge test, then he/she must attend the fundamentals of caregiving or modified fundamentals of caregiving trainings as required.

(4) Contractors who meet the prescribed criteria may be approved by the department to provide the department's designated caregiver training programs within the facility.

(5) Volunteers are exempt from the training requirements listed above unless they provide unsupervised direct personal care to residents.

(6) The contractor shall document that caregivers have met the education and training requirements.

[Statutory Authority: RCW 74.39A.010 and 74.39A.020. 97-19-020, § 388-110-110, filed 9/8/97, effective 10/9/97. Statutory Authority: RCW 74.39A.010, 74.39A.020 and 74.39A.080. 96-21-050, § 388-110-110, filed 10/11/96, effective 11/11/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-110, filed 5/8/96, effective 6/8/96.]

Chapter 388-165 WAC
CONSOLIDATED EMERGENCY ASSISTANCE PROGRAM— SOCIAL SERVICES (CEAP-SS)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-165-005 Purpose. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-005, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-010 General provisions. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-010, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-020 Application procedure. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-020, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-030 Application form. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-030, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-040 Assistance unit. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-040, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-050 Eligibility conditions—Emergent need. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-050, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-060 Eligibility conditions—Income and resource eligibility. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-060, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-070 Eligibility conditions—Living with a relative of a specified degree. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-070, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-080 Eligibility conditions—Job refusal. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-080, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-090 Eligibility conditions—Residency and alien status. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-090, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-100 Payment limitations. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04,050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-100, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-165-005 through 388-165-100 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-200 WAC

FINANCIAL AND MEDICAL ASSISTANCE—GENERAL PROVISIONS

WAC

WAC 388-200-1400 Application of rules—Temporary assistance to needy families. Unless otherwise specified, references in Title 388 WAC to the aid to families with dependent children (AFDC) program shall include the temporary assistance to needy families (TANF) program.

[Statutory Authority: RCW 74.08.090, 74.04.050, 70.04.055 and Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, § 103). 97-07-008, § 388-200-1400, filed 3/10/97, effective 4/10/97.]

Chapter 388-201 WAC

SUCCESS THROUGH EMPLOYMENT PROGRAM (STEP)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-201-100 General provisions. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act Section 1115. 95-24-014 (Order 3925), § 388-201-100, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-200 Definitions. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-200, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-200, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-300 Participation. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-300, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-300, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-400 Hundred-hour treatment group—Elimination of the one-hundred-hour rule. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-400, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-400, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-410 Length-of-stay treatment group—Assessment of past AFDC receipt. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-410, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-410, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-420 Length-of-stay treatment group—Initial length-of-stay grant reductions. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-420, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-420, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-430 Length-of-stay treatment group—Additional length-of-stay grant reductions. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-430, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-430, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-440 Length-of-stay treatment group—Redetermination of length-of-stay grant reductions. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-440, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-440, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-450 Length-of-stay treatment group—Families exempt from length-of-stay grant reductions. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-450, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-450, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-460 Length-of-stay treatment group—Length-of-stay earned income adjustments. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-460, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-460, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-470 Length-of-stay treatment group—Advance notice of impending length-of-stay grant reductions. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-470, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-470, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

388-201-480 Length-of-stay treatment group—Reducing the impact of cumulative length-of-stay grant reductions. [Statutory Authority: RCW 74.12.036, 74.12.420, 74.12.425, 74.12.901 and Social Security Act, Section 1115. 96-07-021 (Order 3955), § 388-201-480, filed 3/13/96, effective 4/13/96; 95-24-014 (Order 3925), § 388-201-480, filed 11/22/95, effective 1/1/96.] Repealed by 97-20-056, filed 9/24/97, effective 10/25/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997).

WAC 388-201-100 through 388-201-480 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-215 WAC
AID TO FAMILIES WITH DEPENDENT CHILDREN—CATEGORICAL ELIGIBILITY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-215-1200 Citizenship and alienage. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-215-1200, filed 5/3/94, effective 6/3/94. Formerly WAC 388-26-120 (part).] Repealed by 97-20-125, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090 and 74.04.0052.

WAC 388-215-1000 Summary of eligibility conditions. (1) The department shall grant TANF on behalf of a child who:

(a) Meets the age requirements under WAC 388-215-1025; and

(b) Lives in the home of a relative as defined under WAC 388-215-1050 through 388-215-1080. For temporary absences, see WAC 388-215-1100 through 388-215-1115; and

(c) Is a citizen or an eligible alien whose immigration status meets the criteria of a qualified alien as specified in federal law at U.S.C. Title 8, Sections 1611, 1612, 1613, 1641, and 1645; and

(d) Is a resident of the state of Washington, or resides with a parent or other relative who is a resident of the state of Washington (see WAC 388-215-1225); and

(e) Is in financial need (see chapters 388-216 through 388-219 WAC); and

(f) Is deprived of parental support or care because of the death (see WAC 388-215-1300), continued absence (see WAC 388-215-1320 through 388-215-1335), incapacity (see WAC 388-215-1340 through 388-215-1360), or unemployment (see WAC 388-215-1370 through 388-215-1385) of a parent. A parent is a person meeting the criteria in WAC 388-215-1060; and

(g) Lives with a parent who has not already received the maximum lifetime limit of sixty months of TANF (see WAC 388-215-1010).

(2) To be eligible, a TANF applicant or recipient shall:

(a) Be a United States citizen or national; or

(b) Meet federal immigrant status eligibility requirements as specified in U.S.C. Title 8, Sections 1611, 1612, 1613, 1641, and 1645; and

(c) Assign to the division of child support any rights to support as required under WAC 388-215-1400; (d) Cooperate with the division of child support as required under WAC 388-215-1400 through 388-215-1490;

(e) Furnish a Social Security number as specified in WAC 388-215-1500;

(f) Cooperate in a review of eligibility as specified in WAC 388-215-1510;

(g) Participate in the WorkFirst program as specified in chapter 388-310 WAC;

(h) Abide by the rules regarding participation in strikes as specified under WAC 388-215-1540; and

(i) Return a completed monthly report to the department when required under WAC 388-215-1560.

(3) The department shall establish assistance units of children and caretaker relatives eligible for TANF under WAC 388-215-1600 through 388-215-1630.

(4) The department shall determine eligibility for a minor child applying for oneself as required under WAC 388-215-1650.

(5) The department shall deny TANF to the following individuals:

(a) Fugitive felons and probation and parole violators as specified under WAC 388-215-1550;

(b) Persons convicted of unlawful practices in obtaining TANF as specified under 388-46-110;

(c) Persons convicted of making fraudulent statements or representation of their place of residence in order to receive federally-funded public assistance as specified under WAC 388-46-120; and

(d) Persons convicted of drug-related felonies as specified under WAC 388-215-1570.

(6) Unmarried pregnant or parenting teens under age eighteen must:

(a) Meet the school attendance requirement under WAC 388-215-1670; and

(b) Live with an adult relative, legal guardian, or in a department-approved living arrangement as specified under WAC 388-215-1660.

[Statutory Authority: RCW 74.08.090. 97-20-128, § 388-215-1000, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090 and Public Law 104-193, § 103 (a)(1) (1996). 97-07-024, § 388-215-1000, filed 3/12/97, effective 4/12/97. Statutory Authority: RCW 74.04.015, 74.04.055, 74.04.057 and 45 CFR 233.10 (a)(1)(ii)(B). 95-14-048 (Order 3860), § 388-215-1000, filed 6/28/95, effective 7/29/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-215-1000, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-24-055, 388-24-125 and 388-26-050.]

WAC 388-215-1010 Five year lifetime time limits. (1) The department shall deny TANF to any family that includes an adult who has received TANF for sixty months after August 1, 1997.

(2) An adult, who may be excluded from the family assistance unit for factors not related to need as specified in WAC 388-215-1620, cannot be excluded solely for having received TANF for sixty months.

(3) In calculating the number of months an adult family member has received TANF for the purposes of subsection (1) of this section, the department shall disregard any month in which the adult received TANF:

(a) As a minor child who was not the head of a household or married to the head of a household. For the purposes of this subsection, a minor child is not the head of a household when residing with a parent, legal guardian, or other adult relative, or living in a department-approved living arrangement under the supervision of a non-related adult; or

(b) While living in Indian country or an Alaskan Native village, if during the month the individual received TANF at least fifty percent of the adults living on the reservation or in the village were unemployed.

(4) After an individual has received fifty-two months of TANF, the department may exempt that person from the requirements of subsection (1) of this section for reasons of hardship or family violence, provided the total number of exempted TANF cases does not exceed twenty percent of the average monthly number of cases statewide during a fiscal year.

[Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, section 103 (a)(1), EHB 3901, sections 103 and 105 (1997). 97-20-056, § 388-215-1010, filed 9/24/97, effective 10/25/97.]

WAC 388-215-1115 Living in the home of a relative of specified degree—Temporary absence—Denial of assistance to a caretaker relative who fails to report a child's absence. (1) When a minor child is temporarily absent from the home, the department shall deny assistance for one month to a parent or other caretaker relative who fails to notify the department within five days of the date it becomes reasonably clear to the parent or other caretaker relative that the absence of the child will exceed ninety days.

(2) In denying assistance to a parent or other caretaker relative for the reason described in subsection (1) of this section, the needs of that individual shall be excluded in determining the need and payment amount of the assistance unit.

(3) The income of a parent or other caretaker relative who is disqualified under this section shall be allocated under WAC 388-218-1640 as if the individual were ineligible due to sanction or noncooperation.

[Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, Section 103 (a)(1) (1996). 97-08-032 and 97-10-041, § 388-215-1115, filed 3/27/97 and 4/30/97, effective 8/1/97.]

WAC 388-215-1200 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-215-1375 Deprivation—Unemployment—Defined. The department shall consider the qualifying parent to be unemployed when the qualifying parent is:

(1) A recipient; or

(2) An applicant who is:

(a) Employed less than one hundred hours a month; or

(b) Employed one hundred hours or more for a particular month if the qualifying parent:

(i) Was employed less than one hundred hours for each of the two previous months; and

(ii) Is expected to be employed less than one hundred hours during the next month.

[Statutory Authority: RCW 74.12.036 and 74.08.090. 97-14-082, § 388-215-1375, filed 7/1/97, effective 7/1/97; 96-23-021, § 388-215-1375, filed 11/12/96, effective 12/13/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-215-1375, filed 5/3/94, effective 6/3/94. Formerly WAC 388-24-074 (part).]

WAC 388-215-1400 Support enforcement—Assignment of support rights—Cooperation with division of child support. (1) As a condition of eligibility, each client of TANF shall assign to the division of child support any rights to support in his or her own behalf or in behalf of the other assistance unit members, and any rights to support which has accrued prior to the time assignment is made.

(a) The department shall require the client to promptly remit to the division of child support any support received directly after assignment is made.

(b) The department shall consider the client's signed application as an assignment of support rights. The client's acceptance of a TANF payment shall constitute an agreement to the assignment of support rights.

(c) If a family member with whom the child lives fails to assign support rights as required in this section, the department shall deny assistance to the entire assistance unit.

(2) As a condition of eligibility, the department shall require each (TANF) client to cooperate with the division of child support as specified under WAC 388-14-200 unless the department has established good cause as specified under WAC 388-215-1400 through 388-215-1490. The IV-D agency, division of child support, shall determine client cooperation.

(3) If the caretaker relative with whom the child lives fails to cooperate with the division of child support, the department shall reduce the assistance paid to the child's assistance unit by twenty-five percent of what the assistance unit would otherwise be eligible to receive.

[Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, Section 103 (a)(1) (1996). 97-08-033 and 97-10-042, § 388-215-1400, filed 3/27/97 and 4/30/97, effective 8/1/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-215-1400, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-24-108 and 388-24-109.]

WAC 388-215-1550 Temporary assistance to needy families (TANF)—Denial of assistance to fugitive felons and probation and parole violators. (1) The department shall not authorize TANF on behalf of an individual who is:

(a) Fleeing to avoid prosecution, or custody or confinement after conviction, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees, or which is a high misdemeanor under the laws of a state, as in the case of New Jersey; or

(b) Violating a condition of probation or parole imposed under federal or state law as determined by an administrative body or court of competent jurisdiction.

(2) Subsection (1) of this section shall not apply to an individual in any month after that individual has been

pardoned by the President of the United States for such conduct described in subsection (1).

[Statutory Authority: RCW 74.04.050, 74.04.055 and P.L. 104-193, Section 103 (a)(1) (1996). 97-06-077, § 388-215-1550, filed 2/28/97, effective 3/31/97.]

WAC 388-215-1570 Denial of assistance to persons convicted of drug-related felonies. (1) Except as provided in subsection (2) below, the department shall deny TANF benefits to an individual convicted after August 21, 1996, under federal or state law, of any felony involving the possession, use or distribution of a controlled substance as defined in section 102(6) of the Controlled Substances Act by excluding the needs of that individual in determining the need and payment amount of the assistance unit.

(2) An individual who has been convicted of possession or use of a controlled substance is exempt from the provision of subsection (1) of this section if that individual:

(a) Was assessed as chemically dependent by a state-certified chemical dependency program; and

(b) Is participating in or completed a rehabilitation plan consisting of chemical dependency treatment and vocational services; and

(c) Was not previously convicted of a felony for possession or use of a controlled substance within three years of the latest conviction.

(3) Each applicant shall attest in writing whether the applicant or a person for whom the applicant is applying has been convicted of a felony as described in subsection (1) of this section.

[Statutory Authority: RCW 74.08.090 and 74.08.025(4) amended in EHB 3901, section 101 (1997). 97-18-074, § 388-215-1570, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, Section 115 (1996). 97-08-034 and 97-10-040, § 388-215-1570, filed 3/27/97 and 4/30/97, effective 8/1/97.]

WAC 388-215-1620 Assistance unit—Excluded persons. The department shall not count people ineligible due to program requirements other than need when deciding how many people are in an assistance unit. Exclusions include, but are not limited to:

(1) A recipient of SSI benefits;

(2) Children under eighteen who are not deprived of parental support or care as defined under WAC 388-215-1300 through 388-215-1390;

(3) Aliens who do not meet the citizenship and alienage requirements (see WAC 388-215-1200);

(4) Adopted children receiving Title IV-E, state or local adoption assistance when including them will result in a decrease in benefits to the assistance unit;

(5) Children who receive Title IV-E, state and local foster care maintenance payments except as provided for under WAC 388-215-1100 and 388-215-1120;

(6) A child who does not live with a relative of specified degree as defined under WAC 388-215-1060 and 388-215-1080;

(7) An adult parent in a two-parent household when:

(a) The other parent is unmarried and under the age of eighteen; and

(b) The department determines the living arrangement is not appropriate under WAC 388-215-1660.

[Statutory Authority: RCW 74.08.090 and 74.12.255. 97-20-128, § 388-215-1620, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090. 94-22-031 (Order 3799), § 388-215-1620, filed 10/26/94, effective 11/26/94; 94-10-065 (Order 3732), § 388-215-1620, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-24-050 and 388-26-145.]

WAC 388-215-1630 Assistance units—Consolidation. (1) Assistance units include mandatory members as required under WAC 388-215-1600 and persons for whom assistance is requested at the option of the caretaker relative. All children included under WAC 388-215-1600 and 388-215-1610 and who live with the same caretaker relative or relative married couple are included in a single assistance unit.

(2) Children do not have to be full, half, or adopted brothers or sisters to be included in the same assistance unit.

(3) When a change of circumstances occurs which makes one or more assistance unit members ineligible for cash benefits, assistance is continued for all assistance unit members who remain eligible.

[Statutory Authority: RCW 74.04.050, 74.05.055 and 74.08.090. 97-20-124, § 388-215-1630, filed 10/1/97, effective 11/1/97.]

WAC 388-215-1650 Assistance to a minor. (1) Minors may apply for TANF from the department.

(2) The department will inform a minor applicant that it will contact the minor's parent or guardian to ask whether they are willing to contribute to the support of the minor before authorizing assistance, unless the minor:

(a) Is married; or

(b) In the military; or

(c) Is emancipated by a court; or

(d) Is applying for medical assistance related to pregnancy.

(3) When the legal guardian has a court-ordered responsibility to support a minor parent, the department will use the guardian's income to figure the amount of the grant according to WAC 388-218-1670.

[Statutory Authority: RCW 74.08.090 and 74.12.255. 97-20-128, § 388-215-1650, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050, 74.04.055 and P.L. 104-193, Section 103 (a)(1) (1996). 97-06-076, § 388-215-1650, filed 2/28/97, effective 3/31/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-215-1650, filed 5/3/94, effective 6/3/94. Formerly WAC 388-24-550.]

WAC 388-215-1660 Unmarried pregnant or parenting teens under age eighteen—Required living arrangement. (1) To be eligible for cash assistance, an unmarried pregnant or parenting teen under age eighteen and the teen parent's child must:

(a) Live in a home approved by the department; and

(b) Have a protective payee as required by WAC 388-265-1275.

(2) The department will approve the home of a parent, legal guardian, or other adult relative, as defined under RCW 74.15.020(4), of the pregnant or parenting teen, unless:

(a) The pregnant or parenting teen has no living parent, legal guardian, or other adult relative that can be located, or if the parent, legal guardian, or other adult relative does not meet applicable state criteria to act as the individual's legal guardian or otherwise does not want the pregnant or parenting teen to reside with them; or

(b) The pregnant or parenting teen or teen parent's child is being or has been subjected to serious physical, emotional or sexual harm, abuse or exploitation in the home of the parent, legal guardian, or other adult relative; or

(c) Substantial evidence exists of an act or failure to act by the parent, legal guarding, or other adult relative that presents an imminent or serious harm to the pregnant or parenting teen or teen parent's child if they resided there; or

(d) The department determines that it is in the best interest of the teen parent's child or the pregnant teen to waive the requirement of living in the home of a parent, legal guardian, or other adult relative.

(3) If the home of a parent, legal guardian, or other adult relative is not available or suitable, the department will approve:

(a) A facility or home licensed under chapter 74.15 RCW that provides a supportive and supervised living arrangement requiring residents to learn parenting skills; or

(b) A maternity home; or

(c) Other adult-supervised living arrangement; or

(d) The client's current or proposed living arrangement if the department determines it is appropriate.

(4) The department will never approve a home that includes the other natural parent of the teen's child or unborn when:

(a) The unmarried pregnant or parenting teen is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for the offenses of rape of a child in the first, second, or third degree as set forth in RCW 9A.44.073, 9A.44.076 and 9A.44.079.

(5) If an unmarried pregnant or parenting teen is disqualified because of this rule:

(a) No child in the assistance unit will be disqualified; and

(b) If the teen parent has income, the department will use it to figure the amount of the child's grant according to WAC 388-218-1640.

[Statutory Authority: RCW 74.08.090 and 74.12.255. 97-20-128, § 388-215-1660, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, Section 103 (a)(1) (1996). 97-09-029, § 388-215-1660, filed 4/10/97, effective 5/11/97.]

WAC 388-215-1670 Unmarried pregnant or parenting teens under age eighteen—Required school attendance. (1) In order to receive assistance, an unmarried pregnant or parenting teen under age eighteen who has not completed a high school education or General Equivalency Diploma (GED) must participate in educational activities leading to the attainment of a high school diploma or GED.

(2) A teen parent with a child under twelve weeks old is exempt from this rule.

(3) The school or program in which the unmarried pregnant or parenting teen is enrolled will set standards for satisfactory attendance that the teen has to meet.

(4) If an unmarried pregnant or parenting teen is disqualified because of this rule:

(a) No one else in the assistance unit is disqualified; and

(b) If the teen parent has income, the department will use it to figure the amount of the child's grant according to WAC 388-218-1640.

[Statutory Authority: RCW 74.08.090. 97-20-124, § 388-215-1670, filed 10/1/97, effective 11/1/97.]

Chapter 388-216 WAC
RESOURCE ELIGIBILITY

WAC

WAC 388-216-2450 Resources—Exempt or disregarded income which is also exempt as a resource. The department will not consider the following exempt or disregarded income as a resource:

(1) Exempt income types as specified in WAC 388-218-1200 (1) through (16) and (18) through (20);

(2) Educational assistance as exempt under Title IV of the Higher Education Act and as referenced in WAC 388-218-1210;

(3) Native American benefits as exempt under federal law and as referenced in WAC 388-218-1220;

(4) Bona fide loans as specified in WAC 388-218-1230(5); and

(5) Monthly child support incentive payments from DCS as specified in WAC 388-218-1230(6).

[Statutory Authority: RCW 74.08.090, 74.04.005, Public Law 104-193, section 103 (A)(1), EHB 3901 (1997 c 58 §§ 308 and 309). 97-19-008, § 388-216-2450, filed 9/4/97, effective 10/5/97. Statutory Authority: RCW 74.08.090, P.L. 103-286 and Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act. 95-14-049 (Order 3862), § 388-216-2450, filed 6/28/95, effective 7/29/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-216-2450, filed 5/3/94, effective 6/3/94.]

WAC 388-216-2500 Resources—Exempt as a resource with no ceiling value. (1) Regardless of value, the department shall exempt the following resources:

(a) The client's home, subject to the conditions specified in sections WAC 388-216-2550 through 388-216-2590.

(b) Household furnishings and personal clothing essential for daily living. The department shall not exempt household furnishings and personal clothing in storage without evidence that these items are essential for daily living.

(c) One cemetery plot for each member of the assistance household.

(d) Personal property of "great sentimental value" when the applicant/recipient establishes the circumstances and conditions giving the personal property this value. "Sentimental value" as used in this section means personal property held primarily because of personal attachment or hobby interest, rather than for its intrinsic value.

(e) A motor vehicle necessary to transport a physically disabled household member. This exemption is limited to one vehicle per physically disabled person.

(2) The department may declare real and personal property which will be used in a self-employment enterprise as an exempt resource:

(a) On the basis of an agreed plan; and

(b) When the department determines that the real or personal property:

(i) Is necessary to restore the client's independence; or

(ii) Will aid in rehabilitating the client or the client's dependents by providing self-employment experience which can reasonably be expected to lead to full or partial self-support.

(3) The department shall consider any increase in value to exempted stock, raw materials, or inventory as:

(a) Exempt, when the increase is necessary to the health of the enterprise; or

(b) Income, when such increase might reasonably be used towards the client's self-support.

(4) In the absence of an agreed plan, the department shall consider the business assets of a self-employment enterprise, if available and nonexempt, as available to the owner in the amount of the sale value minus encumbrances.

(5) Under an agreed plan, the department shall consider accounts receivable as:

(a) An exempt resource when:

(i) The client makes a diligent effort to collect; or

(ii) If efforts to collect are unsuccessful, the client turns the accounts over to a collection agency;

(b) A nonexempt resource when the client does not meet the requirements in (a) of this subsection; and

(c) Earned income from self-employment, when payment is received.

(6) The department shall consider goodwill as an unavailable resource until the business is sold. Goodwill as used in this section means the reputation and patronage of a company. Goodwill can generally be valued as the amount a company would sell for over the value of its physical property, money owed it, and other assets.

[Statutory Authority: RCW 74.08.090, 74.04.005, Public Law 104-193, section 103 (A)(1), EHB 3901 (1997 c 58 §§ 308 and 309). 97-19-008, § 388-216-2500, filed 9/4/97, effective 10/5/97. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.005 (10)(b) and P.L. 104-193, Sec. 103 (a)(1) (1996). 97-06-075, § 388-216-2500, filed 2/28/97, effective 3/31/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-216-2500, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-28-420, 388-28-435 and 388-28-439.]

WAC 388-216-2650 Resources—Exempt within a ceiling value. (1) The department shall exempt the equity value of the resources listed below up to the specified ceiling value. Any excess value is a nonexempt resource and applied to the resource limit of one thousand dollars:

(a) Term or burial insurance, up to a ceiling value of one thousand five hundred dollars per household member;

(b) One used and useful vehicle up to a ceiling value of five thousand dollars per household;

(c) When a vehicle is jointly owned by a TANF client and an SSI recipient, the equity value of the vehicle is prorated between the owners:

(i) The portion of equity value owned by the SSI recipient is not counted for TANF;

(ii) The portion of equity value owned by the TANF client, up to the ceiling value of five thousand dollars, does not count;

(iii) Any portion of the equity value owned by the TANF client in excess of the ceiling value is a nonexempt resource. Under WAC 388-216-2000 (3)(b) nonexempt resources will be considered up to the resource limit of one thousand dollars.

(d) Savings accounts with combined balances of up to an additional three thousand dollars for TANF **recipients**.

(2) The department shall phase in changes to the ceiling values at the first opportunity, when the department first:

(a) Takes a case action;

(b) Determines eligibility; or

(c) Redetermines eligibility.

[Statutory Authority: RCW 74.08.090, 74.04.005, Public Law 104-193, section 103 (A)(1), EHB 3901 (1997 c 58 §§ 308 and 309). 97-19-008, § 388-216-2650, filed 9/4/97, effective 10/5/97. Statutory Authority: RCW 74.08.090, P.L. 103-286 and Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act. 95-14-049 (Order 3862), § 388-216-2650, filed 6/28/95, effective 7/29/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-216-2650, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-28-435 and 388-28-438.]

WAC 388-216-2800 Resources—Value. "Equity value" means fair market value minus encumbrances (legal debts).

(1) The department shall determine the value of all nonexempt resources according to the resource's equity value. When a vehicle is jointly owned by a TANF client and an SSI recipient, the equity value of the vehicle is prorated between the owners:

(a) The portion of equity value owned by the SSI recipient is not counted for TANF;

(b) The portion of equity value owned by the TANF client, up to the ceiling value of five thousand dollars, does not count. Do not apply to additional vehicles;

(c) Any portion of the equity value owned by the TANF client in excess of the ceiling value is a nonexempt resource. Under WAC 388-216-2000 (3)(b) nonexempt resources will be considered up to the resource limit of one thousand dollars.

(2) The department shall reassess the fair market value if the client provides acceptable evidence that:

(a) A good-faith effort has been made to sell the resource at the fair market value determined by the department; and

(b) The current worth of the resource is less than the resource standard.

(3) The department shall:

(a) Use the *National Automobile Dealers Association Official Used Car Guide* to determine the resource value of automobiles. For automobiles listed in this guide, the department shall presume the "average loan" value in the current edition represents the resource value.

(b) Use the *Kelley Bluebook R.V. Guide* to determine the resource value of recreational vehicles. For vehicles listed in this guide, the department shall presume the "wholesale" value in the current edition represents the resource value.

(c) Document the method used to determine the resource value in the case record for vehicles not listed in these guides.

(d) Document evidence in the case record when the values listed in these guides can be overcome by positive evidence to the contrary.

(4) The equity value in the cash discount value of a chattel mortgage or sales contract represents the value of the resource.

[Statutory Authority: RCW 74.08.090, 74.04.005, Public Law 104-193, section 103 (A)(1), EHB 3901 (1997 c 58 §§ 308 and 309). 97-19-008, § 388-216-2800, filed 9/4/97, effective 10/5/97. Statutory Authority: RCW 74.08.090, P.L. 103-286 and Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act. 95-14-049 (Order 3862), § 388-216-2800, filed 6/28/95, effective 7/29/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-216-2800, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-28-400, 388-28-438 and 388-28-450.]

WAC 388-216-2900 Resources—Newly acquired resources. When a client obtains a newly acquired resource, the department shall:

(1) Apply the resource exemptions to newly acquired resources.

(2) Treat income tax refunds as follows:

(a) Consider an income tax refund as a nonexempt resource in the month of receipt; and

(b) Consider the Earned Income Tax Credit (EITC) portion of an income tax refund as an exempt resource in the month of receipt and in the month following the month of receipt. The department shall consider the EITC as a nonexempt resource in the second month following the month of receipt.

(3) Treat lump sum compensatory awards and related settlements not exempt under WAC 388-218-1530 as resources exempt within ceiling limits on the first of the month following the month of receipt. A recipient may reduce the value of a compensatory award or settlement prior to the first of the month following the month of receipt provided the award or settlement monies are not transferred for less than adequate consideration with the intent to qualify for assistance as provided under chapter 388-217 WAC.

(4) Add the value of the client's newly acquired resources to the client's existing nonexempt resources. If the recipient's total nonexempt resources are in excess of the resource standard, the recipient is ineligible.

(5) Any increase in the value of a resource (such as interest on a savings account, stock dividends, or livestock births) affects eligibility only to the extent the increased value causes the total value of the client's nonexempt resources to exceed the resource standard. The excess is considered income.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.005 (11)(b) and P.L. 104-193, Sec. 103 (a)(1) (1996). 97-06-078, § 388-216-2900, filed 2/28/97, effective 3/31/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-216-2900, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-28-435 and 388-28-482.]

WAC 388-216-3000 Individual development account. (1) The department will not use funds from an individual development account established under section 307, chapter 58, Laws of 1997 when determining TANF eligibility.

(2) If funds are withdrawn from an individual development account for a purpose other than those defined in section 307, chapter 58, Laws of 1997, the department will use the funds to determine eligibility according to WAC 388-216-2000, Resources—Eligibility.

[Statutory Authority: RCW 74.08.090 and 1997 c 58 § 307. 97-20-124, § 388-216-3000, filed 10/1/97, effective 11/1/97.]

Chapter 388-218 WAC
AID TO FAMILIES WITH DEPENDENT CHILDREN—INCOME POLICIES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-218-1420 Earned income disregards—General. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1420, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-570 (part).] Repealed by 97-18-073, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005).

388-218-1450 Thirty dollars and one-third disregard. [Statutory Authority: P.L. 103-286, RCW 74.08.090 and The Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act. 95-11-124 (Order 3857), § 388-218-1450, filed 5/24/95, effective 6/24/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1450, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-570 (part).] Repealed by 97-18-073, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005).

388-218-1460 Thirty-dollar disregard. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1460, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-570 (part).] Repealed by 97-18-073, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005).

388-218-1480 Circumstances where earned income disregards are not allowed. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1480, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-570 (part).] Repealed by

97-18-073, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005).

388-218-1730 One hundred percent of need test. [Statutory Authority: P.L. 103-286, RCW 74.08.090 and The Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act. 95-11-124 (Order 3857), § 388-218-1730, filed 5/24/95, effective 6/24/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1730, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-480 (part).] Repealed by 97-18-073, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005).

WAC 388-218-1210 Exempt and disregarded income—Educational assistance. (1) The department shall exempt from consideration as income when determining need educational assistance, in the form of grants, loans, or work study, issued to a student from the following sources:

(a) Title IV of the Higher Education Amendments; or

(b) Bureau of Indian Affairs student assistance programs.

(2) The department shall disregard the following types of income when determining need:

(a) Grants or loans made or insured under any programs administered by the department of education to an undergraduate student for educational purposes.

(b) Educational assistance in the form of grants, loans, or work study, issued under the Carl D. Perkins Vocational and Applied Technology Education Act, P.L. 101-391, for attendance costs as identified by the institution. For a student attending school:

(i) At least half-time, attendance costs include tuition, fees, costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study, books, supplies, transportation, dependent care, and miscellaneous personal expenses; or

(ii) Less than half-time, attendance costs include tuition, fees, and costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study.

(c) Educational assistance in the form of grants, work study, scholarships, or fellowships, from sources other than those identified in subsections (1)(a) and (b), (2)(a) and (b)(i) and (ii) of this section for attendance costs as identified by the institution. Attendance costs include tuition, fees, costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study, books, supplies, transportation, dependent care, and miscellaneous personal expenses.

(d) Any remaining educational assistance, in the form of grants, work study, scholarships, or fellowships, not disregarded in subsections (1)(a) and (b), (2)(a), (b)(i) and (ii), and (c) of this section, as allowed under WAC 388-218-1540 Assistance from other agencies and organizations.

(e) One-half of the gross earned income received from work study earnings not disregarded in subsections (1)(a) and (b), (2)(a), (b)(i) and (ii), (c), and (d) of this section. If applicable, deduct the dependent care disregard as specified in WAC 388-218-1470.

(f) Veterans' Administration educational assistance for the student's educational expenses and child care necessary for school attendance. Attendance costs include tuition, fees, costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study, books, supplies, transportation, dependent care, and miscellaneous personal expenses.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1210, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-16-044 (Order 3759), § 388-218-1210, filed 7/27/94, effective 9/1/94; 94-10-065 (Order 3732), § 388-218-1210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-575 (part).]

WAC 388-218-1230 Disregarded income types. The department shall disregard the following types of income when determining need:

(1) Child's earned income. Earned income of a child when student eligibility conditions in WAC 388-218-1410 Earned income of a child, have been met.

(2) Foster care payments. Disregard as income a foster care payment made for the care of a child. See WAC 388-218-1400 Earned income types, for the treatment of foster care retainer fees.

(3) Gifts:

(a) Cash gifts. Nonrecurring cash gifts up to thirty cumulative dollars received by each member of the TANF assistance unit per calendar quarter. The department, unless otherwise specified by the donor, shall determine an individual's share in a gift to more than one person by dividing the amount of the gift by the number of persons receiving the gift.

(b) Noncash gifts. Gifts other than cash as defined under chapter 388-22 WAC provided such gifts are within the allowable program resource limits.

(4) Household cost funds. Funds representing another person's or family's share of household costs.

(5) Loans.

(a) Bona fide loans. The department shall consider a loan bona fide when the loan is a debt the borrower has an obligation to repay.

(b) Loan repayments. The department shall not consider as income to a client money received from loan repayment; however, the department shall consider any interest paid in the loan as newly acquired income.

(6) Office of support enforcement pass-through payments. The monthly child support incentive payment from the office of support enforcement (OSE);

(7) Overpayments recovered by source agency. Any overpayment amount withheld from a client's benefit in order to recover an overpayment by the source agency.

(8) Per diem and transportation. Per diem and transportation funds paid to TANF advisory committee members.

(9) Settlements. Settlements for destroyed, stolen exempt property, or back medical bills when conditions in, WAC 388-218-1530 Determining net income—Other income, have been met.

(10) Self-produced or supplied items. The value of self-produced or supplied items except as specified in, WAC 388-218-1340 Self-produced or supplied items, when:

(a) Self-produced items are sold for cash; or

(b) The household's requirement for shelter is supplied.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1230, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-16-044 (Order 3759), § 388-218-1230, filed 7/27/94, effective 9/1/94; 94-10-065 (Order 3732), § 388-218-1230, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-28-480, 388-28-532 and 388-28-575.]

WAC 388-218-1300 Self-employment income. (1) Earned income from self-employment is the amount left after deducting allowable business expenses from gross business income.

(2) Disregard one-half of the self-employment earned income to determine the net amount available to meet need. If applicable, deduct the dependent care disregard as specified in WAC 388-218-1470.

(3) In order to establish eligibility for public assistance, a self-employed client must maintain and make available to the department a record clearly documenting all business expenses and income.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1300, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1300, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-520 (part).]

WAC 388-218-1350 Deductible self-employment expenses. The department shall consider the following items as deductible business expenses in a self-employment enterprise:

(1) Rental of business equipment or property.

(2) Utilities.

(3) Postage.

(4) Telephone.

(5) Office supplies.

(6) Advertising.

(7) Insurance.

(8) Legal, accounting, and other professional fees.

(9) The cost of goods sold, including wages paid to employees producing salable goods, raw materials, stock, and replacement or reasonable accumulation of inventory, provided inventory has been declared exempt on the basis of an agreed plan pursuant to WAC 388-216-2500.

(10) Interest on business indebtedness.

(11) Wages and salaries paid to employees not producing salable goods.

(12) Commissions paid to agents and independent contractors.

(13) Documented and verified costs of self-employment business-related transportation. These costs are limited to gas, oil, and fluids; necessary services and repairs; replacement of worn items such as tires; registration and licensing fees; and interest on automobile loans.

(a) The client may choose:

(i) To itemize the actual operating cost of a vehicle; or

(ii) A cost per mile established by the department using a prevailing rate based on market standards.

(b) The cost of tolls and parking related to the business shall be deducted as a business expense.

(c) If a vehicle is needed for both business and private purposes, the mileage and expenses attributable to the business must be documented in a daily log and is subject to verification by the department.

(d) Transportation to and from the place of business is not a business expense.

(14) Nonpersonal taxes on the business and business property, including the employer's share of federal Social Security taxes on business employees and state and federal unemployment insurance contributions, if any. The self-employed person's personal income taxes and self-employment taxes are not business deductions.

(15) Repairs to business equipment and property, excluding vehicles. An expenditure to maintain property in its usual working condition is deductible as a repair.

(16) Other expenditures reasonable and necessary to the efficient and profitable operation of the self-employment enterprise.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1350, filed 9/2/97, effective 10/3/97. Statutory Authority: P.L. 103-286, RCW 74.08.090 and The Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act. 95-11-124 (Order 3857), § 388-218-1350, filed 5/24/95, effective 6/24/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1350, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-520 (part).]

WAC 388-218-1410 Earned income of a child. The department shall apply the following rules when determining the amount of a child's earned income available to meet the current need of the assistance unit of which the child is a member:

(1) The department shall disregard all of the child's monthly earned income when the following circumstances apply:

(a) When determining whether total family income exceeds one hundred and eighty-five percent of the need standard for a child who is a full-time student. This disregard is limited to six months per calendar year;

(b) When determining the payment amount for:

(i) A child, who is a full-time student; or

(ii) A child, who is a part-time student carrying at least half the normal school load and working fewer than one hundred fifty hours per month.

(2) A child earning income by working in a sheltered workshop or other training facility for handicapped children shall be considered, for purposes of income exemption, as being at least a part-time student working less than full time.

(3) To be employed full time, a child must be working one hundred fifty hours per month or the number of hours considered full time by the industry for which he or she works, whichever is less.

(4) Summer employment of students shall not be considered as full-time employment due to the temporary nature of such employment, even though the hours worked may exceed thirty-five hours a week.

(5) In determining the amount of a nonstudent child's earned income available to meet the current needs of the assistance unit, net income shall be computed without application of the earned income disregards specified in this section.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1410, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1410, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-535 (part).]

WAC 388-218-1420 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-218-1430 Earned income disregards—Deduction sequence. Earned income disregards shall be applied in the following sequence:

(1) Earned income disregard; and

(2) Dependent care disregard.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1430, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1430, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-570 (part).]

WAC 388-218-1440 Earned income disregard. (1) Disregard one-half of the gross earned income for each month the client receives earned income.

(2) When payment of income over a period of more than one month is delayed, the earned income disregard applies to the period during which the income was earned.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1440, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1440, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-570 (part).]

WAC 388-218-1450 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-218-1460 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-218-1470 Dependent care disregard. Disregard the actual cost for care of each dependent child or incapacitated adult living in the same home and receiving TANF provided:

(1) Conditions under WAC 388-290-110 (1)(c) are met for each dependent child;

(2) No disregard will be allowed for care provided by a parent or stepparent;

(3) The provider verifies the cost incurred;

(4) The cost is incurred for the month of employment being reported; and

(5) The cost for each dependent child or incapacitated adult, depending on the number of hours worked per month does not exceed the following:

Hours Worked per month	Dependent Care Maximum Deductions Dependent Two Years of Age or Older	Dependent Care Maximum Deductions Dependent Under Two Years of Age
0 - 40	$ 43.75	$ 50.00
41 - 80	87.50	100.00
81 -120	131.25	150.00
121 or More	175.00	200.00

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1470, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1470, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-570 (part).]

WAC 388-218-1480 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-218-1530 Determining net income—Other income. (1) Net income from any other nonexempt source shall be the gross amount less any cost of securing or maintaining the income.

(2) The department shall consider any payments on mortgages or contracts as income less any cost of securing or maintaining the income.

(3) The department shall consider a compensatory award or related settlement covering destroyed or stolen exempt property as a newly acquired resource as provided under WAC 388-216-2900 unless the client, within sixty days of receipt:

(a) Expends the funds to repair or replace the destroyed or stolen exempt property for which the settlement was intended; or

(b) Pays medical bills for which the settlement was intended.

(4) The department shall consider funds deposited into a joint account or into an account held for another, or funds held for others as the income of the client since the entire amount is at the client's disposal, except when the client can show that all or a portion of the funds are:

(a) Derived from funds belonging exclusively to the other holder; and

(b) Held and/or utilized solely for the benefit of that holder. The department shall not consider all funds so verified as actually available to the client.

(5) When appointment of a legal guardian is required by the Social Security Administration or the Veterans Administration as a condition for receipt of a benefit from either agency, the necessary costs of securing a guardian shall be deducted from the benefit received to determine the client's net income.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.005 (11)(b) and P.L. 104-193, Sec. 103 (a)(1) (1996). 97-06-078, § 388-218-1530, filed 2/28/97, effective 3/31/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1530, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-28-438, 388-28-474, 388-28-555 and 388-28-580.]

WAC 388-218-1630 Allocation of assistance unit income for support of legal dependents. (1) The department shall allocate the income of a parent, stepparent or caretaker relative included in the assistance unit to meet the needs of the assistance unit after deducting:

(a) One-half of the gross earned income for each employed person;

(b) An amount for the support of the parent, stepparent or caretaker relative and other dependents not eligible for inclusion in the assistance unit for factors other than sanction or disqualification, not to exceed the appropriate payment standard for an assistance unit of the same composition; and

(c) An amount for court or administratively ordered support for a legal dependent, not living in the parent or stepparent's home not to exceed the lesser of the amount

actually paid or the appropriate need standard for each dependent;

(2) The department shall consider a dependent to be one who:

(a) Is or could be claimed for federal income tax purposes by the parent, stepparent or caretaker relative; or

(b) The parent, stepparent or caretaker relative is legally obligated to support.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1630, filed 9/2/97, effective 10/3/97. Statutory Authority: P.L. 103-286, RCW 74.08.090 and The Confederated Tribes of the Colville Reservation Grand Coule Dam Settlement Act. 95-11-124 (Order 3857), § 388-218-1630, filed 5/24/95, effective 6/24/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1630, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-500 (part).]

WAC 388-218-1710 Income tests. To be eligible for TANF, a client shall meet the following income tests:

(1) One hundred eighty-five percent of need test, as specified in WAC 388-218-1720 One hundred eighty-five percent of need test; and

(2) Payment standard test, as specified in WAC 388-218-1740 Payment standard test.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1710, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-480 (part).]

WAC 388-218-1720 One hundred eighty-five percent of need test. A client whose nonexempt gross income exceeds one hundred eighty-five percent of the standard of need for the appropriate household size plus additional requirements authorized for that assistance unit, shall not be eligible for TANF from the date specified in WAC 388-218-1830 Treatment of income—Suspension of a grant.

(1) The department shall consider the income of all members of the assistance unit and the income of natural, adoptive, or stepparents of children in the assistance unit, residing in the same household, in this test except for income specifically exempted or disregarded and in subsection (2) of this section.

(2) In determining the total income of the family, the department shall exclude:

(a) The earned income of a child who is a full-time student is excluded for six months per calendar year; and

(b) The first fifty dollars per month of the current monthly support obligation of any child support collected on the family's behalf or received by the family.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1720, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1720, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-28-480 and 388-28-484.]

WAC 388-218-1730 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-218-1735 The maximum amount a TANF family can earn. (1) "Family members" includes everyone in the TANF assistance unit, and:

(a) Adults or children who would otherwise be included in the assistance unit under WAC 388-215-1600 but who do not meet TANF eligibility requirements;

(b) The unborn child of a woman in her third trimester of pregnancy; and

(c) When residing together, the husband of a woman in her third trimester of pregnancy.

(2) Gross earned income does not include exempt or disregarded income.

(3) Deduct from the gross earned income:

(a) Court or administratively ordered support paid to meet the needs of legal dependents, up to:

(i) The amount actually paid; or

(ii) A one-person need standard for each legal dependent.

(b) Authorized ongoing additional requirement payment as defined in chapter 388-225 WAC, Special payments.

[Statutory Authority: RCW 74.08.090. 97-20-124, § 388-218-1735, filed 10/1/97, effective 11/1/97.]

WAC 388-218-1740 Payment standard test. The assistance unit's monthly nonexempt unearned income, after applying the earned income disregards, plus monthly nonexempt earned income shall be below the appropriate state payment standard plus additional requirements.

[Statutory Authority: RCW 74.08.090, Public Law 104-193 section 103 (a)(1), EHB 3901, sections 308 and 309(11) (1997) (amends RCW 74.04.005). 97-18-073, § 388-218-1740, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1740, filed 5/3/94, effective 6/3/94. Formerly WAC 388-28-480 (part).]

WAC 388-218-1820 Treatment of nonrecurring income—Lump sum payments. The department shall treat nonrecurring lump sum payments received by a client and used to accumulate cash reserves in the following manner:

(1) Compensatory awards or related settlements shall be treated as follows:

(a) Awards or settlements for destroyed or stolen exempt property or medical bills as provided under WAC 388-218-1530; and

(b) All other compensatory awards or settlements as newly acquired resources as provided under WAC 388-216-2900.

(2) All other lump sum payments shall be treated as follows:

(a) The department shall exempt the difference between the resource ceiling and the client's existing resources when the client received the lump sum. Any excess shall be considered as newly acquired income in the month received.

(b) In determining the client's existing resources, the department shall deduct any unexpended grant monies received within thirty days of the date the client received the lump sum.

(c) Such exemption shall apply once for each nonrecurring lump sum received.

(3) The department shall also apply these requirements to the income of persons required to be included in the assistance unit but are excluded for reasons of sanction or noncooperation.

(4) If the client's newly acquired income, plus any other income, after applicable disregards is less than the payment standard, plus authorized additional requirements, the

department shall deduct the difference from the corresponding payment month.

(5) If the client's newly acquired income, plus any other income, after applicable disregards is equal to or exceeds the payment standard plus authorized additional requirements, the department shall discontinue assistance:

(a) If such income is equal to or in excess of one month's payment standard, but less than two months' payment standard plus authorized additional requirements, the department shall:

(i) Suspend assistance effective the first day of the payment month;

(ii) Deduct the income in excess of one month's payment standard plus authorized additional requirements from the grant for the month following the month of suspension; and

(iii) Treat a person acquiring income during suspended status as a recipient in terms of eligibility.

(b) If the income, plus other income, is in excess of two months' payment standard plus authorized additional requirements, the department shall terminate assistance effective the first day of the month of receipt of the income:

(i) Ineligibility shall continue for two months (maximum period of ineligibility is two months);

(ii) Upon completion of the two-month period of ineligibility, the department shall determine eligibility for those that reapply on the same basis as other new applicants.

(6) The department may shorten the period of ineligibility specified in subsection (5)(b) of this section when the following conditions are met:

(a) An event occurs which, had the assistance unit been receiving assistance, would result in an increase in the payment standard; or

(b) The income received, or any part thereof, has become unavailable to the members of the assistance unit for reasons beyond their control; or

(c) Members of the assistance unit incur, become responsible for, and pay medical expenses.

(7) Assistance is authorized only after the events in subsection (6)(a), (b), or (c) of this section have been verified and current eligibility has been established.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.005 (11)(b) and P.L. 104-193, Sec. 103 (a)(1) (1996). 97-06-078, § 388-218-1820, filed 2/28/97, effective 3/31/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-218-1820, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-28-480 and 388-28-484]

Chapter 388-220 WAC
STATE FAMILY ASSISTANCE

WAC

WAC 388-220-0001 Purpose of program. As authorized by state law under ESB 6098 (1997); chapter 57, Laws of 1997, the state family assistance (SFA) program is a state-funded program providing for the needs of legal immigrants with dependent children who are ineligible for the temporary assistance for needy families (TANF) program because of their immigration status.

[Statutory Authority: RCW 74.08.090 and 1997 c 57. 97-20-124, § 388-220-0001, filed 10/1/97, effective 11/1/97.]

WAC 388-220-0030 State family assistance eligibility. (1) To qualify for state family assistance (SFA), individuals must:

(a) Be lawfully admitted for permanent residence or otherwise reside permanently in the United States under color of law; and

(b) Meet all TANF requirements except for immigrant status eligibility rules specified in U.S.C. Title 8, Sections 1611, 1612, 1613, and 1641.

(2) The department will deny SFA to any assistance unit that includes an adult who has received SFA, TANF, or a combination of SFA and TANF for a total of sixty months since August 1, 1997.

(3) In calculating the number of months an adult family member has received SFA or TANF, the department will disregard any month in which the individual who received SFA or TANF was:

(a) A minor child who was not the head of a household or married to the head of a household; or

(b) Living in Indian country or in an Alaskan Native village, if during the month the individual received TANF, at least fifty percent of the adults living in Indian country or in the village were unemployed.

(4) For an assistance unit which includes both SFA and TANF recipients, the assistance unit's combined SFA and TANF grant payment cannot exceed the TANF grant payment level for their household size.

[Statutory Authority: RCW 74.08.090 and 1997 c 57. 97-20-124, § 388-220-0030, filed 10/1/97, effective 11/1/97.]

Chapter 388-222 WAC
DIVERSION ASSISTANCE

WAC

WAC 388-222-001 Definitions. "Adult." Any person age eighteen or older.

"Bona fide need." An actual, established need a family has for living expenses.

"Crisis." A family situation that the family can take care of if they receive help with one or more bona fide needs as defined in this chapter.

"DCA benefit begin date/month." The date/month of application or the date/month in which TANF or SFA eligibility exists if the applicant is not TANF or SFA eligible in the application month.

"Diversion assistance." The array of government and community services and resources, including diversion cash assistance (DCA), that is available to help some low income families so that the family does not have to go on temporary assistance for needy families (TANF) or state family assistance (SFA).

"Diversion cash assistance." A state-funded program that can provide up to fifteen hundred dollars of brief

emergency money to TANF or SFA eligible families who are in crisis and have a bona fide need(s).

"Family." At least one TANF or SFA eligible adult(s), any other people who must be included with that adult(s) in one TANF or SFA assistance unit, and any caretaker adult(s) who would be included in the TANF or SFA assistance unit but is ineligible because of TANF disqualification, citizenship status or any other reason.

"Unsubsidized job." A job in which the government does not give the employer any money to help pay the wage or salary of the person who has the job.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-001, filed 10/1/97, effective 11/1/97.]

WAC 388-222-010 Diversion cash assistance (DCA). To get DCA, the family has to:

(1) Meet all the eligibility rules for TANF or SFA that are in chapters 388-215, 388-216, 388-217, and 388-218 WAC except:

(a) The family does not have to meet the TANF or SFA work requirements that are in chapter 388-310 WAC; and

(b) The family does not have to meet the child support rules, including cooperating with division of child support, that are in WAC 388-215-1400 through 388-215-1490; and

(c) TANF or SFA recipients who are terminated and who apply for DCA within thirty days of termination are treated as applicants; and

(d) After the family is determined eligible for DCA their countable income and resources will not be used to decide how much DCA the family can receive.

(2) Meet all the other eligibility requirements of DCA including:

(a) The family must be in crisis as defined in this chapter;

(b) The family must have a bona fide need. Bona fide needs include, but are not limited to:

(i) Child care bills;

(ii) Rent payments;

(iii) Transportation costs;

(iv) Food costs, unless an adult member of the family has been disqualified for food stamps;

(v) Medical costs, unless an adult member is not eligible because of noncooperation with third party liability (TPL) requirements; or

(vi) Money needed to get or keep an unsubsidized job.

(c) The family must provide proof that the bona fide needs exist;

(d) The amount of DCA the family receives can not be more than the cost of the bona fide need(s) and must keep the family from going on TANF;

(e) The family has to have, or be likely to get, enough income or other resources that a reasonable person could expect the family to support themselves for at least twelve months.

(3) All money, except TANF and SFA, and all services which the federal government pays for, that can be used to meet the family's crisis, should be used before DCA is used.

(4) An family cannot get DCA if:

(a) Any adult member of the family is ineligible for TANF or SFA due to disqualification, drug conviction, lump sum income rule, or any other reason, except receipt of Supplemental Security Income (SSI);

(b) All adult family members are ineligible for TANF or SFA due to receipt of SSI; or

(c) Any adult member has received TANF/SFA in the current DCA benefit month or has received DCA within the past twelve months.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-010, filed 10/1/97, effective 11/1/97.]

WAC 388-222-020 Diversion cash assistance payments. (1) When all other DCA eligibility requirements are met, an assistance unit can get DCA payment for bona fide needs that occur prior to or during the thirty-day period following the benefit begin date.

(2) DCA will be paid directly to vendor(s) whenever possible.

(3) If a DCA adult recipient reapplies for TANF or SFA:

(a) Eligibility is determined without regard to the DCA payment if twelve months or more have gone by since the DCA benefit month.

(b) A DCA loan is established if fewer than twelve months have gone by since the DCA benefit month. The DCA loan is one-twelfth of the DCA received multiplied by the number of months that are left before the twelve months have gone by.

(4) The DCA loan has to be repaid having five percent of the TANF or SFA grant taken out of the TANF or SFA check each month.

(5) DSHS collects back the DCA loan solely by grant deduction.

(6) If the adult(s) who has to pay the loan goes off TANF or SFA before the loan is repaid, collection of the loan is suspended unless the adult(s) goes back on TANF or SFA. If the family goes back on TANF or SFA collection of the loan is resumed.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-020, filed 10/1/97, effective 11/1/97.]

Chapter 388-230 WAC
GENERAL ASSISTANCE FOR PREGNANT WOMEN

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-230-0040 Summary of eligibility conditions. [Statutory Authority: RCW 74.08.090. 93-16-059 (Order 3556), § 388-230-0040, filed 7/29/93, effective 8/29/93.] Repealed by 97-20-125, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090 and 74.04.0052.

WAC 388-230-0010 Purpose of program. (1) General assistance for pregnant women (GA-S) is a state-funded grant assistance program providing for the needs of:

(a) A pregnant woman; or

(b) A woman who has relinquished her newborn for adoption if the woman was receiving:

(i) GA-S at the time of the birth of the child; or

(ii) TANF at the time of the birth of the child and subsequently loses TANF eligibility because an eligible child does not reside in the household.

(2) Assistance granted under subsection (1)(b) of this section shall be limited to the end of the month containing the last day of the six-week period following the day the child is born.

(3) Refer to RCW 74.04.005 (6)(a) and (g).

[Statutory Authority: RCW 74.08.090 and 74.04.0052. 97-20-128, § 388-230-0010, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090. 93-16-059 (Order 3556), § 388-230-0010, filed 7/29/93, effective 8/29/93.]

WAC 388-230-0040 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-230-0060 Eligibility conditions—Program criteria. For GA-S, the department shall apply the temporary assistance for needy families (TANF) program criteria applicable to:

(1) Citizenship or alien status;

(2) Social Security number;

(3) Residency; and

(4) Minor teen living arrangements, as defined by the TANF program.

[Statutory Authority: RCW 74.08.090 and 74.04.0052. 97-20-128, § 388-230-0060, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090. 93-16-059 (Order 3556), § 388-230-0060, filed 7/29/93, effective 8/29/93.]

Chapter 388-235 WAC
GENERAL ASSISTANCE UNEMPLOYABLE

WAC

388-235-2000 Resources.

WAC 388-235-2000 Resources. The department shall determine eligibility for general assistance using the resource and transfer of property rules in chapters 388-216 and 388-217 WAC, except for funds in an individual development account established under WAC 388-216-3000.

[Statutory Authority: RCW 74.08.090 and 1997 c 58 § 307. 97-20-128, § 388-235-2000, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090. 94-16-044 (Order 3759), § 388-235-2000, filed 7/27/94, effective 9/1/94; 93-16-058 (Order 3559), § 388-235-2000, filed 7/29/93, effective 8/29/93.]

Chapter 388-250 WAC
GRANT STANDARDS

WAC

WAC 388-250-1225 TANF payment standards for recent arrivals to Washington state. (1) Eligibility and benefit levels for TANF recipients are determined according to length of residency and payment standard requirements established under RCW 74.08.025 (amended in section 101, chapter 58, Laws of 1997).

(2) The length of residency requirement does not apply to a dependent child who lives with a caretaker relative if the relative has resided in Washington for twelve or more consecutive months prior to applying for TANF benefits for the child.

[Statutory Authority: RCW 74.04.050, 74.04.057 and 74.08.090. 97-20-124, § 388-250-1225, filed 10/1/97, effective 11/1/97.]

WAC 388-250-1310 Maximum earned income levels. (1) Effective November 1, 1997, the department will use the following maximum earned income levels for temporary assistance for needy families (TANF) clients:

Number of Family Members	Maximum Earned Income Levels
1	$ 698
2	880
3	1,092
4	1,284
5	1,480
6	1,682
7	1,942
8	2,150
9	2,360
10 or more	2,566

(2) To calculate a family's gross earned income apply rules defined in WAC 388-218-1735.

[Statutory Authority: RCW 74.08.090. 97-20-124, § 388-250-1310, filed 10/1/97, effective 11/1/97.]

WAC 388-250-1700 Standards of assistance—Supplemental security income. Effective January 1, 1997, the standards of SSI assistance paid to an eligible individual and couple are:

(1) Living alone (own household or alternate care, except nursing homes or medical institutions).

	Standard	Federal SSI Benefit	State Supplement
Area I: King, Pierce, Snohomish, Thurston, and Kitsap Counties			
Individual	$512.00	$484.00	$ 28.00
Individual with one essential person	748.00	726.00	22.00
Couple:			
Both eligible	748.00	726.00	22.00
Includes one essential person	748.00	726.00	22.00
Includes ineligible spouse	652.20	484.00	168.20
Area II: All Counties Other Than the Above			
Individual	$491.55	484.00	7.55
Individual with one essential person	726.00	726.00	0
Couple:			
Both eligible	726.00	726.00	0
Includes one essential person	726.00	726.00	0
Includes ineligible spouse	622.25	484.00	138.25

Areas I and II:

Eligible individual with more than one essential person: $484.00 for eligible individual plus $242.00 for each essential person (no state supplement).

Eligible couple with one or more essential persons: $726.00 for eligible couple plus $242.00 for each essential person (no state supplement).

(2) Shared living (Supplied shelter): Area I and II

	Standard	Federal SSI Benefit	State Supplement
Individual	$328.48	$322.67	$ 5.81
Individual with one essential person	490.30	484.00	6.30
Couple:			
Both eligible	490.30	484.00	6.30
Includes one essential person	490.30	484.00	6.30
Includes ineligible spouse	426.43	322.67	103.76

Area I and II:
Eligible individual with more than one essential person: $322.67 for eligible individual plus $161.33 for each essential person (no state supplement).

Eligible couple with one or more essential persons: $484.00 for eligible couple plus $161.33 for each essential person (no state supplement).

(3) Residing in a medical institution: Area I and II

	Standard	Federal SSI Benefit	State Supplement
No change	$41.62	$30.00	$11.62

(4) Mandatory income level (MIL) for grandfathered claimant. Increased by three dollars and seventy-eight cents for all MIL clients, except for those converted in a "D" living arrangement (residing in a medical institution at the time of conversion).

[Statutory Authority: RCW 74.08.090, 74.04.630 and Social Security Act COLA Increases (Federal Register 61 pages 55346-51) 1997. 97-14-011, § 388-250-1700, filed 6/19/97, effective 8/1/97. Statutory Authority: RCW 74.08.090 and Legislative decision in the 1995 Budget Bill. 96-10-044 (Order 3972), § 388-250-1700, filed 4/26/96, effective 5/27/96; 95-20-028 (Order 3903), § 388-250-1700, filed 9/27/95, effective 10/28/95. Statutory Authority: RCW 74.04.050 and 45 CFR 233.20 (a)(2)(vi). 95-03-046 (Order 3822), § 388-250-1700, filed 1/11/95, effective 2/11/95. Statutory Authority: 1994 sp.s. c 6. 94-15-003 (Order 3750), § 388-250-1700, filed 7/7/94, effective 8/7/94. Statutory Authority: RCW 74.08.090. 94-09-001 (Order 3729), § 388-250-1700, filed 4/6/94, effective 5/7/94.]

Chapter 388-265 WAC
PAYMENT OF GRANTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-265-1350 Protective payment—AFDC clients sanctioned for failure or refusal to cooperate with the office of support enforcement. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1350, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-453 (part).] Repealed by 97-08-033 and 97-10-042, filed 3/27/97 and 4/30/97, effective 8/1/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, Section 103 (a)(1) (1996).

WAC 388-265-1275 Protective payment—TANF or GA parenting or pregnant minor. Refer to RCW 74.04.0052.

[Statutory Authority: RCW 74.08.090 and 74.04.057. 97-20-128, § 388-265-1275, filed 10/1/97, effective 11/1/97. Statutory Authority: Chapter 74.12 RCW and E2 SHB 2798. 94-20-040 (Order 3785), § 388-265-1275, filed 9/28/94, effective 10/29/94.]

WAC 388-265-1350 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-265-1750 Protective payee fees. (1) The department may authorize a fee to cover approved administrative costs of the protective payee under the following conditions:

(a) The person serving as protective payee is not a department employee; and

(b) The client is eligible for:

(i) GA-U;

(ii) TANF when the department has determined a client is unable to manage the client's assistance funds;

(iii) TANF when the department has determined a client is under sanction due to failure, without good cause, to participate in the jobs opportunity and basic skills training (JOBS) program; or

(iv) GA or TANF and is a pregnant or parenting minor, and protective payment established under RCW 74.04.0052 or RCW 71.12.255.

(2) The department shall not allow the protective payee to withhold money from the client's grant for payment of the protective payee's costs or services.

(3) "Administrative costs fee" means a fixed amount per assistance recipient, as set forth in the contract between the protective payee and the department.

[Statutory Authority: RCW 74.08.090 and 74.08.280. 97-13-091, § 388-265-1750, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090, 1994 c 299 § 33, RCW 74.08.280 and 74.50.060(2). 95-11-119 (Order 3858), § 388-265-1750, filed 5/24/95, effective 6/24/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1750, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-455 (part).]

Chapter 388-290 WAC
SUBSIDIZED CHILD CARE

WAC

388-290-110 Repealed.
388-290-115 Repealed.
388-290-120 Repealed.
388-290-123 Repealed.
388-290-130 Repealed.
388-290-135 Repealed.
388-290-140 Repealed.
388-290-155 Repealed.
388-290-160 Repealed.
388-290-170 Repealed.
388-290-180 Repealed.
388-290-210 Repealed.
388-290-250 Repealed.
388-290-260 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-290-040 Assurances and responsibilities under JOBS, income assistance, and transitional child care. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-040, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-110 JOBS, income assistance, and transitional child care programs. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-110, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-115 JOBS, income assistance, and transitional child care programs—Eligible children and recipients. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-115, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-120 JOBS, income assistance, and transitional child care program—Payment. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-120, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-123 JOBS, income assistance, and transitional child care programs—Effective dates. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-123, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-130 Income assistance and transitional child care programs—Effect on eligibility and payments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-130, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-135 JOBS, income assistance, and transitional child care—Hearings. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 96-09-058 (Order 3965), § 388-290-135, filed 4/12/96, effective 5/13/96; 95-23-028 (Order 3916), § 388-290-135, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-140 Income assistance child care program—Conversion. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-140, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-155 Transitional child care—Purpose and initial eligibility. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-155, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-160 Transitional child care—Co-payment. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-160, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-170 Transitional child care—Ongoing eligibility. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-170, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-180 Child care overpayments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-180, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-210 Other supportive services. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-210, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-250 Transitional supportive services. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-250, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

388-290-260 Supportive services overpayments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-260, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

WAC 388-290-010 Subsidized child care—Purpose. The purpose of this program is to provide child care services necessary to assist families with dependent children to become or remain employed.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-010, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-010, filed 11/8/95, effective 12/9/95.]

WAC 388-290-020 Subsidized child care—Definitions. Except as specified in this chapter, terms used under chapter 388-290 WAC shall have the same meaning as in the WorkFirst and TANF programs.

"Able" means an adult physically or mentally capable of caring for a child in a responsible manner.

"Adjusted earned income" means the gross earned income minus the average payroll and income tax paid at that income level.

"Available" means an adult able to provide care due to not participating in an approved WorkFirst activity and/or employment during the time child care is needed.

"Consumer" for the purposes of this chapter, means a parent or guardian who applies for, or receives subsidized child care services funded by the department.

"In-home/relative provider" means an unlicensed child care provider who is:

(1) One of the following adult relatives providing care in either the child's or relative's home:

(a) An adult sibling living outside the child's home; or

(b) A grandparent, aunt, uncle, first cousin, or great-grandparent, great-aunt, or great-uncle; and

(c) Not the child's biological, adoptive, or stepmother or stepfather.

(2) An adult friend or neighbor providing care in the child's own home; or

(3) An adult extended tribal family member as defined under chapter 74.15 RCW (Care of children, expectant mothers, developmentally disabled) who is providing care.

"Parent" for the purposes of this chapter, means a parent by blood, marriage, or adoption, or a legal guardian).

"Subsidy unit" for the purposes of this chapter, means child care assistance unit.

"Total income" for the purposes of this chapter, means the sum of adjusted earned income, self-employment income, and unearned income.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-020, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-020, filed 11/8/95, effective 12/9/95.]

WAC 388-290-025 Subsidy units and copayments. (1) Only individuals residing in the same household can be included in subsidy unit size.

(2) The minimum copayment is assessed for minor parents who are:

(a) Receiving TANF and living independently;

(b) The TANF head of household;

(c) Part of another TANF grant.

(3) The department can assess copayments above the minimum for:

(a) Related adults, other than spouses, and their respective child(ren). These are each separate subsidy units.

(b) Unmarried parents with a mutual child(ren). This is a single subsidy unit.

(c) Married or unmarried parents and their mutual and nonmutual children, if there is at least one mutual child. This is a single subsidy unit.

(d) Unmarried adults without a mutual child(ren). These are each separate subsidy units.

(e) A non-TANF minor parent living independently. This is a single subsidy unit.

(f) A child or minor parent living with a nonresponsible caretaker. This is a separate subsidy unit.

(4) Eligibility for subsidized child care ends when the consumer fails to pay, or arrange payment for, required copayment fees.

(5) The department reinstates the subsidy unit's eligibility for subsidized child care when back copayment fees are paid or satisfactory arrangements are made to make full payments.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-025, filed 10/1/97, effective 11/1/97.]

WAC 388-290-030 Responsibilities for the department, the consumer, and the provider under the subsidized child care program. (1) The department provides a program of subsidized child care for income-eligible consumers as follows:

(a) Only authorize payment to child care providers who allow parents or guardians access to their children whenever the children are in care;

(b) Take the child's needs into account when the department authorizes child care;

(c) Assure the parent's choice of child care facility or provider is protected;

(d) Only authorize payment when no adult in the subsidy unit is able and available to care for the children;

(e) Respond to requests for subsidized child care within ten days;

(f) Inform consumers of the child care options for which the department can make payment;

(g) Inform consumers of community resources which can help them select child care, if needed;

(h) Inform consumers of their rights and responsibilities in relation to child care; and

(i) Provide prompt child care payments to the provider.

(2) Consumers will:

(a) Be responsible to choose the provider and make the child care arrangements, including backup care arrangements;

(b) Notify the department of any change in providers within ten days;

(c) Pay the in-home/relative provider after the department pays the consumer for in-home/relative care;

(d) Be responsible to pay, or make arrangements to pay, any required copayment directly to the child care provider;

(e) Supply the department with necessary information to allow payment to the authorized provider;

(f) Notify the provider within ten days when the department discontinues or changes the child care authorization;

(g) Provide notice to the department within ten days of any change in household size or income level; and

(h) Assure the in-home/relative provider furnishes a valid social security number to the department, if the consumer chooses this kind of provider.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-030, filed 10/1/97, effective 11/1/97.]

WAC 388-290-035 Providers eligible for payment under the subsidized child care program. (1) A licensed child care provider must be licensed as required by chapter 74.15 RCW and chapters 388-73, 388-155 (Minimum licensing requirements for family child day care homes), and 388-150 WAC (Minimum licensing requirements for child day care centers).

(2) Child care providers exempt from licensing but who must be certified by the department include:

(a) Tribal child care facilities meeting the requirements of tribal law;

(b) Child care facilities on a military installation;

(c) Child care facilities operated on public school property by a school district.

(3) In-home/relative providers are exempt from licensing and certification, but must be registered with the department and meet the requirements of WAC 388-15-170.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-035, filed 10/1/97, effective 11/1/97.]

WAC 388-290-040 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-050 Eligible children and consumers under the subsidized child care program. (1) To be eligible for subsidized child care, the consumer must:

(a) Be a caretaker of one or more children; and

(b) Not care for their own child(ren) during the time child care is authorized, if the consumer is an employee of the child care facility to which the department has authorized payment.

(2) The department may authorize subsidized child care for a child between thirteen and nineteen years old if the child is:

(a) Under court supervision;

(b) Physically, mentally or emotionally incapable of self-care. This must be verified by a licensed medical practitioner or masters-level or above mental health professional.

(3) TANF consumers in sanction are not eligible for subsidized child care unless child care is necessary to:

(a) Obtain or maintain employment;

(b) Enroll in, or maintain enrollment in, an approved WorkFirst activity; or

(c) Remove the sanction.

(4) The child(ren) for whom the consumer applies must be a citizen or legally residing in the country.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-050, filed 10/1/97, effective 11/1/97.]

WAC 388-290-055 Payment for subsidized child care. (1) The department pays for child care for:

(a) A consumer's hours of participation in an approved WorkFirst activity and/or hours of employment;

(b) Transportation time between the place of employment or approved WorkFirst activity and the location of child care, if needed;

(c) Self-employment under WAC 388-290-070.

(2) The department may authorize child care payments for up to two weeks for a TANF consumer waiting to enter an approved WorkFirst activity.

(3) The department may authorize child care payments for up to four weeks for a consumer who experiences a gap in employment, or approved WorkFirst activity, if all the following conditions are met:

(a) The gap is for reasons out of the consumer's control;

(b) Employment, or the approved WorkFirst activity, will resume within that period;

(c) The consumer received subsidized child care immediately before the gap in employment, or approved WorkFirst activity; and

(d) Child care arrangements would otherwise be lost.

(4) The department pays initial and ongoing annual registration/equipment fees only if the fees are:

(a) Required of all parents whose (child(ren) are in care with that provider; and

(b) Needed to maintain a child care arrangement.

(5) The department may pay ongoing activity fees to the child care provider if the conditions in subsection (4)(a) and (b) of this section are met.

(6) The department may establish a protective payee due to mismanagement of funds for consumers who fail to pay the in-home/relative child care provider, when:

(a) The department issued a child care warrant to the correct address and twelve or more working days have passed since the issuance date; and

(b) The consumer has not reported the warrant lost, stolen, or destroyed.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-055, filed 10/1/97, effective 11/1/97.]

WAC 388-290-060 Adequate notice requirements and effective dates. (1) The department authorizes subsidized child care payments effective the following dates:

(a) For TANF consumers, the date an approved WorkFirst activity begins, or the date of request for TANF assistance, whichever is later.

(b) For non-TANF consumers, the date employment begins, or the date of request for child care, whichever is later.

(2) The department provides advance and adequate notice to consumers for changes in payment when the change results in a discontinuation, suspension, reduction, termination, or forces a change in child care arrangements.

(3) Advance and adequate notice requirements do not apply for other changes in the manner of payment.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-060, filed 10/1/97, effective 11/1/97.]

WAC 388-290-070 Self-employment and subsidized child care. (1) To be and remain eligible for subsidized child care, a self-employed person must maintain and make available to the department a record which clearly documents all claimed business expenses and income.

(2) For the first twelve months of self-employment starting from the date the consumer first became eligible for child care for self-employment, the consumer's required hours of child care are based on the greater of the following:

(a) Written documentation of the number of hours needed based on hours worked, as approved by the department; or

(b) The number of hours calculated by dividing the consumer's monthly self-employment income by the federal minimum wage.

(3) After the first twelve months, the consumer's necessary hours of child care are based on the lesser amount in subsection (2)(a) or (b) of this section.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-070, filed 10/1/97, effective 11/1/97.]

WAC 388-290-080 Subsidized child care—Fair hearings. (1) Consumers may request fair hearings under chapter 388-08 WAC (Practice and procedure—Fair hearing) on any action affecting child care benefits except for changes resulting from a change in policy or law.

(2) Consumers of subsidized child care may be eligible for continued child care benefits pending the outcome of a fair hearing if the consumer requests the fair hearing on or before the effective date of the action or within ten days of the notice of adverse action.

(3) The department shall consider any child care benefits the consumer receives pending a fair hearing or hearing decision to be an overpayment if the fair hearing decision subsequently finds against the consumer.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-080, filed 10/1/97, effective 11/1/97.]

WAC 388-290-090 Income eligibility and copayments. (1) The department determines income eligibility for subsidized child care by using the best available documentation of the subsidy unit's current and expected income.

(2) All consumers contribute to the subsidized child care cost by making monthly copayments, as follows:

(a) Ten dollars for subsidy units with total income at or below seventy-four percent of the Federal Poverty Level (FPL);

(b) Twenty dollars for subsidy unit with total income above seventy-four percent and up to one hundred percent of the FPL;

(c) Subsidy units with total income over one hundred percent of the FPL pay the greater of:

(i) Twenty dollars; or

(ii) Forty-seven percent of total income exceeding one hundred percent of the FPL.

(3) The department shall calculate copayments:

(a) At the time of the initial eligibility determination or authorization;

(b) At least every six months, starting from the first month of eligibility;

(c) When monthly income increases one hundred dollars or more;

(d) When monthly income decreases; or

(e) When subsidy unit size increases or decreases.

(4) The department authorizes subsidized child care for up to six months at a time.

(5) The military family's housing and food allowance is counted as unearned income for the purposes of subsidized child care.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-090, filed 10/1/97, effective 11/1/97.]

WAC 388-290-105 Subsidized child care—Overpayments. (1) In areas not covered by this section, child care consumers are subject to chapter 388-270 WAC (Incorrect payments).

(2) When establishing an overpayment, the department reduces child care overpayment by the amount of a child care underpayment when applicable.

(3) When a provider receives payment for child care services not provided, the department establishes the overpayment in the provider's name.

(4) The department recovers overpayments in cases:

(a) Of fraud;

(b) Involving current or past consumers; and

(c) Where cost of recovery does not exceed the overpayment amount.

(5) The department may recover child care overpayments from current TANF or non-TANF consumers from their child care benefits. Recovery may not interfere with child care arrangements.

(6) The department may recover child care overpayments from TANF benefits on voluntary request of the TANF recipient.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-105, filed 10/1/97, effective 11/1/97.]

WAC 388-290-110 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-115 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-120 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-123 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-130 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-135 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-140 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-155 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-160 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-170 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-180 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-210 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-250 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-260 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-300 WAC
JOB OPPORTUNITIES AND BASIC SKILLS TRAINING (JOBS) PROGRAM (Formerly chapter 388-47 WAC)

WAC

388-300-0100 through 388-300-3900 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-300-0100 Job opportunities and basic skills training (JOBS) program—Authority and purpose. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0100, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-0200 Definitions. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0200, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-0300 Providing program information and opportunity to participate. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0300, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-0400 Participation exemptions. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0400, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-0500 Required participation. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0500, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-0600 Referral to pathways. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0600, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-0700 Re-employment pathway. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0700, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-0800 Young person education pathway. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0800, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-0900 Employment investment pathway. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-0900, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1000 Disability advocacy pathway. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1000, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1100 Employability assessment. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1100, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1200 Employability plan. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1200, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1300 Component approval. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1300, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1400 Funding priority criteria. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1400, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1500 Annual review for continued funding. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1500, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1600 Component costs and supportive service funding conditions. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1600, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1700 Lack of program funds. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1700, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1800 Termination of payments for component costs, supportive services, and child care. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1800, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-1900 Notice of component decisions or funding decisions. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-1900, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2000 Child care. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2000, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2100 Unemployed parent program. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2100, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective

11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2200 Basic educational activities. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2200, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2300 Job readiness activities. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2300, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2400 Job search program. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2400, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2500 Jobs skills training. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2500, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2600 Post-secondary education. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2600, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2700 Work experience program (WEX). [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2700, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2800 On-the-job training (OJT). [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2800, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-2900 Work supplementation program (WSP). [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-2900, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3000 Self-initiated training or education. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3000, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3100 Job development and placement services. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3100, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3200 Good cause for refusal or failure to participate. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3200, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3300 Conciliation. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3300, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3400 Sanctions for refusal or failure to participate. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3400, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3500 Complaints and grievances. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3500, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3600 Fair hearings. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3600, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3700 Displacement of regular employees. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3700, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3800 Employment protection. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3800, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

388-300-3900 Tribal JOBS. [Statutory Authority: Chapter 74.25A RCW and RCW 74.08.090. 95-19-075 (Order 3897), § 388-300-3900, filed 9/18/95, effective 10/19/95.] Repealed by 97-20-126, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090, 74.04.050 and EHB 3901 1997 part III and federal legislation under Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

WAC 388-300-0100 through 388-300-3900 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-310 WAC
WORKFIRST

WAC

WAC 388-310-0100 WorkFirst—Authority and purpose. (1) The WorkFirst program is established under Title 74 RCW.

(2) The goals of WorkFirst are to:

(a) Reduce poverty by helping those receiving temporary assistance for needy families (TANF) and state family assistance (SFA) get and keep jobs;

(b) Sustain the independence of those who become employed by helping them keep jobs; and

(c) Protect children and other vulnerable residents.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0200 WorkFirst—Components. Except as otherwise specified, the terms used in this chapter, 388-310 WAC, shall have the same meaning as applied to the TANF program, and terms defined under chapter 388-22 WAC.

WorkFirst components are:

(1) **Paid employment**, either:

(a) Unsubsidized, including self-employment; or

(b) Subsidized and includes on-the-job training, work-study, and wage subsidy programs.

(2) **Work experience**;

(3) **Community service**;

(4) **Job search**;

(5) **Vocational educational training**;

(6) **Basic education activities**;

(7) **Post-employment services** which include employment retention and career development services.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0300 WorkFirst—Participation exemptions. (1) All TANF and state family assistance (SFA) recipients who are sixteen years of age and older and all custodial parents are required to participate in WorkFirst unless exempted under subsection (2)(a) of this section.

(2) A person is exempt from WorkFirst participation requirements if:

(a) The person is needed in the home to personally provide care for a child under twelve months of age.

(b) The person may use this exempt status for a total of twelve months during the person's sixty-month lifetime limit for assistance.

(3) Persons who are exempt may volunteer to participate and will not be subject to sanction for subsequent refusal to participate if still eligible for the exemption.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0300, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0400 WorkFirst—Participation requirements. (1) Participants are required to participate in job search as the first WorkFirst activity unless temporarily deferred. The department may defer a participant from immediate job search if the participant is:

(a) Working twenty or more hours a week;

(b) Under the age of eighteen and has not completed high school or GED, or is under the age of twenty and is currently attending high school, or its equivalent full-time; or

(c) Experiencing personal or family circumstances which prevents the person's immediate participation in job search.

(2) Participants who are temporarily deferred must participate as part of their individual responsibility plan in an evaluation of their employability from the department.

(3) The department may sanction a person who is nonexempt and who refuses to participate in the employability evaluation under WAC 388-310-0600.

(4) Persons approved by the department or a tribal JOBS or tribal native employment works (NEW) program for post-secondary education or training program prior to the effective date of this chapter will be permitted to continue in the program under WorkFirst until June 30, 1998.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0500 WorkFirst—Job search. (1) The purpose of job search is to provide the participant with the opportunity to learn and use skills and abilities needed to find and keep employment. Job search activities include:

(a) Classroom instruction on job finding techniques and employer expectations;

(b) Structured, consistent, and monitored efforts of the person to discover job openings and apply for available or potentially available employment; and

(c) Self-directed efforts of the person to find and obtain employment.

(2) A participant must meet the published standards of job search participation established in each region or community service office or tribal work program.

(3) A person's participation in job search must be of a quality and frequency that would clearly indicate that the individual is making sincere efforts to immediately obtain any employment.

(4) Participants may participate in pre-employment training as an activity equivalent to seeking employment. Pre-employment training is job skills training which has a prior commitment from an employer to hire the trainee

immediately upon completion of the training, at an hourly wage greater than the local entry level wage.

(5) The department may not require a participant to participate in job search for more than twelve weeks without evaluating the person's employability under WAC 388-310-0600.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0600 WorkFirst—Evaluation of employability. (1) A participant's employability will be evaluated by the department when:

(a) The person has not obtained paid, unsubsidized employment at the conclusion of job search; or

(b) The person was not referred for immediate job search.

(2) The purpose of the employability evaluation process is to determine:

(a) The reasons why a person is unable to find work in the local labor market; and

(b) Which WorkFirst components, support services, or child care services are needed by the participant to become employed in the shortest time possible.

(3) The evaluation will be focused on factors related to the person's ability to find and retain employment in the local labor market.

(4) Information gathered in the evaluation will be the basis for modifying the participant's individual responsibility plan.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0700 WorkFirst—Individual responsibility plan. (1) The purpose of the individual responsibility plan is to set forth:

(a) The participant's responsibility to participate in the WorkFirst components as required;

(b) The services the department will provide to the person to enable the person to participate.

(2) The department and the participant will work together in the development and decision-making process for component assignment. If needed, the department may assign the component which will provide the person with the job search, work experience, job skills, substance abuse assessment and treatment, family counseling, or family violence counseling or housing search, acquisition, and stabilization assistance as necessary to be employed in the shortest possible time.

(3) The plan includes the following:

(a) The WorkFirst component, in which participation is required, for what period of time and for how many hours a week;

(b) Any specific requirements relating to participation in the component;

(c) The services the department has determined are necessary for the person to participate in the component which may include provision of direct component cost funding, support services and child care subsidies.

(d) The participant's acknowledgement of their obligations to become and remain employed as quickly as possible.

(4) The department will review the elements in a participant's individual responsibility plan as necessary to ensure the plan continues to meet the person's employability needs.

(5) The participant will sign and receive a copy of their individual responsibility plan at the time the plan is developed and whenever the plan is modified.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0800 WorkFirst—Support service and direct component cost funding. (1) The purpose of support service and direct component cost funding is to provide participants access to necessary goods or services which cannot be paid for by another funding source.

(2) The department or its agent will fund support services when:

(a) Determined necessary by the department or its agent;

(b) Denial would prevent participation in the required component; and

(c) It is within available funds.

(3) Support services which may be funded include:

(a) Employment related needs such as work clothing or uniforms, tools, equipment, relocation expenses, or fees;

(b) Transportation costs such as mileage reimbursement, public transportation vouchers, and car repair;

(c) Professional services such as certification or diagnostic testing, counseling or medical examinations or services;

(d) Personal needs such as clothing appropriate for job search or other component activities; and

(e) Special needs such as accommodations for employment.

(4) The department will provide support services and direct component cost funding to support components approved prior to the effective date of this chapter until June 30, 1998 if the participant is making satisfactory progress toward completion of the activity.

(5) WorkFirst participants are eligible for child care subsidy payments under chapter 388-290 WAC.

(6) No funds available to carry out the WorkFirst program may be used to assist, promote, or deter religious activity.

(7) The department may establish maximum funding limits for support services.

(8) The department may provide funding for direct component costs for vocational education activities when the participant:

(a) Is in an approved component as stated on the individual responsibility plan; and

(b) Does not qualify for sufficient student financial aid to meet the cost.

(9) Support services may be identified and provided in order to address specific needs American Indians may have due to location or employment needs.

(10) If the person is not participating as required they will lose eligibility for direct component costs and support services.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0900 WorkFirst—Basic education. (1) Basic education is high school completion and classes to prepare for and testing to acquire GED certification. It may include adult basic education (ABE) or English as a second language (ESL) training if:

(a) The ABE or ESL is needed by the person to meet the current standards of the local labor market; and

(b) The activity is combined with paid or unpaid employment or job search.

(2) The department may require a nonexempt custodial parent eighteen and nineteen years of age who lacks a high school diploma or GED certification to participate in basic education if such education is needed by the person to meet the current standards of the local labor market.

(3) Nonexempt participants twenty years of age and older may participate in basic education activities but must also participate in paid or unpaid employment or job search for a minimum of twenty hours a week in addition to the basic education.

(4) The department may require sixteen and seventeen year old TANF and SFA recipients to be in high school or GED certification programs.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0900, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1000 WorkFirst—Vocational education. (1) Vocational education is training in a specific occupation provided by a private college, technical school or community college licensed, authorized or certified by the state, or provided by a certified tribal college. It may not exceed twelve months in length with respect to any individual. It also includes job skills training in specific skills directly related to employment, and entrepreneurial training, offered through community-based organizations, businesses and tribal governments.

(2) The department may include vocational education in the individual responsibility plan when the person:

(a) Is employed twenty or more hours a week in subsidized or unsubsidized employment; or

(b) Lacks job skills presently in demand for entry level jobs in the local labor market and vocational education can provide such skills; and

(c) Would not be able to acquire the skills needed to obtain employment though available openings in:

(i) Work experience under WAC 388-310-1100; or

(ii) On-the-job training under WAC 388-300-1200.

(3) A nonexempt TANF/SFA recipient may participate in vocational education or other post-secondary education or training activities not included on their individual responsibility plan on their own if the person is meeting WorkFirst hourly participation requirements.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1000, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1100 WorkFirst—Work experience. (1) Work experience (WEX) is unpaid work with a private nonprofit organization, federal, state, local or tribal government or district. Entities providing WEX unpaid employment positions to WorkFirst participants must be in compliance with all applicable state and federal health and safety standards.

(2) The purpose of WEX is to provide the participant with instruction in essential work practices and to practice or expand work skills.

(3) Participant may be required to conduct a self-directed job search.

(4) Participants must accept offered paid employment while participating in WEX.

(5) A person's assignment to a specific WEX activity in excess of six months requires a department review. The review will determine if the person requires more time to gain the skills and abilities established as the desired outcome of the WEX assignment.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1200 WorkFirst—On-the-job training. (1) On-the-job training (OJT) is skills training provided by an employer at the employer's place of business. It may include some classroom training release time.

(2) A participant may be eligible for OJT employment if:

(a) The person lacks skills which are in demand in the local labor market; and

(b) There are employers in the area able to provide the training.

(3) An employer providing OJT may be reimbursed for up to fifty percent of the total gross wages for regular hours of work and pre-approved release time for training.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1400 WorkFirst—Community service program. (1) Community service is:

(a) Unpaid work performed for a charitable nonprofit organization, federal, state, local, or tribal government or district such as the work performed by volunteer workers; or

(b) An activity approved by the department which benefits the person, the person's family, or the person's community or tribe. These activities may include traditional activities that perpetuate tribal culture and customs.

(2) Activities which may be approved by the department under subsection (1)(b) of this section as part of the individual responsibility plan include:

(a) Caring for a disabled family member;

(b) Nonparental caretaker relative over age fifty caring for a child;

(c) Provision of child care for a WorkFirst participant by a WorkFirst participant;

(d) Active participation in a drug or alcohol assessment or treatment program certified or contracted through chapter 70.96A RCW;

(e) Specialized services as required by the participant to become employable or retain employment such as family violence counseling or active participation in a drug or alcohol assessment or treatment program certified or contracted through chapter 70.96A RCW.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1500 WorkFirst—Employment conditions. (1) Participants will not be required to accept

paid or unpaid employment or engage in an activity in which an employer-employee relationship exists which:

(a) Is not covered by industrial insurance under Title 51 RCW, unless the employee is employed by a tribal government or a tribal private, for-profit business;

(b) Is available because of a labor dispute;

(c) Has working hours or other conditions which interfere with the participant's bona fide religious beliefs or observations;

(d) Involves conditions which are in violation of federal, state or tribal health and safety standards;

(e) Has unreasonable work demands or conditions, such as working without getting paid on schedule with regard to paid work; or

(f) Participants will not be required to participate in unpaid work components for more hours than would equal the family's TANF/SFA grant divided by state or federal minimum wage, whichever is higher. For two-parent families in which both parents are nonexempt, the combined hours of required participation in unpaid work may not exceed the family's TANF/SFA grant divided by the higher of the state or federal minimum wage.

(2) Participants will not be required to accept paid employment when the conditions of employment or the employer:

(a) Pays less than the federal, state, or tribe minimum wage, whichever is higher;

(b) Does not provide unemployment compensation coverage under Title 50 RCW, unless the employee is employed by a tribal government, tribal private for-profit business or the employee is exempt under section 7873 of the Internal Revenue Code because the person is a treaty fishing rights related worker;

(c) Requires the person to resign from or refrain from joining a legitimate labor organization; or

(d) Does not provide benefits to participants equal to those provided to other similarly employed workers.

(3) Nothing contained herein shall be in violation of federal or tribal employment laws.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1600 WorkFirst—Determination of reasons for nonparticipation. (1) The following actions will be considered failure to participate in WorkFirst requirements:

(a) Refusal of a bona fide offer of employment;

(b) Failure to fulfill participation requirements of any components on the person's individual responsibility plan including not participating in:

(i) Drug and/or alcohol assessment;

(ii) Drug and/or alcohol treatment programs when assessed and determined as drug and/or alcohol dependent by a program certified and contracted through chapter 70.96A RCW;

(c) Failure to provide information requested by the department necessary for the development of the individual responsibility plan; or

(d) Not appearing for one or more appointments scheduled by the department or its agent.

(2) When a participant fails to participate in WorkFirst:

(a) The participants will have the opportunity to explain their nonparticipation; and

(b) The department will determine the adequacy of the reasons for nonparticipation. The department may make a determination based on available information if the participant does not provide information as requested.

(3) The department will determine that failure to participate is refusal, unless the participant provides evidence the nonparticipation is based on an inability to participate such as:

(a) Urgent personal or family circumstances interfering with participation which include but are not limited to:

(i) Threatened or actual family violence issues;

(ii) Eviction or immediate legal problems;

(iii) Injury or illness of the participant or of a family member which requires the presence of the participant; or

(iv) Death of a significant person in the participant's life.

(b) Breakdown in support services necessary for the person to participate and the person had no readily available alternative;

(c) The participant is unable to locate formal or informal child care for a child under the age of twelve years of whom they personally provide care and the department fails to provide such care;

(d) The participant is unable to locate other care services for an incapacitated individual living in the same home as a dependent child and the department fails to provide such care;

(e) Determination by a licensed health professional that a physical, mental, or emotional condition is interfering with the required participation; or

(f) The person did not receive a notice of appointment or program requirement.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1700 WorkFirst—Sanctions. (1) Refusal to participate will result in sanction.

(2) Sanction for refusing to participate will affect the family's TANF/SFA grant as follows:

(a) For the first month a person is sanctioned the family's TANF/SFA grant amount (less any income deductions) will be reduced by the participant's share.

(b) For second and subsequent months of continuous sanction status a protective payee will be established for reduced grant amount established under subsection (2)(a) of this section.

(c) For the third and subsequent months of continuous sanctions status the family's grant (less any income deductions) will be reduced by the amount established under subsection (2)(a) of this section or by forty percent whichever is higher. The protective payee will continue.

(3) The department will restore the full TANF/SFA grant amount retroactive to the day the participant begins or resumes participation in the component specified on the person's individual responsibility plan when the person meets participation requirements for the component for a minimum of two weeks.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1800 WorkFirst—Displacement of regular employees. (1) A person is not required to participate in subsidized employment or unpaid work activities which:

(a) Result in the displacement of any currently employed worker including partial displacement, such as reduction in hours of overtime or nonovertime work, reduction in wages, or employment benefits;

(b) Impair existing contracts for services or collective bargaining agreements;

(c) Result in the employment or assignment of a participant or the filling of a position when:

(i) Any other person is on layoff from the same or a substantially equivalent job within the same organizational unit; or

(ii) An employer has created a vacancy for the purpose of hiring a WorkFirst participant by terminating any regular employee or otherwise reduced its workforce.

(d) Infringe on promotional opportunities of any currently employed person.

(2) The department will terminate wage subsidy program or OJT payments to an employer if the employer's worksite or operation becomes involved in a strike, lockout, or bona fide labor dispute.

(3) When a wage subsidy program or OJT agreement has been terminated and payment to the employer discontinued due to displacement of a regular employee, the WorkFirst participant's continued employment with that employer is at the sole discretion of the person and the employer.

(4) A regular employee (or the employee's representative) of an employer which has hired a WorkFirst participant into a subsidized or unpaid work activity who believes the participant's work activity violates any of the provisions under this section has the right to:

(a) A grievance procedure under WAC 388-200-1100; and

(b) A fair hearing under chapter 388-08 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1900 WorkFirst—Services for American Indian tribal members and other American Indians. (1) The department will refer American Indian TANF applicants and recipients to the person's tribe, according to populations and service area(s) specified by a tribal government for comparable WorkFirst services when:

(a) The tribal government operates a federally-approved Tribal TANF program; and

(b) The person is included in the population and service area identified by the tribal government in the plan.

(2) All other American Indian TANF recipients have equitable access to WorkFirst program components and services under this chapter.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1900, filed 10/1/97, effective 11/1/97.]

Chapter 388-320 WAC
PUBLIC RECORDS DISCLOSURE—ADMINISTRATIVE PROCEDURES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-320-400 Petition for rule making—Form, content, and filing. [Statutory Authority: RCW 34.05.220, 42.17.340 and chapters 17.250 and 17.260 RCW. 93-24-057 (Order 3673), § 388-320-400, filed 11/24/93, effective 12/25/93. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-400, filed 2/5/90, effective 3/1/90.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-320-410 Petition for rule making—Consideration and disposition. [Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-410, filed 2/5/90, effective 3/1/90.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-320-470 Subscription to adjudicative orders involving nursing homes. [Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-470, filed 11/27/91, effective 12/28/91.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-320-500 Updating mailing lists. [Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-500, filed 2/5/90, effective 3/1/90.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-320-225 Qualifications on nondisclosure. (1) To the extent that nondisclosable information can be deleted from the specific records sought, the remainder of the records shall be disclosable.

(2) No exemptions shall be construed to require nondisclosure of statistical information not descriptive of identifiable persons, as required by RCW 42.17.310(2).

(3) Inspection and copying of any specific records otherwise nondisclosable is permissible pursuant to an order of the superior court enforcing a subpoena in accordance with the provisions of RCW 42.17.310(3), or an order of the office of hearings enforcing a subpoena.

(4) Upon written request of a person who has been properly identified as an officer of the law with a felony arrest warrant or a properly identified United States immigration official with a warrant for an illegal alien the department shall disclose to such officer or official the current address and location of the person described in the warrant, as required by RCW 74.04.062.

(5) The department shall furnish a federal, state, or local law enforcement officer, upon the request of the officer, with the current address of any recipient of temporary assistance for needy families if the officer furnishes the agency with the name of the recipient and notifies the agency that:

(a) The recipient:

(i) Is fleeing prosecution, or custody or confinement after conviction;

(ii) Is a fugitive felon or probation or parole violator as described in WAC 388-215-1550; or

(iii) Has information that is necessary for the officer to conduct the official duties of the officer; and

(b) The location or apprehension of the recipient is within such official duties.

(6) Any person may inquire of the department whether a named individual is a recipient of welfare assistance in accordance with RCW 74.04.060.

(7) Any records of the department may be made accessible for research purposes provided that the research complies with the guidelines published by the department in response to 45 C.F.R. 46 or other applicable state and federal law.

[Statutory Authority: RCW 74.08.090, 74.04.050, 70.04.055 and Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, § 103). 97-07-008, § 388-320-225, filed 3/10/97, effective 4/10/97. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-225, filed 2/19/81.]

WAC 388-320-400 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-320-410 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-320-470 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-320-500 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-330 WAC
BACKGROUND INQUIRIES

WAC

WAC 388-330-035 Appeal of disqualification. (1) Whenever a person in good faith desires employment in an agency licensed under chapter 74.15 RCW, the person, prior to applying for employment, upon request, shall promptly receive from the department an informal meeting on whether the person is disqualified from employment for not meeting the minimum requirements pursuant to chapter 74.15 RCW or rules promulgated thereunder.

(a) Prior to receiving an informal meeting under this subsection, it shall be the responsibility of a person requesting the meeting to demonstrate a good faith desire for employment in an agency licensed under chapter 74.15 RCW. Such demonstration of good faith shall include, but not be limited to, a showing of educational qualifications, employment history information, current employment, and plans for obtaining employment in a licensed agency in the near future. The department's determination regarding whether the person requesting the meeting has demonstrated a good faith desire for employment is final and not subject to a proceeding under chapter 34.05 RCW. The department shall notify such person promptly following the meeting of its determination in writing.

(b) If the department determines, subsequent to an informal meeting under this subsection, that a person is disqualified, the department shall give written notice of the disqualification to the person. The notice shall state what the person is disqualified from doing, the reasons for the disqualification, the applicable law under which the person is disqualified, and their right to an adjudicative proceeding under chapter 34.05 RCW.

(2) If the department during employment or at the time of employment, determines that a person is disqualified from employment with a child care agency for not meeting minimum requirements under chapter 74.15 RCW or rules promulgated thereunder, the department shall give written notice of disqualification to the person. The notice shall state what the person is disqualified from doing, reasons for the disqualification, and the applicable law under which the person is disqualified, and their right to an adjudicative proceeding under chapter 34.05 RCW.

(3) The procedures in RCW 43.20A.205 shall apply whenever the department issues a notice of disqualification to a person under this section. If the disqualified person requests an adjudicative proceeding, the department shall have the burden of proving disqualification by a preponderance of the evidence.

(4) A licensee under chapter 74.15 RCW may not allow a person disqualified under this section to be employed by or associate with the licensee's agency. Disqualification of a person may not be contested by a licensee.

(5) The provisions of this section do not preclude the department from taking any action against a licensee in accordance with chapter 74.15 RCW or rules promulgated thereunder.

(6) If after a hearing under chapter 34.05 RCW it is determined that the allegations are not supported by a preponderance of the evidence, the department's records shall be supplemented to so state and the person and any employer shall be informed that there is nothing prohibiting the person from being employed by or associated with a licensed child care agency. If an employer is aware that the hearing has occurred, the employer shall additionally be informed that the department failed to prove the allegations at issue in the hearing.

(7) If at a hearing under chapter 34.05 RCW the appellant proves by clear, cogent and convincing evidence that the incident of abuse or neglect on which the notice of disqualification is based did not occur and that the allegation is false, the record shall be supplemented to so state, and the department shall restrict access to all such reports so that the reports will not thereafter be considered by the department in determining whether a person is disqualified.

(8) The department in accordance with WAC 388-330-030 may remove a disqualification based on conviction of a crime.

The department may remove a disqualification based on a reason other than conviction of a crime if the disqualified person demonstrates by clear, cogent, and convincing evidence that the person is sufficiently rehabilitated to warrant public trust and to comply with the requirements of chapter 74.15 RCW, and the rules promulgated thereunder.

[Statutory Authority: RCW 74.15.030. 97-13-002, § 388-330-035, filed 6/4/97, effective 7/5/97; 96-10-043 (Order 3974), § 388-330-035, filed 4/26/96, effective 5/27/96.]

Chapter 388-501 WAC
ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

WAC 388-501-0135 Patient requiring regulation.

(1) The department shall operate a patient requiring regulation (PRR) program to identify a client overutilizing, unnecessarily, or inappropriately obtaining medical care under the federally funded and state-funded medical programs. The department may restrict such a client to a single primary care provider and pharmacy for medical care.

(2) The purpose of the PRR program shall be to:

(a) Protect the client's health and safety;

(b) Provide continuity of medical care;

(c) Avoid duplication of services by providers;

(d) Avoid excessive, contraindicated, or potentially harmful use of prescription medications.

(3) For the purposes of this section, "primary care provider (PCP)" means a provider who has responsibility for supervising, coordinating and providing initial and primary care to clients, initiating referrals for specialist care, and maintaining the continuity of patient care. A PCP shall be either:

(a) A physician who meets the criteria under WAC 388-87-007;

(b) An advanced registered nurse practitioner (ARNP) who meets the criteria under WAC 388-87-007; or

(c) A licensed physician assistant, practicing with a sponsoring or supervising physician.

(4) For a client not enrolled in a department-contracted managed care plan, the department shall designate staff to determine the client's overuse, inappropriate, or unnecessary usage of medical care by reviewing medical assistance administration (MAA) payment records and other medical information.

(5) For a client enrolled in a department-contracted managed care plan, the department shall designate staff to evaluate the medical records and other documents provided by the client's managed care plan to determine the client's inappropriate or unnecessary use of medical care.

(6) When a client has been enrolled in more than one managed care plan during the review period, the department shall obtain and evaluate the client's medical records and other documents from all department-contracted managed care plan(s) in which the client is or has been enrolled during the review period.

(7) The department shall use medical review guidelines established by nurse advisors, physicians, pharmacy consultants, and other reference sources.

(8) The department shall consider the following levels of utilization during a period of three consecutive months or less as medical review guidelines for the PRR program:

(a) Repeated and documented efforts by the client to seek medically unnecessary health services, including but not limited to prescription medication, after having been counseled at least once by a health care provider or managed care plan representative concerning appropriate utilization of health care services;

(b) Services from four different physicians;

(c) Prescriptions from four different pharmacies;

(d) Ten prescriptions received;

(e) Two emergency room visits; or

(f) Four prescribers.

(9) The department shall notify the client in writing that the client is assigned to PRR, when the medical review indicates the client overuses medical services, or uses medical services inappropriately or unnecessarily as determined by the department's review of the client's:

(a) Medical records and other documents which indicate the client's use of medical services meets the criteria in subsection (8)(a) of this section or meets or exceeds three of the five guidelines under subsections (8)(b) through (f) of this section; and

(b) Diagnoses, the history of services provided or other medical information supplied by the health care provider or managed care plan.

(10) The department shall notify the client of the right to:

(a) A fair hearing as required under chapter 388-08 WAC; and

(b) Continue as unrestricted when a fair hearing is requested in a timely manner.

(11) A client shall respond to the department's notice within twenty calendar days by:

(a) Writing or calling the PRR representative identified in the notice;

(b) Requesting a fair hearing;

(c) Selecting a PCP and pharmacy. For a client enrolled with a department-contracted managed care plan, the client must select a PCP and pharmacy from those identified as available within their managed care plan;

(d) Requesting assistance in selecting a PCP and pharmacy; or

(e) Submitting additional medical information.

(12) The department shall assign a PCP and pharmacy for any client who fails to select a PCP and pharmacy within twenty calendar days, unless the client requests a fair hearing. The selected or assigned PCP and pharmacy shall be:

(a) Located in the client's local geographic area; or

(b) Reasonably accessible to the client.

(13) The client shall not change PCP or pharmacy for twelve months except when the:

(a) Client moves to a new residence outside the designated geographic area of the providers;

(b) PCP or pharmacy moves from the client's geographical area;

(c) PCP or pharmacy refuses to continue as the designated provider;

(d) A client may change, once within the initial sixty days, the PCP and pharmacy assigned by the department under subsection (12) of this section. For a client enrolled with a department-contracted managed care plan, the client must select a PCP and pharmacy from those identified as available within their managed care plan;

(e) PCP or pharmacy no longer participates in a department-contracted managed care plan;

(f) PCP is no longer contracted with the client's managed care plan. The client shall have the option of:

(i) Selecting a new PCP from the list of available PCPs provided by the plan; or

(ii) Transferring enrollment of all family members to the new department-contracted plan which the established PCP has joined.

(g) Client chooses a new plan during an open enrollment period which occurs in the twenty-four-month restriction period.

(14) For a client enrolled in the PRR program, the department shall:

(a) Assign a client to the program for a period of twenty-four months;

(b) Review the client's utilization at the end of the twenty-four-month period;

(c) Continue the client in the PRR program when the client continues to meet the criterion in subsection (8)(a) of this section or meet or exceed three of the five criteria in subsection (8)(b) through (f) of this section;

(d) Review continuation of the client in the PRR program at least every twelve months thereafter; and

(e) Allow the client the opportunity to change PCP or pharmacy after twelve months; except as allowed under subsection (13)(d) of this subsection.

(15) When the department designates a PCP and pharmacy for the client, the department shall issue a medical identification card identifying the client as a patient requiring regulation.

(16) When an emergency occurs as defined under WAC 388-500-0005, a provider other than the selected PCP may see the client.

(17) The PCP may refer the client to a specialist.

(18) For a client not enrolled in a department-contracted managed care plan, the department shall only pay for MAA-covered services authorized by the PCP, referred specialist, selected pharmacy, and those services specified in subsections (16) and (20) of this section.

(19) The client shall be responsible for payment of covered services not authorized by the PCP, referred specialists or selected pharmacist with the exception of services described under subsections (16) and (20) of this section.

(20) A client assigned to the PRR program may self-refer for family planning services.

(21) A client may self-refer to women's health care services. For a client enrolled with a department-contracted plan, the client must self-refer within the plan network.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 97-03-038, § 388-501-0135, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0135, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-100.]

Chapter 388-503 WAC
PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

WAC

WAC 388-503-0310 Categorically needy eligible persons. The department shall determine eligible for categorically needy medical assistance a client who is:

(1) Receiving or eligible to receive a cash assistance payment under:

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

(b) Supplemental security income (SSI) including a grandfathered person and a person with an essential spouse; or

(c) State supplemental payment (SSP) to a person as assistance based on need in supplementation of SSI benefits. This payment includes mandatory state supplement or optional state supplement as defined under WAC 388-500-0005. The ineligible spouse of an SSI beneficiary receiving a state supplement payment for the ineligible spouse is not eligible for noninstitutional categorically needy medical assistance.

(2) A person twenty years of age or younger who meets the:

(a) One-person AFDC financial requirements and is in:

(i) Foster care; or

(ii) Subsidized adoption; or

(iii) A nursing facility or intermediate care facility for mentally retarded (ICF/MR); or

(iv) An approved inpatient psychiatric facility.

(b) Eligibility requirements under chapter 388-509 WAC.

(3) A current client of Title II, Social Security Administration (SSA) benefits who:

(a) Was a concurrent client of Title II and SSI benefits;

(b) Is ineligible for SSI benefits and/or state supplementary payments; and

(c) Would be eligible for SSI benefits if the department deducts the following from the current Title II benefit amount:

(i) All Title II cost-of-living benefit increases under P.L. 94-566, Section 503 received by the client since termination from SSI/SSP; and

(ii) All Title II cost-of-living benefit increases received during the time period in subsection (3)(c)(i) of this section by the client's spouse and/or other financially responsible family member living in the same household.

(4) An SSI client, after January 1, 1981, who continues to be eligible for medical assistance under P.L. 96-265 and 99-643;

(5) A currently disabled client receiving widow's or widower's benefits under Section 202 (e) or (f) of the Social Security Act if the disabled client:

(a) Was entitled to a monthly insurance benefit under Title II of the Social Security Act for December 1983; and

(b) Was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act for January 1984;

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

(d) Has been continuously entitled to a widow's or widower's benefit under Section 202 (e) or (f) of the act;

(e) Would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent cost-of-living increases provided under Section 215(i) of the act, were disregarded;

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

(g) Filed an application for Medicaid coverage before July 1, 1988.

(6) Effective January 1, 1991, any person receiving Title II disabled widow/widower benefits (DWB) under Section 202 (e) or (f) of the SSA, if the person:

(a) Is not eligible for the hospital insurance benefits under Medicare Part A of Title XVIII;

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

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

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

(7) A disabled or blind client receiving Title II Disabled Adult Childhood (DAC) benefits under Section 202(d) of the SSA if the client:

(a) Has attained eighteen years of age;

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

(c) Would be eligible for SSI/SSP if the amount of the DAC benefits or increase under Section 202(d) of the SSA and any subsequent cost-of-living increases provided under Section 215(i) of the SSA Act were disregarded.

(8) A client who:

(a) In August 1972, received:

(i) Old age assistance (OAA);

(ii) Aid to blind (AB);

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

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

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

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

(9) A pregnant woman whose family income is at or below one hundred eighty-five percent of the Federal Poverty Level (FPL), or postpartum woman as described under WAC 388-508-0830;

(10) A child, born to a woman eligible for and receiving medical assistance on the date of the child's birth, from the date of birth for a period of one year when the child remains a member of the mother's household;

(11) A child eighteen years of age or younger meeting residence, citizenship, and Social Security number requirements whose countable family income is at or under two hundred percent of the FPL.

(12) In a family unit ineligible for AFDC financial assistance as a result (wholly or in part) of the collection or increased collection of child or spousal support shall be eligible for medical assistance for four months beginning with the month of ineligibility, if the family unit received AFDC financial assistance in at least three of the six months immediately preceding the month of ineligibility;

(13) In a family unit which becomes ineligible for AFDC before April 1, 1990, solely because of increased hours or increased income from employment shall remain categorically eligible for medical assistance for four calendar months beginning with the month of ineligibility, provided:

(a) The family received AFDC in at least three of the six months immediately preceding the month of ineligibility; and

(b) A member of such family continues to be employed; and

(c) The department considers earned income tax credits (EITC) as income for the purposes of this subsection.

(14) Denied AFDC cash payments solely because of a departmental recovery of an overpayment;

(15) In a medical facility and:

(a) Who would be eligible for cash assistance if the person was not institutionalized; or

(b) Is an SSI-related institutionalized person and has gross income above the cash assistance level but below three hundred percent of the Federal Benefit Rate.

(16) Sixty-five years of age or older, a patient in an institution for mental diseases (IMD), and is resource and income eligible as described under subsection (15)(a) or (b) of this section;

(17) A person eligible for and accepting hospice services as described under WAC 388-86-047 and who shall be:

(a) SSI categorically related with gross income less than three hundred percent of the SSI Federal Benefit Rate; or

(b) AFDC categorically related.

(18) Blind or presumptively disabled under SSI criteria, as described under WAC 388-511-1105, and the person receives continuing general assistance (GA-X) cash assistance;

(19) An alien ineligible for AFDC or SSI cash assistance because of deeming of income of the alien's sponsors;

(20) Not an inmate of a public institution;

(21) Not receiving cash assistance because of special situations as defined under WAC 388-507-0740; or

(22) A client who:

(a) Was entitled to RSDI benefits in August 1972; and

(b) Is ineligible for AFDC or SSI solely because of the twenty percent increase in Social Security benefits under PL 92-336.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-036, § 388-503-0310, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090 and SPA 95-11. 96-12-001 (Order 3981), § 388-503-0310, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-17-036 (Order 3769), § 388-503-0310, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-503-0310, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-010 and 388-82-115.]

Chapter 388-505 WAC
ELIGIBILITY FACTORS COMMON TO MEDICAL PROGRAMS

WAC

WAC 388-505-0510 Residence. (1) A client receiving medical care program benefits other than medically indigent shall be a resident of the state of Washington. A client need not be a resident of the county in which medical care is obtained.

(2) The department shall consider a client a resident if the client:

(a) Intends to remain permanently or for an indefinite period in the state; or

(b) Enters the state with a job commitment or seeks employment, whether the client is or is not currently employed.

(3) The department shall not consider a person temporarily entering the state, for the sole purpose of obtaining medical care, as a resident. For an institutionalized person, refer to WAC 388-513-1320(4).

(4) The department shall consider a client's residence the state:

(a) Making a state supplemental security income (SSI) supplementary payment; or

(b) Making federal payments for foster or adoption assistance under Title IV-E of the Social Security Act; or

(c) Of residence of the parent or legal guardian, if one has been appointed, for an institutionalized minor child; or

(d) Of residence of the parent or legal guardian, if one has been appointed, for an institutionalized client twenty-one years of age or older who became incapable of determining residential intent before twenty-one years of age; or

(e) Where a client is residing if the person becomes incapable before twenty-one years of age; or

(f) Making a placement in an out-of-state institution.

(5) The department shall determine the state of residence of a noninstitutionalized child, unless married or emancipated, following the rules under chapter 388-215 WAC.

(6) The department shall ensure married or emancipated minor children follow the rules of subsections (1), (2), (3) and (4) of this section.

(7) When two or more states cannot agree which state is the client's state of residence, the department shall require the state in which the client is physically located to be the state of residence.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2). 97-15-025, § 388-505-0510, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-025.]

WAC 388-505-0540 Assignment of medical support rights. (1) As a condition of eligibility for any medical program, a client shall assign to the state of Washington all right, title, and interest to any medical care support available as a result of:

(a) A court order; or

(b) An administrative agency order; or

(c) Any third-party payments for medical care.

(2) When payments for covered services have been made under medical care programs under chapter 74.09 RCW, or under a contract between a managed health care plan and the department under RCW 74.09.522, for health care items or services furnished to an eligible client, if a third party has a legal or contractual liability to make payments, the state acquires the rights of the client to payment from any other party for those health care items or services.

(3) The client shall assign rights of payment to any medical care support the client may have in the client's own behalf or on the behalf of any other client for whom the client can legally assign such rights.

(4) As assignee of the eligible client's right to receive medical support payments, the department may sign coordination of benefit forms or other forms, as necessary, to ensure the efficient and proper payment of medical care support.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 97-04-005, § 388-505-0540, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0540, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-012.]

Chapter 388-506 WAC
MEDICAL FINANCIAL RESPONSIBILITY

WAC

WAC 388-506-0630 SSI-related income deeming. (1) At the client's option, the department shall consider an SSI-related person, living with a spouse or parent who is ineligible for SSI, as a separate MAU. The department shall deem income from a financially responsible spouse or parent to the SSI-related person, who lives in the same household, as follows when determining:

(a) Categorically needy or medically needy eligibility for an SSI-related child. The department shall consider the income of the parents available to the SSI-related child except for:

(i) Income exemptions under WAC 388-511-1140, including the twenty dollar deduction and the sixty-five dollars plus one-half of the balance earned income deduction; and

(ii) A child's allowance for each SSI-ineligible child equal to one-half of the Federal Benefit Rate (FBR) minus any income of that child; and

(iii) A parent's allowance equal to:

(A) One-person FBR for a single parent; or

(B) Two-person FBR for two parents.

(b) Categorically needy Medicaid for an SSI-related spouse. The department shall:

(i) Allow the financially responsible spouse the income exemptions under WAC 388-511-1140 except the:

(A) Twenty dollars deduction; and

(B) Sixty-five dollars plus one-half earned income deduction.

(ii) Deduct from the financially responsible spouse's income, a child's allowance for each SSI ineligible child

equal to one-half of the FBR minus any income of that child;

(iii) Deem from the financially responsible spouse:

(A) Zero income when the financially responsible spouse's income equals or is less than one-half of the FBR after allowing the income deductions in (b)(i) and (ii) of this subsection; or

(B) All the financially responsible spouse's income when the income exceeds one-half of the FBR after allowing the income deductions in (b)(i) and (ii) of this subsection.

(c) Medically needy Medicaid for an SSI-related spouse. The department shall:

(i) Allow the financially responsible spouse the income deductions in (b)(i) and (ii) of this subsection;

(ii) Deem from the financially responsible spouse:

(A) Zero income when the financially responsible spouse's income equals or is less than the one-person medically needy income level (MNIL) after allowing the income deductions in (b)(i) and (ii) of this subsection;

(B) The financially responsible spouse's income above the MNIL after allowing the income deductions in (b)(i) and (ii) of this subsection;

(iii) From the SSI-related spouse's income, allow an amount needed to bring the financially responsible spouse's income up to the MNIL.

(2) The department shall consider a person eligible for Medicaid when the person is ineligible for SSI cash assistance because of income or resources deemed available from an alien sponsor.

[Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-506-0630, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0630, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-027 and 388-99-020.]

Chapter 388-507 WAC
AFDC-RELATED MEDICAL ELIGIBILITY

WAC

388-507-0710 AFDC-related medical income standards.

WAC 388-507-0710 AFDC-related medical income standards. (1) The department shall determine income standards for AFDC-related clients as described under WAC 388-505-0590 (2) and (4).

(2) Effective January 1, 1997, the department shall set the medically needy income level (MNIL) at:

(a) One person	$ 512
(b) Two persons	$ 592
(c) Three persons	$ 667
(d) Four persons	$ 742
(e) Five persons	$ 858
(f) Six persons	$ 975
(g) Seven persons	$1,125
(h) Eight persons	$1,242
(i) Nine persons	$1,358
(j) Ten persons and above	$1,483

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 97-09-112, § 388-507-0710, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-507-0710, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-507-0710, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-507-0710, filed 5/3/94, effective 6/3/94.]

Chapter 388-508 WAC
PREGNANT WOMEN MEDICAL ELIGIBILITY

WAC

388-508-0805 Pregnant woman—Income standards.

WAC 388-508-0805 Pregnant woman—Income standards. (1) The department shall find a pregnant woman eligible for Medicaid as categorically needy when the pregnant woman meets the income requirements of this section.

(2) The department shall ensure total family income will not exceed one hundred eighty-five percent of the Federal Poverty Level (FPL). One hundred eighty-five percent of the current FPL is:

Family Size	Monthly Income
(a) One	$1,217
(b) Two	$1,636
(c) Three	$2,056
(d) Four	$2,475
(e) Five	$2,894
(f) Six	$3,314
(g) Seven	$3,733
(h) Eight	$4,152
(i) Nine	$4,572
(j) Ten	$4,991

(k) For family units with more than ten members, add $420 to the monthly income for each additional member.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-508-0805, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-508-0805, filed 7/10/96, effective 7/10/96; 95-11-045 (Order 3848), § 388-508-0805, filed 5/10/95, effective 6/10/95; 94-10-065 (Order 3732), § 388-508-0805, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-032 (part).]

Chapter 388-509 WAC
CHILDREN'S MEDICAL ELIGIBILITY

WAC

388-509-0920 Children's health program.

388-509-0960 Children's income standards.

WAC 388-509-0920 Children's health program. (1) The department shall consider a child seventeen years of age or younger, eligible for state-funded medical services with the same coverage as categorically needy, when:

(a) The child is not eligible for a federally-funded Medicaid program; and

(b) The child's nonexempt family income does not exceed one hundred percent of the current federal poverty level (FPL). See income guidelines as described under subsection (4) of this section.

(2) The department shall determine nonexempt family income by:

(a) Following AFDC methodology; and

(b) Applying the medical income rules as described under WAC 388-506-0610.

(3) The department shall not require a child to meet the following eligibility factors:

(a) Citizenship;

(b) Social Security number; or

(c) Resources limits.

(4) The department shall find that one hundred percent of the current FPL equals:

Family Size	Monthly Income
(a) One	$658
(b) Two	$885
(c) Three	$1,111
(d) Four	$1,338
(e) Five	$1,565
(f) Six	$1,791
(g) Seven	$2,018
(h) Eight	$2,245
(i) Nine	$2,471
(j) Ten	$2,698

(k) For family units with more than ten members, add $227 to the monthly income for each additional member.

(5) For a child determined eligible under this section, the department shall not consider a change in family income during the certification period.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-509-0920, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-509-0920, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-509-0920, filed 5/11/95, effective 6/11/95; 94-17-036 (Order 3769), § 388-509-0920, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-509-0920, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-033 (part).]

WAC 388-509-0960 Children's income standards. (1) The department shall determine a child meeting the eligibility requirements under WAC 388-509-0910 eligible as categorically needy when the total family countable income does not exceed two hundred percent of the federal poverty level (FPL). The department shall find that two hundred percent of the current FPL equals:

Family Size	Monthly Income
(a) One	$1,315
(b) Two	$1,769
(c) Three	$2,222
(d) Four	$2,675
(e) Five	$3,129
(f) Six	$3,582
(g) Seven	$4,035
(h) Eight	$4,489
(i) Nine	$4,942
(j) Ten	$5,395

(k) For family units with more than ten members, add $454 to the monthly income for each additional member.

(2) For a child determined eligible under WAC 388-509-0910, the department shall not consider a change in family income during the certification period.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-509-0960, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-509-0960, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-509-0960, filed 5/11/95, effective 6/11/95. Statutory Authority: RCW 74.08.090 and Letter from HCFA approving State Plan Transmittal 94-21. 95-05-023 (Order 3833), § 388-509-0960, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-17-036 (Order 3769), § 388-509-0960, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-509-0960, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-033 (part).]

Chapter 388-511 WAC
SSI-RELATED MEDICAL ELIGIBILITY

WAC

WAC 388-511-1105 SSI-related eligibility requirements. (1) For the purposes of SSI-related medical assistance, the client shall be:

(a) Sixty-five years of age or over; or

(b) Blind with:

(i) Central visual acuity of 20/200 or less in the better eye with the use of a correcting lens; or

(ii) A limitation in the fields of vision so the widest diameter of the visual field subtends an angle no greater than twenty degrees; or

(c) Disabled.

(i) Decisions on SSI-related disability are the responsibility of the medical assistance administration (MAA) and shall be subject to the authority of:

(A) Federal statutes and regulations codified at 42 U.S.C. Sec 1382c and 20 C.F.R. Parts 404 and 416, as amended; or

(B) Controlling federal court decisions which define the OASDI and SSI disability standard and determination process.

(ii) For MAA's purposes, "disabled" means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which:

(A) Can be expected to result in death; or

(B) Has lasted or can be expected to last for a continuous period of not less than twelve months.

(iii) In the case of a child seventeen years of age or younger, if the child suffers from any medically determinable physical or mental impairment of comparable severity.

(2) When a person has applied for Title II or Title XVI benefits and the SSA has denied the person's application solely because of a failure to meet Title II and Title XVI blindness or disability criteria, the SSA denial shall be binding on the department, unless the applicant's:

(a) SSA denial is under appeals in the reconsideration stage, the SSA's administrative hearing process, or the SSA's appeals council; or

(b) Medical condition has changed since the SSA denial was issued.

(3) The ineligible spouse, of an SSI beneficiary receiving a state supplement payment for the ineligible spouse, shall not be eligible for Medicaid as noninstitutional categor-

ically needy. Such ineligible spouse may be eligible for noninstitutional medically needy.

(4) The client shall be resource eligible under WAC 388-511-1110 on the first day of the month to be eligible for any day or days of that month. The department shall make a resource determination of the first moment of the first day of the month. The department shall determine changes in the amount of a client's countable resources during a month do not affect eligibility or ineligibility for that month. Refer to WAC 388-513-1395 for an institutionalized client.

(5) The department shall consider a client under 1619(b) of the Social Security Act as eligible for SSI.

(6) The department shall provide a resident of Washington requiring medical assistance outside the United States care according to WAC 388-501-0180.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-036, § 388-511-1105, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605. 95-08-070 (Order 3845), § 388-511-1105, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1105, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-85-115 and 388-92-015.]

WAC 388-511-1130 SSI-related income availability. The department shall:

(1) Consider client checks received in advance of the month the checks are normally received as income in the month of normal receipt;

(2) Consider electronically transferred client funds available as income in the month of normal receipt, regardless of whether the banking institution posted the funds to the client's bank account before or after the month the funds are payable;

(3) Include as countable income the earned or unearned income amounts withheld due to garnishment under a court, administrative or agency order. See WAC 388-513-1380(4) for garnishment affecting an institutionalized client; and

(4) As a condition of eligibility, require a client to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which the client is entitled, unless the client can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veteran's compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.

[Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-511-1130, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-034 (part).]

WAC 388-511-1140 SSI-related income exemptions. (1) The department shall exempt:

(a) Any public agency's refund of taxes paid on real property or on food;

(b) State public assistance and supplemental security income (SSI) based on financial need;

(c) Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, or other necessary educational expense at an educational institution;

(d) Income that a client does not reasonably anticipate, or receives infrequently or irregularly, when such income does not exceed twenty dollars per month if unearned, or ten dollars per month if earned;

(e) Any amount a client receives for the foster care of a child who lives in the same household, if the child is not SSI-eligible and was placed in such home by a public or nonprofit child placement or child care agency;

(f) One-third of any payment for child support a parent receives from an absent parent for a minor child who is not institutionalized;

(g) The first twenty dollars per month of earned or unearned income, not otherwise excluded in subsection (1)(a) through (f) of this section, for a client at home. The department shall consider the exemption only once for a husband and wife. The department shall not apply such exemption on income paid on the basis of an eligible person's needs, which is totally or partially funded by the federal government or a private agency;

(h) Tax exempt payments Alaska natives receive under the Alaska Native Claims Settlement Act;

(i) Tax rebates or special payments exempted under other statutes;

(j) Compensation provided to volunteers in ACTION programs established by P.L. 93-113, the Domestic Volunteer Service Act of 1973;

(k) From the income of a single SSI-related parent or a married SSI-related parent whose spouse does not have income, an amount to meet the needs of an ineligible minor child living in the household of SSI-related parent. See WAC 388-506-0630 when the SSI-related client has a spouse with income. The exemption is one-half of the one-person Federal Benefit Rate (FBR) less any income of the child;

(l) Veteran's benefits designated for the veteran's:

(i) Dependent; or

(ii) Aid and attendance/housebound allowance and unusual medical expense allowance (UME). For an institutionalized client, see WAC 388-513-1345;

(m) COLA increases in Title II Social Security Administration benefits for a noninstitutionalized client:

(i) Received by the client since the client's termination from SSI/SSP; or

(ii) Received by the client's spouse or other financially responsible person living in the household during the time period since the SSI/SSP termination.

(n) A fee a guardian or representative payee charges as reimbursement for providing services, when such services are a requirement for the client to receive payment of the income;

(o) Income an ineligible or nonapplying spouse receives from a governmental agency for services provided to an eligible client such as chore services;

(p) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(q) Restitution payment and any interest earned from such payment to a person of Japanese or Aleut ancestry under P.L. 100-383;

(r) The amount of the expenses directly related to a client's impairment that allows the permanently and totally disabled client to continue to work;

(s) The amount of the blindness-related work expenses of a blind client;

(t) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separately identified burial funds set aside on or after November 1, 1982;

(u) Earned income tax credit (EITC);

(v) Crime victim's compensation funds;

(w) Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims under P.L. 101-201;

(x) Payments to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act. Interest earned on this income is not exempt;

(y) Payments to the injured person, the surviving spouse, children, grandchildren, or grandparents under the Radiation Exposure Compensation Act; and

(z) Payments under section 500 through 506 of the Austrian General Social Insurance Act. The department shall consider the earned interest from such payments as countable income;

(aa) Payments from the Dutch government, under the Netherlands' Act on Benefits for Victims of Persecution (WUV). The department shall consider interest earned on such payments as countable income; and

(bb) Up to two thousand dollars per year derived from an individual interest in Indian trust or restricted land.

(2) Unless income is contributed to the client, the department shall exempt all earned income of an ineligible or nonapplying person twenty years of age and under who is a student regularly attending a school, college, university, or pursuing a vocational or technical training designed to prepare the student for gainful employment.

(3) For the SSI-related client, the department shall exempt the first sixty-five dollars per month of earned income not excluded according to subsection (1) of this section, plus one-half of the remainder.

(4) The department shall exempt as income the unearned income amounts which represent an essential expense incurred in receiving the unearned income.

(5) Effective November 1, 1995, the department shall exempt income which causes the client to lose SSI eligibility due solely to the reduction in state supplement payment (SSP).

(6) The department shall exempt any portion of self-employment income normally allowed as an income deduction by the Internal Revenue Service (IRS).

[Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-511-1140, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and State Plan Amendment Sup. 8a to Article 2.6-A page 6. 96-05-010 (Order 3943, #100295), § 388-511-1140, filed 2/9/96, effective 3/11/96. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605. 95-08-070 (Order 3845), § 388-511-1140, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1140, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-034 and 388-92-036.]

WAC 388-511-1160 SSI-related resource exemptions. (1) The department shall exempt the following resources in determining eligibility for medical care programs:

(a) Home;

(i) "Home" means any shelter:

(A) In which a client has ownership interest; and

(B) The client uses as the principal place of residence. The department shall only consider one home as the client's principal place of residence.

(ii) The client's absence from the home shall not affect the home exemption. The client's home shall remain the principal place of residence as long as:

(A) The client intends to return home. The department shall accept the client's statement of intent without challenge; or

(B) A client's spouse or dependent relative uses the home during the client's absence. The department shall:

(I) Consider a person a dependent relative when such a person is either financially or medically dependent on the client; and

(II) Accept the client's or dependent relative's written statement of dependency or relationship unless the department has reason to question such statement.

(iii) The department shall exempt the proceeds from the sale of the home providing the client uses the proceeds to purchase another home within three months of the receipt of the proceeds. Proceeds include:

(A) Real estate contracts or any similar home financing arrangements; and

(B) The amount of income that does not reflect interest from such a contract.

(iv) The department shall evaluate transfers of the home by an institutional client or client's spouse under WAC 388-513-1365;

(b) Household goods and personal effects;

(c) Vehicle; the department shall:

(i) Exempt one vehicle regardless of its value if, for the client or a member of the client's household, the vehicle is:

(A) Necessary for employment; or

(B) Necessary for the treatment of a specific or regular medical problem; or

(C) Modified for operation by, or transportation of, a handicapped person; or

(D) Necessary due to climate, terrain, distance, or similar factors to provide the client transportation to perform essential daily activities.

(ii) Exempt one of the client's vehicles to the extent its current market value does not exceed four thousand five hundred dollars;

(iii) Count any excess against the resource limit;

(iv) Exempt a vehicle under this subsection only if a vehicle is not exempt under (c)(i) of this subsection;

(v) Treat the client's ownership of other vehicles as nonexempt resources and count the equity value toward the resource limit.

(d) Property essential to self-support. The department shall exempt:

(i) Property regardless of value, when the client uses the property:

(A) In a trade or business;

(B) As an employee for work; or

(C) As authorized by the government for income-producing activity.

(ii) Nonbusiness property up to six thousand dollars equity, when the client uses the property for producing goods

or services essential to daily activities, solely for the client's household;

(iii) Nonbusiness property up to six thousand dollars equity, when the client uses the property to produce an annual income return of six percent or more of the exempt equity or is expected to produce at least a six percent return within a twenty-month period as long as the client:

(A) Currently uses the property in the activities described in subsection (1)(d) of this section; or

(B) Is expected to resume using the property in the activities described in subsection (1)(d) of this section within twelve months;

(e) Resources necessary to fulfill an approved plan for a blind or disabled client to achieve self-support as long as such plan remains in effect;

(f) Alaska Native Claims Settlement Act:

(i) Shares of stock held in a regional or village corporation;

(ii) Cash received from a native corporation, including cash dividends on stock received from a native corporation to the extent the cash does not exceed two thousand dollars per person per year;

(iii) Stock issued or distributed by a native corporation as a dividend or distribution on the stock;

(iv) A partnership interest;

(v) Land or an interest in land, including land or an interest in land received from a native corporation, as a dividend or distribution on stock;

(vi) An interest in a settlement trust.

(g) Life insurance:

(i) The department shall exempt the total cash surrender value when the total face value of all policies held by each person is one thousand five hundred dollars or less;

(ii) The cash surrender value applies to the resource limit under WAC 388-511-1110 if the face value of all policies held by each person is over one thousand five hundred dollars; and

(iii) When determining total face value in subsection (1)(g)(i) of this section, the department shall not include term or burial insurance with no cash surrender value.

(h) Restricted allotted land owned by an enrolled tribal member and spouse, if married, if such land cannot be sold, transferred, or otherwise disposed of without the permission of other persons, the tribe, or an agency of the federal government;

(i) A settlement the client receives for the purpose of repairing or replacing a specific exempt resource for a period of:

(i) Nine months when the client uses the total amount of the cash to repair or replace the exempt resource;

(ii) Nine additional months when:

(A) Circumstances beyond the control of the client prevent the repair or replacement of the exempt resource; and

(B) The client uses the total amount of the cash to repair or replace the exempt resource; and

(iii) Twelve additional months, for a maximum of thirty months, when:

(A) The settlement is a result of a catastrophe which is declared a major disaster by the President of the United States;

(B) The exempt resource is geographically within the disaster area as defined by the presidential order;

(C) The client intends to repair or replace the exempt resource; and

(D) Circumstances beyond the control of the client prevented the repair or replacement of the exempt resource in the time frames described under subsection (1)(i)(i) and (ii) of this section.

(iv) The department shall consider any settlement excluded and not used within the allowable time period as described under subsection (1)(i) of this section as an available resource.

(j) Burial spaces for the client, the client's spouse, or any member of the client's immediate family.

(i) The department shall consider burial spaces includes conventional grave sites, crypts, mausoleums, urns, and other repositories customarily and traditionally used for the remains of deceased persons.

(ii) The department shall consider burial spaces as including a burial space purchase agreement as well as any interest accrued on and left to accumulate as part of the value of the burial space purchase agreement.

(iii) For purposes of subsection (1)(j) and (k) of this section, "immediate family" means a client's minor and adult children, including adopted children and stepchildren; a client's brothers, sisters, parents, adoptive parents, and the spouses of those persons. The department shall not consider dependency or living-in-the-same-household as factors in determining whether a person is an immediate family member;

(k) Burial funds:

(i) The department shall ensure funds specifically set aside for the burial arrangements of a client or the client's spouse not exceed one thousand five hundred dollars for each spouse. The department shall count burial funds in excess of this limit toward the resource limit in WAC 388-511-1110.

(ii) The department shall require funds set aside for burial expenses to be kept separate from all other resources and separately identified and designated as set aside for burial. If the exempt burial funds are mixed with other resources, the department shall not apply this exemption to any portion of the funds unless the client intends to use the nonexempt funds for burial-related items or services. The department may exempt designated burial funds retroactively back to the first day of the month in which the person intended the funds to be set aside for burial.

(iii) Funds set aside for burial include revocable burial contracts, burial trusts, other burial arrangements, cash, accounts, or other financial instruments with a definite cash value the person clearly designates as set aside solely for the person's or spouse's burial expenses.

(iv) The department shall reduce the one thousand five hundred dollar exemption by:

(A) The face value of the client's insurance policies owned by the person or spouse on the life of the person if the policies have been exempted as provided in subsection (1)(g) of this section; and

(B) Amounts in an irrevocable burial trust.

(v) The department shall exempt the interest earned on exempt burial funds and appreciation in the value of exempt

burial arrangements if the exempt interest and appreciation are left to accumulate and become part of the separately identified burial fund.

(vi) When used for other purposes, the department shall consider as available income any exempt burial funds, interest, or appreciated values set aside for burial expenses if, at the first of the month of use, when added to other nonexempt resources, the total exceeds the resource limit;

(l) Other resources considered exempt by federal statute;

(m) Retroactive SSI payments, including benefits a client receives under the interim assistance reimbursement agreement with the Social Security Administration, or OASDI payments for six months following the month of receipt. This exemption applies to:

(i) Payments received by the client, spouse, or any other person received that the department considers available to meet the client's needs;

(ii) SSI payments made to the client for benefits due for a month before the month of payment;

(iii) OASDI payments made to the client for benefits due for a month that is two or more months before the month of payment; and

(iv) Payments that remain in the form of cash, checking accounts, or saving accounts. The department shall not apply this exemption once the retroactive payment has been converted to any other form.

(n) Payments for medical or social services, for one-calendar month following the month of receipt, certain cash payments an SSI person receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(o) Restitution payment and any interest earned from such payment to persons of Japanese or Aleut ancestry relocated and interned during war time, under P.L. 100-383;

(p) The annuity payment of trust funds to Puyallup Tribal Indians received under P.L. 101-41;

(q) Funds received from the Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims under P.L. 101-201;

(r) Payments from the Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV). See WAC 388-511-1140 (1)(aa) for the treatment of interest earned on such payment.

(s) Payments to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act. Interest earned on conserved payment is not exempt;

(t) Unspent assistance payments the client receives because of a presidential declaration of a major disaster, under P.L. 93-288, are exempt for nine months from the date of receipt.

(i) The department shall determine the exemption may extend an additional nine months, if circumstances beyond the client's control:

(A) Prevents the client from repairing or replacing the damaged or destroyed property; or

(B) Keeps the client from contracting for such repair or replacement.

(ii) Interest earned on the exempt resource is exempt for the period the exemption applies;

(u) Earned income tax credit refunds and payments are exempt during the month of receipt and the following month;

(v) Payments from a state administered victim's compensation program for a period of nine calendar months after the month of receipt;

(w) Payments, or interest accrued on payments received under the Radiation Exposure Compensation Act received by the injured person, the surviving spouse, children, grandchildren, or grandparents;

(x) Payments under section 500 through 506 of the Austrian General Social Insurance Act. The department shall:

(i) Not consider such payments as income or resources for determining eligibility or post-eligibility; and

(ii) Count the interest from such payments as unearned income for the client.

(2) The department shall consider a sales contract:

(a) An exempt resource when the current market value of the contract:

(i) Is zero or the contract is unsalable; or

(ii) When combined with other resources, exceeds the resource limit, and the sales contract was executed:

(A) On or before November 30, 1993; or

(B) On or after December 1, 1993, and:

(I) Was received as compensation for the sale of the client's principal place of residence. For an institutionalized client, this rule shall apply only to the client's principal place of residence before institutionalization of the client; and

(II) Provides for an interest rate within prevailing rates at the time of the sale; and

(III) Requires the repayment of a principal amount equal to the fair market value of the property; and

(IV) Payment on the amount owed does not exceed thirty years.

(iii) The department shall consider payment of principal and interest on a sales contract meeting the criteria of subsection (2)(a)(i) or (ii) of this section under WAC 388-505-0590 (4)(b);

(b) An available resource when the current market value of a sales contract does not meet the requirements in subsection (2)(a)(i) or (ii) of this section. For a sales contract the department determines to be an available resource, the department shall consider the payment that represents:

(i) Principal, an available resource; and

(ii) Interest, under WAC 388-505-0590 (4)(c).

(c) An available resource when transferred by the client to a person other than the client's spouse. See WAC 388-513-1365; and

(d) An exempt resource to the extent the proceeds from the sale of a home are used to purchase another home. The department shall not consider payments received under such sales contract as income as described under subsection (1)(a)(iii) of this section.

(3) The department shall consider cash received from the sale of an exempt resource as a nonexempt resource to the extent that the cash is not:

(a) Used to replace an exempt resource; or

(b) Invested in an exempt resource within the same month, unless specified differently under this section.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-034, § 388-511-1160, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605. 95-08-070 (Order 3845), § 388-511-1160,

filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-045.]

Chapter 388-513 WAC
CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC

WAC 388-513-1320 Institutional status. (1) The department shall find that a person has achieved institutional status when the person is residing or expected to reside in a Medicaid-certified medical facility for a period of at least:

(a) Ninety consecutive days for an AFDC-related child seventeen years of age or younger in residential mental health or chemical dependency/substance abuse treatment; or

(b) Thirty consecutive days for an SSI-related person and AFDC-related persons other than as described under subsection (1)(a) of this section.

(2) The department shall consider a person receiving waivered program services or hospice services to have achieved institutional status.

(3) The department shall make medical assistance available to an otherwise eligible person who has achieved institutional status as described under subsection (1) or (2) of this section.

(4) The department shall not deny Medicaid eligibility to a person in a nursing facility:

(a) On the grounds that the person did not establish residence in this state before entering the nursing facility; and

(b) When the person meets residency requirements described under chapter 388-505 WAC at the time the person applies for medical assistance.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2). 97-15-025, § 388-513-1320, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090. 96-11-072 (Order 3980), § 388-513-1320, filed 5/10/96, effective 6/10/96; 94-10-065 (Order 3732), § 388-513-1320, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1330 Institutional—Available income. (1) Income is defined under chapter 388-511 WAC for a SSI-related client and under WAC 388-22-030 for an AFDC-related client.

(2) The methodology and standards for determining and evaluating income are defined under chapter 388-513 WAC.

(3) The department shall consider the following income available to an institutionalized person when determining income eligibility unless the criteria in subsection (4) of this section is met:

(a) Income the institutionalized spouse receives in the institutionalized spouse's name;

(b) Income paid on the behalf of the institutionalized spouse, but received in the name of the institutionalized spouse's representative;

(c) One-half of the income the community and institutionalized spouses receive in both names; and

(d) Income from a trust as provided by the trust.

(4) The department shall consider income as available to an institutionalized person when:

(a) Both spouses are institutionalized; or

(b) An institutionalized person has a community spouse and income in excess of three hundred percent of the SSI federal benefit rate (FBR). For the determination of eligibility only:

(i) Use community property law in determining ownership of income for purposes of Medicaid eligibility;

(ii) Presume all income received after marriage by husband or wife to be community income;

(iii) Divide the total of the community income, by two assigning one-half of the total to each person; and

(iv) Consider if the community income received in the name of the nonapplying spouse exceeds the community income received in the name of the applying spouse, the applicant's interest in that excess shall be unavailable to the applicant.

(5) The department shall consider income the community spouse receives in the community spouse's name as unavailable to the institutionalized spouse.

(6) The department shall consider an agreement between spouses transferring or assigning rights to future income from one spouse to the other spouse, or to a trust for the benefit of the other spouse, to the extent the income is not derived from a resource which has been transferred, as invalid in determining eligibility for medical assistance or the limited casualty program for the medically needy.

(7) The department shall consider any agreement or trust transferring or assigning rights to future income, to the extent the income is not derived from a resource which has been transferred, as invalid in determining eligibility for medical assistance or the limited casualty program for the medically needy.

(8) The department shall consider income produced by transferred or assigned resources as the separate income of the transferee.

(9) When an institutionalized spouse establishes the unavailability of income by a preponderance of evidence through a fair hearing, subsection (3) of this section shall not apply.

(10) See WAC 388-511-1130 for treatment of advance dated checks, and electronically transferred funds.

[Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-513-1330, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1330, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1330, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-335 and 388-95-340.]

WAC 388-513-1350 Institutional—Available resources. (1) Resources are defined under chapter 388-511 WAC for an SSI-related client and under WAC 388-22-030 for an AFDC-related client.

(2) The methodology and standards for determining and evaluating resources are under WAC 388-513-1310, 388-513-1330, 388-513-1340, and 388-513-1360. Transfers of resources are evaluated under WAC 388-513-1365.

(3) The department shall determine ownership of resources following Washington state community property principles for a person:

(a) Whose most recent period of institutionalization began on or before September 30, 1989; and

(b) Who remains continuously institutionalized.

(4) For purposes of Medicaid eligibility, the department shall consider resources are:

(a) Community resources when jointly held in the:

(i) Names of both the institutionalized and community spouse; or

(ii) Name of the institutionalized spouse only.

(b) The separate property of the community spouse when:

(i) Held in the separate name of the community spouse; or

(ii) Transferred between spouses as described under WAC 388-513-1350(7).

(5) The department shall:

(a) Divide by two, the total value of the community resources the spouses own; and

(b) Assign one-half of the total value of the community resources to each spouse.

(6) The department shall not consider a person continuously institutionalized if, for thirty consecutive days, the person:

(a) Is absent from an institution; or

(b) Does not receive home-based or community-based waivered services.

(7) For the purpose of determining Medicaid eligibility of a person, hose most recent continuous period of institutionalization starts on or after October 1, 1989, the department shall:

(a) Exclude resources as described under WAC 388-511-1160; except, the department shall exempt one vehicle without regard to use or value when the institutionalized person has a community spouse;

(b) Consider available to the community spouse, resources in the name of either the community spouse or the institutionalized spouse, except resources exceeding the greater of:

(i) Seventy-nine thousand twenty dollars effective January 1, 1997;

(ii) An amount established by a fair hearing under chapter 388-08 WAC when the community spouse's resource allowance is inadequate to provide a minimum monthly maintenance needs allowance; or

(iii) An amount ordered transferred to the community spouse by the court.

(c) Ensure resources available to the community spouse are in the name of the community spouse or transferred to the community spouse or to another person for the sole benefit of the community spouse:

(i) Before the first regularly scheduled eligibility review; or

(ii) As soon as practicable thereafter, taking into account such time as may be necessary to obtain a court order for the support of the community spouse.

(d) Consider resources greater than such resources described under subsection (7)(b) of this section available to the institutional spouse.

(8) The department shall consider resources of the community spouse:

(a) Unavailable to the institutionalized spouse:

(i) The month after the institutionalized spouse is determined eligible for institutional benefits; and

(ii) While the institutionalized spouse remains in a continuous period of institutionalization.

(b) Available to the institutionalized spouse when the institutionalized spouse:

(i) Acquires resources which, when added to resources held by the institutionalized spouse, exceed the one-person resource maximum, if the most recent period of institutionalization began on or after October 1, 1989; or

(ii) Has a break of thirty days or more in a period of institutionalization.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

WAC 388-513-1365 Transfer of assets. (1) The terms in this section shall have the following definitions:

(a) **"Assets"** means all income and resources of a client and the client's spouse, including such income or resources the person is entitled to but does not receive because of action by:

(i) The client or the client's spouse;

(ii) A person, court or administrative body, with legal authority to act in place of or on behalf of the client or the client's spouse; or

(iii) A person, court or administrative body, acting at the direction or upon the request of the client or the client's spouse.

(b) **"Community spouse"** means the person married to an institutionalized client.

(c) **"Fair market value (FMV)"** means the price the asset may reasonably sell for on the open market at the time of transfer or assignment. A transfer of assets for love and affection is not considered a transfer for FMV.

(d) **"Institutional services"** means a level of care provided in a nursing facility, equivalent nursing facility in a medical institution, or in a home-based or community-based program under WAC 388-515-1505 or 388-515-1510.

(e) **"Institutional spouse"** means a client who meets the requirements of subsection (1)(f) of this section and is married to a spouse who is not:

(i) In a medical institution;

(ii) In a nursing facility; or

(iii) Receiving home-based or community-based services under WAC 388-515-1505 or 388-515-1510.

(f) **"Institutionalized client"** means a person who is:

(i) An inpatient in a nursing facility;

(ii) An inpatient in a medical institution where the payment is made for a level of care provided in a nursing facility; or

(iii) In need of the level of care provided in a nursing facility or medical institution, but receiving home-based or

community-based services under WAC 388-515-1505 or 388-515-1510; and

(iv) Expected to be in a nursing facility, in a medical institution, or receiving home-based or community-based services under WAC 388-515-1505 or 388-515-1510 for thirty consecutive days or more.

(g) **"Transfer"** means any act or omission to act, by a client or a nonapplying joint tenant, whereby title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person, including but not limited to:

(i) Delivery of personal property;

(ii) Bills of sale, deeds, mortgages, and pledges; or

(iii) Any other instrument conveying or relinquishing an interest in property.

(h) **"Uncompensated value"** means the FMV of an asset at the time of transfer minus the value of compensation the person receives in exchange for the resource.

(i) **"Undue hardship"** means the client's inability to meet shelter, food, clothing, and health needs.

(j) **"Value of compensation received"** means the consideration the purchaser pays or agrees to pay. Compensation includes:

(i) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable agreement whereby the eligible client shall transfer the resource; and

(ii) The payment or assumption of a legal debt the client owes in exchange for the resource.

(2) The department shall not impose any penalty for the transfer of any exempt asset for less than FMV except as specified under subsection (11) of this section when the client transfers the client's home.

(3) The department shall determine whether the client or the client's spouse transferred an asset within a look-back period of the following duration:

(a) Thirty months when determining eligibility for services received:

(i) On or before September 30, 1993; or

(ii) On or after October 1, 1993, with respect to transfers of assets on or before August 10, 1993;

(b) Thirty-six months when determining eligibility for services on or after October 1, 1993, with respect to transfers of assets on or after August 11, 1993; or

(c) Sixty months when determining eligibility for services received on or after October 1, 1993, and all or part of the transferred assets are placed in a trust established on or after August 11, 1993, and all or part of the assets are deemed transferred as described under WAC 388-505-0595.

(4) The department shall consider the look-back period as the number of months described under subsection (3) of this section but not including any month before August, 1993 in the case of subsections (3)(b) and (3)(c) of this section, before the first day of the month the client:

(a) Becomes an institutionalized person, if the client is eligible for medical assistance on that date; or

(b) Applies for institutional care when the client is not eligible for medical assistance as of the date the client initially became institutionalized.

(5) The department shall calculate a period of ineligibility for nursing facility services, equivalent nursing facility services in a medical institution, and services described under WAC 388-515-1505 and 388-515-1510, for the institutionalized client when the client or the client's spouse transfers an asset for less than FMV during or after the look-back periods as described under subsections (3) and (4) of this section.

(6) When the client or the client's spouse has transferred assets, the department shall establish a period of ineligibility:

(a) Under subsection (7) of this section for assets transferred on or before August 10, 1993;

(b) Under subsection (8) of this section for assets transferred on or after August 11, 1993 and on or before February 28, 1997; and

(c) Under subsection (9) of this section for assets transferred on or after March 1, 1997.

(7) With respect to transfers of assets on or before August 10, 1993, and in any month within the applicable look-back period, the department shall establish a period of ineligibility which:

(a) Begins the first day of the month in which the assets were transferred;

(b) Is the lessor of:

(i) Thirty months; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets transferred in the month by the state-wide average monthly cost of nursing facility services to a private patient at the time of the application; and

(c) Runs concurrently when transfers of assets have been made in multiple months during the look-back period.

(8) With respect to transfers of assets on or after August 11, 1993 and on or before February 28, 1997, and in any month within the applicable look-back period occurring on or after August 11, 1993, the department shall establish a period of ineligibility as follows:

(a) For such transfers during the look-back period:

(i) The period of ineligibility shall begin on the first day of the month in which such assets were transferred; and

(ii) Equal the number of whole months found by dividing the total, cumulative uncompensated value of all such assets transferred during the look-back period by the state-wide average monthly cost of nursing facility services to a private patient at the time of application.

(b) For such transfers of assets made while receiving medical assistance as an institutionalized client, or for such transfers made during a period of ineligibility established under this section:

(i) The period of ineligibility shall begin on the first day of the month in which such assets were transferred, or after the expiration of all other periods of ineligibility established under this section, whichever is later; and

(ii) Equal the number of whole months found by dividing the total, uncompensated value of such transferred assets by the state-wide average monthly cost of nursing facility services to a private patient at the time of application.

(9) With respect to transfers of assets on or after March 1, 1997 and in any month within the applicable look-back period occurring on or after August 11, 1993, the department shall:

(a) For a single transfer or multiple transfers within a single month during the look-back period:

(i) Add the value of all transferred assets;

(ii) Divide the total value of all transferred assets by the statewide average monthly cost of nursing facility services to a private patient at the time of application; and

(iii) Establish a period of ineligibility:

(A) Equal to the number of whole months as established under subsection (9)(a)(i) and (ii) of this section; and

(B) Which begins on the first day of the month of transfer.

(b) For multiple transfers during multiple months during the look-back period:

(i) Treat assets transferred in each month as a separate event with its own period of ineligibility;

(ii) Divide the total value of assets transferred in a month by the statewide average monthly cost of nursing facility services to a private patient at the time of application; and

(iii) Establish multiple periods of ineligibility:

(A) Equal to the number of whole months as established under subsection (9)(b)(i) and (ii) of this section; and

(B) Which begin the latter of:

(I) The first day of the month of each transfer; or

(II) The first day of the month following the expiration of a previously computed period of ineligibility.

(10) The department shall not consider gifts or donations totaling one thousand dollars or under in any month as transfers of assets under subsections (7), (8), or (9) of this section.

(11) The department shall not find the institutionalized client ineligible for institutionalized services when the transferred asset was a home and the home was transferred to the client's:

(a) Spouse; or

(b) Child who is:

(i) Blind, or permanently and totally disabled; or

(ii) Twenty years of age or under.

(c) Sibling who has:

(i) Equity in the home; and

(ii) Lived in the home for at least one year immediately before the client became institutionalized.

(d) Child, other than described under subsection (11)(b) of this section who:

(i) Lived in the home for two years or more immediately before the client became institutionalized; and

(ii) Provided care to the client to permit the client to remain at home.

(12) The department shall not find the institutionalized client ineligible for institutionalized services if the asset other than the home was transferred:

(a) To the client's spouse or to another person for the sole benefit of the client's spouse;

(b) From the client's spouse to another person for the sole benefit of the client's spouse;

(c) To the client's blind or permanently and totally disabled child, or to a trust established solely for the benefit of such child; or

(d) To a trust established solely for the benefit of a person sixty-four years of age or younger who is disabled according to SSI criteria.

(13) The department shall only consider a transfer of assets or trust established under subsection (12) of this section for the sole benefit of the named person when:

(a) The transfer or trust document provides for the expenditure of funds for the benefit of the person; and

(b) Such expenditures must be on a basis that is actuarially sound, based on the life expectancy of the person.

(14) The department shall consider a transfer of asset or trust established under subsection (12) of this section which does not meet the criteria found under subsection (13) of this section under subsection (7), (8), or (9) of this section.

(15) The department shall not find a person ineligible under this section when the client can satisfactorily show the department that:

(a) The client intended to transfer the asset at FMV or other valuable consideration;

(b) The client transferred the asset exclusively for a purpose other than to qualify for medical assistance;

(c) All assets transferred by the client for less than FMV have been returned to the client; or

(d) The client's denial of eligibility would cause an undue hardship.

(16) The department shall not impose a period of ineligibility on a client unless the client is subject to a period of ineligibility, as calculated under this section, with respect to any month for which eligibility for institutional services is sought.

(17) A client or the spouse of such a client, the department determines ineligible under this section, may request a hearing to appeal the determination of ineligibility. The procedure for the hearing is described under chapter 388-08 WAC.

(18) The department shall:

(a) Exempt cash received from the sale, transfer, or exchange of an asset to the extent that the cash is used for an exempt asset within the same month, except as specified under WAC 388-511-1160; and

(b) Consider any cash remaining as an available asset.

(19) When the transfer of an asset has resulted in a period of ineligibility for one spouse, the department shall not impose a period of ineligibility for the other spouse for the transfer of the same asset.

(20) The department shall disregard the transfer of assets to a family member when:

(a) The family member has received the assets for providing care to the client which keeps the client out of a nursing facility;

(b) The client and the family member initiated a written agreement at the time the care began; and

(c) The written agreement states:

(i) The fair market value of the care; and

(ii) That the care is to be paid from the assets of the client.

(21) When the fair market value of the care described under subsection (20) of this section is less than the value of the transferred asset, the department shall consider the difference as the transfer of an asset without adequate consideration.

(22) The department shall consider the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (20) of

this section as a transfer of an asset without adequate consideration.

(23) When the transfer of an asset includes the right to receive a stream of income received on a regular basis which has been transferred to a spouse, to the extent the income is not derived from a transferred resource, the department shall consider such a transfer under WAC 388-513-1330(6).

(24) When the transfer of an asset includes the right to receive a stream of income received on a regular basis which has been transferred to a person other than a spouse, to the extent the income is not derived from a transferred resource, the department shall:

(a) Add the total amount of income expected to be transferred during the person's lifetime, based on an actuarial projection of the person's life expectancy to the extent the income is not derived from a transferred resource; and

(b) Divide the total value of the transferred income by the statewide average monthly cost of nursing facility services to a private patient at the time of application; and

(c) Establish a period of ineligibility:

(i) Equal to the number of whole months as established under subsection (24)(a) and (b) of this section; and

(ii) Which begins the latter of:

(A) The first day of the month the person transferred the income stream; or

(B) The first day of the month following the expiration of a previously computed period of ineligibility.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.585 and § 17 of the Social Security Act. 97-05-040, § 388-513-1365, filed 2/14/97, effective 3/17/97. Statutory Authority: RCW 74.08.090. 95-02-027 (Order 3818), § 388-513-1365, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-513-1365, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-395.]

WAC 388-513-1380 Institutional—Participation. (1) In reducing payment to the institution, the department shall consider the institutionalized client's:

(a) Income under WAC 388-513-1330 (3)(a), (b), (c), and (d); and

(b) Resources under WAC 388-513-1350, 388-513-1360, and 388-513-1365.

(2) In reducing payment to the institution, the department shall consider the eligible institutionalized client's excess resources available to meet the cost of care after the following allocations:

(a) Health insurance and Medicare premiums, deductions, and co-insurance not paid by a third party; and

(b) Noncovered medical bills which are the liability of the client and not paid by a third party.

(3) The department shall not use allocations used to reduce excess resources under subsection (2) of this section to reduce income under subsection (4) of this section.

(4) The department shall deduct the following amounts, in the following order, from the institutionalized client's total income, including amounts disregarded in determining eligibility:

(a) Specified personal needs allowance as follows:

(i) One hundred sixty dollars for a veteran living in a Medicaid-certified state veteran's home nursing facility;

(ii) Ninety dollars for a single veteran receiving an improved veteran's pension; or

(iii) Forty-one dollars and sixty-two cents for all other clients in medical institutions.

(b) Federal, state, or local income taxes:

(i) Mandatorily withheld from earned or unearned income for income tax purposes before receipt by the client;

(ii) Not covered by withholding, but are owed or have been paid by the client; and

(iii) Does not exceed the one-person medically needy income level less the client's personal needs allowance.

(c) Wages not to exceed the one-person medically needy income level (MNIL) less the client's personal needs allowance for a client who:

(i) Is SSI-related; and

(ii) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction, the department shall:

(A) Not allow a deduction for employment expenses; and

(B) Apply the client's wages not deducted under this subsection to the client's cost of care.

(d) The total amounts deducted under subsection (4)(a), (b), and (c) of this section shall not exceed the one-person MNIL.

(e) A monthly needs allowance for the community spouse not to exceed, effective January 1, 1997, one thousand nine hundred seventy-six dollars, unless specified in subsection (6) of this section. The department shall ensure the monthly needs allowance is:

(i) An amount added to the community spouse's gross income to provide a total community spouse's income of one thousand three hundred twenty-seven dollars;

(ii) Excess shelter expenses as specified under subsection (5) of this section; and

(iii) Allowed only to the extent income of the institutionalized spouse is made available to the community spouse.

(f) An amount for the maintenance needs of each dependent family member residing with the community spouse:

(i) Equal to one-third of the amount one thousand three hundred twenty-seven dollars exceeds the family member's income. Child support received from an absent parent is the child's income.

(ii) **"Family member"** means a:

(A) Dependent or minor child;

(B) Dependent parent; or

(C) Dependent sibling of the institutionalized or community spouse.

(g) When an institutional client does not have a community spouse, an amount for the maintenance needs of family members residing in the client's home equal to the medically needy income level for the number of legal dependents in the home less the income of the dependents.

(h) Amounts for incurred medical expenses not subject to third-party payment which are the current liability of the client including, but not limited to:

(i) Health insurance premiums, coinsurance, or deductible charges; and

(ii) Necessary medical care recognized under state law, but not covered under Medicaid.

(i) Maintenance of the home of a single person or couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period; and

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social service staff documents initial need for the income exemption and reviews the person's circumstances after ninety days.

(5) For the purposes of this section, the department shall:

(a) Determine shelter expenses to be the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard allowance for utilities, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(b) Consider the standard shelter allocation to be three hundred ninety-nine dollars, effective April 1, 1997.

(c) Consider as "excess shelter expenses" an amount equal to the actual expenses under subsection (5)(a) of this section less the standard shelter allocation under subsection (5)(b) of this section.

(6) The department shall determine the amount the institutional spouse allocates to the community spouse may only be greater than the amount in subsection (4)(e)(i) of this section when:

(a) A court enters an order against the institutionalized client for the community spouse support; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(7) The client shall use the income remaining after allocations specified in subsection (4) of this section toward payment of the client's cost of care at the department rate.

(8) SSI-related clients.

(a) SSI-related clients shall continue to receive total payment under 1611 (b)(1) of the Social Security Act for the first three full calendar months of institutionalization in a public or Medicaid-approved medical institution or facility when the:

(i) Stay in the institution or facility is not expected to exceed three months; and

(ii) SSI-related clients plan to return to former living arrangements.

(b) The department shall not consider the SSI payment when computing the client's participation amount.

(9) The department shall not consider income from reparation payments made by the Federal Republic of Germany when computing the client's participation amount.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-513-1380, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1380, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 95-11-045 (Order 3848), § 388-513-1380, filed 5/10/95, effective 6/10/95. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

Chapter 388-517 WAC
MEDICARE-RELATED MEDICAL ELIGIBILITY

WAC

WAC 388-517-1720 Qualified Medicare beneficiaries—Income and resources. (1) The department shall provide Medicare cost sharing for a qualified medical beneficiary (QMB) client having:

(a) A total countable income, as determined under chapter 388-511 WAC, except as specified in subsection (2) of this section, not exceeding one hundred percent of the current federal poverty level (FPL). One hundred percent of the current FPL is:

Family Size	Monthly
(i) One	$658
(ii) Two	$885

(b) Resources, as determined under WAC 388-511-1110, not exceeding twice the maximum supplemental security income (SSI) resource limits.

(2) The department shall not consider a person's Social Security cost-of-living increase until April 1 of each year.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-517-1720, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1720, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1720, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).]

WAC 388-517-1740 Special low-income Medicare beneficiaries (SLMB)—Income and resources. (1) The department shall provide Medicare cost sharing for a SLMB client having:

(a) A total countable income, as determined under chapter 388-511 WAC, over one hundred percent of the current federal poverty level (FPL), but not exceeding one hundred twenty percent of the FPL. One hundred twenty percent of the current FPL is:

Family Size	Monthly
(i) One	$789
(ii) Two	$1,061

(b) Resources, as determined under WAC 388-511-1110, not exceeding twice the maximum supplemental security income (SSI) resource limits.

(2) The department shall not consider a person's Social Security cost-of-living increase until April 1 of each year.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-517-1740, filed 7/24/97,

effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1740, filed 7/10/96, effective 7/10/96; 95-23-030 (Order 3917, #100251), § 388-517-1740, filed 11/8/95, effective 12/9/95; 95-11-056 (Order 3848A), § 388-517-1740, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1740, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).]

WAC 388-517-1760 Qualified disabled working individuals (QDWI) income and resources. The department shall pay premiums for Medicare Part A for a person having:

(1) A total countable family income, as determined under chapter 388-511 WAC, not exceeding two hundred percent of the current FPL. Two hundred percent of the current FPL is:

Family Size	Monthly
(a) One	$1,315
(b) Two	$1,769

(2) Resources, as determined under WAC 388-511-1110, not exceeding twice the maximum supplemental security income (SSI) resource limits.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-517-1760, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1760, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1760, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1760, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).]

Chapter 388-522 WAC
MEDICAL ELIGIBILITY CHANGES

WAC

388-522-2205 Redetermination of medical assistance.

WAC 388-522-2205 Redetermination of medical assistance. (1) Before termination of a client's medical assistance, the department shall redetermine the client's eligibility for other medical assistance programs or the medically indigent program.

(a) When additional information is necessary to redetermine eligibility, the department shall give the client ten days notice and an opportunity to provide such information.

(b) The department shall give the client advance and adequate notice of the redetermination decision before termination of medical assistance as described under WAC 388-245-1700.

(c) The client shall remain eligible for categorically needy medical benefits until the department redetermines a client's eligibility according to the requirements of this section.

(2) When SSA terminates the client's SSI/SSP financial benefits, refer to WAC 388-524-2405.

[Statutory Authority: RCW 74.08.090, 74.09.530, 42 CFR 435 and 42 U.S.C. 1302. 97-15-084, § 388-522-2205, filed 7/17/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-522-2205, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-85-105 and 388-85-110.]

Chapter 388-524 WAC
MEDICAL TERMINATIONS

WAC

388-524-2405 SSI/state supplement termination.

WAC 388-524-2405 SSI/state supplement termination. (1) The department shall provide uninterrupted medical assistance for a period of up to one hundred twenty days:

(a) For a person whose SSI/state supplemental is terminated; and

(b) While the department redetermines the person's eligibility for other financial or medical programs.

(2) The department shall continue medical assistance for a person:

(a) Who has filed a timely request for a hearing under SSA jurisdiction; and

(b) Until SSA makes a final decision on the hearing request and any subsequent timely appeals.

(3) The department shall only submit a request for a redetermination of blindness or disability if:

(a) The person presents new medical evidence;

(b) The person's medical condition changes significantly; or

(c) The termination of SSI/state supplement or Social Security Disability Insurance was not based on a review of current medical evidence.

[Statutory Authority: RCW 74.08.090, 74.09.530, 42 CFR 435 and 42 U.S.C. 1302. 97-15-084, § 388-524-2405, filed 7/17/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-524-2405, filed 5/3/94, effective 6/3/94. Formerly WAC 388-85-110 (part).]

Chapter 388-528 WAC
RECEIPT OF RESOURCES WITHOUT GIVING ADEQUATE CONSIDERATION

WAC

388-528-2810 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-528-2810 Receipt of resources—Penalties. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-528-2810, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-052.] Repealed by 97-03-037, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090 and 43.20B.710.

WAC 388-528-2810 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-538 WAC
MANAGED CARE

WAC

388-538-110 Client grievances.

WAC 388-538-110 Client grievances. (1) A client aggrieved by a decision of a managed care contractor or the

department shall have the right to a fair hearing as required under WAC 388-81-040.

(2) A client enrolled in a plan:

(a) Shall exhaust a plan's grievance procedure before requesting a fair hearing, except as provided in subsection (3) of this section;

(b) Shall receive a written decision containing the following information:

(i) Action the plan intends to take;

(ii) Reasons for the intended action;

(iii) The specific information supporting the action;

(iv) Client's right to request a fair hearing;

(v) Full translation into the primary language of the limited English proficient recipient.

(c) May request a fair hearing when a:

(i) Grievance decision is adverse;

(ii) Plan does not respond in writing within thirty days from the date the client requests the grievance.

(3) The client may request a fair hearing at the same time a grievance is filed when:

(a) The plan denies medical care that a client indicates is urgently needed and the client requests a grievance in writing; or

(b) The subject matter of the grievance is one for which a client has a fair hearing right under chapters 34.05 RCW, 388-08 WAC, or this chapter.

(4) The managed care contractor shall advise a client of the client's right to request a fair hearing at the time the contractor notifies the client of the grievance decision.

[Statutory Authority: RCW 74.08.090. 97-04-004, § 388-538-110, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-110, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 94-04-038 (Order 3701), § 388-538-110, filed 1/26/94, effective 2/26/94; 93-17-039 (Order 3621), § 388-538-110, filed 8/11/93, effective 9/11/93.]

Chapter 388-550 WAC
HOSPITAL SERVICES

WAC

WAC 388-550-1000 Applicability. The department shall pay for hospital services provided to eligible clients when:

(1) The eligible client is a patient in a general hospital and the hospital meets the definition in RCW 70.41.020;

(2) The services are medically necessary as defined under WAC 388-500-0005; and

(3) The conditions, exceptions and limitations in this chapter are met.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1050 Definitions. Unless otherwise specified, the terms used in this chapter have the following meaning:

"Accommodation costs" mean the expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made, such as, but not limited to, a regular hospital room, special care hospital room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Acute" means a term describing medical condition of severe intensity with sudden onset.

"Acute care" means care provided by an agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015).

"ADATSA/DASA assessment center" means an agency contracted by the division of alcohol and substance abuse (DASA) to provide chemical dependency assessment for clients and pregnant women in accordance with the alcohol and drug addiction treatment and support act (ADATSA). Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

"Add-on procedure" means a secondary procedure that is performed in addition to another procedure.

"Administrative day" means a day of a hospital stay in which an acute inpatient level of care is no longer necessary, and an appropriate noninpatient hospital placement is not available.

"Admitting diagnosis" means the diagnosis, coded according to the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM), indicating the medical condition which precipitated the client's admission to an inpatient hospital facility.

"Advance directive" means a document, such as a living will, executed by a client, that tells the client's health care providers and others the client's decisions regarding his or her medical care, particularly whether the client wishes to accept or refuse extraordinary measures to prolong his or her life.

"Aggregate capital cost" means the total cost or the sum of all capital costs.

"Aggregate cost" means the total cost or the sum of all constituent costs.

"Aggregate operating cost" means the total cost or the sum of all operating costs.

"Alcohol and drug addiction treatment and support act (ADATSA)" means the law and the state-funded program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

"Alcoholism and/or alcohol abuse treatment" means the provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.

"All-patient grouper (AP-DRG)" means a computer program that determines the diagnosis-related group (DRG) assignments.

"Allowed charges" mean the maximum amount for any procedure that the department will recognize.

"Ancillary hospital costs" mean the expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. Such services include, but are not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), and operating room (including anesthesia and postoperative recovery rooms).

"Ancillary services" mean additional or supporting services, such as, but not limited to, laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services, provided by a hospital to a patient during his or her hospital stay.

"Approved treatment facility" means a treatment facility, either public or private, profit or nonprofit, approved by DSHS.

"Audit" means an assessment, evaluation, examination, or investigation of a health care provider's accounts, books and records, including:

(1) Medical, financial and billing records pertaining to billed services paid by the department through Medicaid or other state programs, by a person not employed or affiliated with the provider, for the purpose of verifying the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical and medical records, including mathematical computations and special studies conducted supporting Medicare cost reports HCFA Form 2552, submitted to the department for the purpose of establishing program rates of reimbursement to hospital providers.

"Audit claims sample" means a subset of the universe of paid claims from which the sample is drawn, whether based upon judgmental factors or random selection. The sample may consist of any number of claims in the population up to one hundred percent. See also **"random claims sample"** and **"stratified random sample."**

"Authorization number" means a nine-digit number assigned by MAA that identifies individual requests for approval of services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

"Authorization requirement" means MAA's requirement that a provider present proof of medical necessity to MAA, usually before providing certain medical services or equipment to a client. This takes the form of a request for authorization of the service(s) and/or equipment, including a complete, detailed description of the client's diagnosis and/or any disabling conditions, justifying the need for the equipment or the level of service being requested.

"Average hospital rate" means the weighted average of hospital rates in the state of Washington.

"Bad debt" means an operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

"Base period" means, for purposes of establishing a provider rate, a specific period or timespan used as a reference point or basis for comparison.

"Base period costs" mean costs incurred in or associated with a specified base period.

"Beneficiary" means a recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.

"Benefit period" means a "spell of illness" for Medicare payments. For part A coverage, the benefit period begins on the first day a Medicare beneficiary is furnished inpatient hospital or extended care services by a qualified

provider, and ends when the beneficiary has been out of the hospital or other covered facility for sixty-consecutive days.

"Billed charge" - See **"usual and customary charge."**

"Blended rate" means a mathematically weighted average rate.

"Border area hospital" means a hospital located in an area defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, or The Dalles; Idaho - Coeur d'Alene, Lewiston, Moscow, Priest River or Sandpoint.

"Bundled services" mean interventions which are incidental to the major procedure and are not separately reimbursable.

"Buy-in premium" means a monthly premium the state pays so a client is enrolled in part A and/or part B Medicare.

"By report" means a method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules by requiring the provider to submit a "report" describing the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping physician staff on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services; usually associated with hospital emergency room, surgery, laboratory and radiology services.

"Capital-related costs" mean the component of operating costs related to capital assets, including, but not limited to:

(1) Net adjusted depreciation expenses;

(2) Lease and rentals for the use of depreciable assets;

(3) The costs for betterment and improvements;

(4) The cost of minor equipment;

(5) Insurance expenses on depreciable assets;

(6) Interest expense; and

(7) Capital-related costs of related organizations that provide services to the hospital.

It excludes capital costs due solely to changes in ownership of the provider's capital assets.

"Case mix complexity" means, from the clinical perspective, the condition of the patients treated and the treatment difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution.

"Case mix index" means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using diagnosis-related group weights as a measure of relative cost.

"Charity care" means necessary hospital health care rendered to indigent persons, as defined in this section, to the extent that these persons are unable to pay for the care or to pay the deductibles or coinsurance amounts required by a third-party payer, as determined by the department.

"Chemical dependency" means an alcohol or drug addiction; or dependence on alcohol and one or more other psychoactive chemicals.

"Children's hospital" means a hospital primarily serving children.

"Coinsurance" - See WAC 388-500-005.

"Comorbidity" means of, relating to, or caused by a disease other than the principal disease.

"Complication" means a disease or condition occurring subsequent to or concurrent with another condition and aggravating it.

"Comprehensive hospital abstract reporting system (CHARS)" means the department of health's hospital data collection, tracking and reporting system.

"Contract hospital" means a licensed hospital located in a selective contracting area, which is awarded a contract to participate in the department's selective contracting hospital program.

"Contractual adjustment" means the difference between the amount billed at established charges for the services provided and the amount received or due from a third-party payer under a contract agreement. A contractual adjustment is similar to a trade discount.

"Conversion factor" means a hospital-specific dollar amount that reflects the average cost of treating Medicaid clients in a given hospital. See **"cost-based conversion factor (CBCF)"** and **"negotiated conversion factor (NCF)."**

"Cost proxy" means an average ratio of costs to charges for ancillary charges or per diem for accommodation cost centers used to determine a hospital's cost for the services where the hospital has charges for the services has does not report costs in corresponding centers in its Medicare cost report.

"Cost report" means the HCFA Form 2552, Hospital and Hospital Health Care Complex Cost Report, completed and submitted annually by a provider:

(1) To Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and

(2) To Medicaid to establish appropriate DRG and RCC reimbursement.

"Costs" mean MAA-approved operating, medical education, and capital-related costs as reported and identified on the HCFA 2552 form.

"Cost-based conversion factor (CBCF)" means a hospital-specific dollar amount that reflects the average cost of treating Medicaid clients in a given hospital. It is calculated from the hospital's cost report by dividing the hospital's costs for treating Medicaid clients during a base period by the number of Medicaid discharges during that same period and adjusting for the hospital's case mix. See also **"conversion factor"** and **"negotiated conversion factor."**

"County hospital" means a hospital established under the provisions of chapter 36.62 RCW.

"Covered service" means a service that is included in the Medicaid program and is within the scope of the eligible client's medical care program.

"Critical care services" mean services for critically ill or injured patients in a variety of medical emergencies that require the constant attendance of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications). For Medicaid reimbursement purposes, critical care services must be provided in a Medicare qualified critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility, to qualify for reimbursement as a special care level of service.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians; it is published annually by the American Medical Association (AMA).

"Customary charge or fee" - See **"Allowed charges"** and **"usual and customary charge."**

"Customary charge payment limit" means the limit placed on aggregate diagnosis-related group (DRG) payments to a hospital during a given year to assure that DRG payments do not exceed the hospital's charges to the general public for the same services.

"Day outlier" means a case that requires MAA to make additional payment to the hospital provider but which does not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."**

"Day outlier payment" means the additional amount paid to a disproportionate share hospital for a client five years old or younger who has a prolonged inpatient stay which exceeds the day outlier threshold but whose charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.

"Day outlier threshold" means the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus twenty days.

"Deductible" means the amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

"Detoxification" means treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Diabetic education program" means a comprehensive, multidisciplinary program of instruction offered by an MAA-approved facility to diabetic clients on dealing with diabetes, including instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" means a set of alphabetic, numeric, or alpha-numeric characters assigned by the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as a shorthand symbol to represent the nature of a disease.

"Diagnosis-related group (DRG)" means a classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or complications, and other relevant criteria.

"Direct medical education costs" means the direct costs of providing an approved medical residency program as recognized by Medicare.

"Discharging hospital" means the institution releasing a client from the acute care hospital setting.

"Disproportionate share payment" means additional payment(s) made by the department to a hospital which serves a disproportionate number of Medicaid and other low-income clients and which qualifies for one or more of the disproportionate share hospital programs identified in the state plan.

"Disproportionate share program" means a program that provides additional payments to hospitals which serve a disproportionate number of Medicaid and other low-income clients.

"Dispute conference" means a meeting for deliberation during a provider administrative appeal.

(1) At the first level of appeal it is usually a meeting between auditors and the audited provider and/or staff to resolve disputed audit findings, clarify interpretation of regulations and policies, provide additional supporting information and/or documentation.

(2) At the second level of appeal the dispute conference is a more formal hearing, held by the office of contracts and asset management which issues a decision articulating the department's final position on the contested issue(s).

(3) See WAC 388-81-042.

"Distinct unit" means a Medicare-certified distinct area for rehabilitation services within a general acute care hospital or a department-designated unit in a children's hospital.

"DRG" - See **"diagnosis-related group."**

"DRG-exempt services" mean services which are paid for through other methodologies than those using cost-based or negotiated conversion factors.

"DRG payment" means the payment made by MAA for a client's inpatient hospital stay; it is calculated by multiplying the hospital-specific conversion factor by the DRG relative weight for the client's medical diagnosis.

"DRG relative weight" means the average cost of a certain DRG divided by the average cost for all cases in the entire data base for all DRGs, expressed in comparison to a designated standard cost.

"Drug addiction and/or drug abuse treatment" means the provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families.

"Elective procedure or surgery" means a nonemergent procedure or surgery that can be scheduled at convenience.

"Emergency medical condition" - See WAC 388-500-0005, Medical definitions.

"Emergency medical expense requirement (EMER)" - See WAC 388-500-0005, Medical definitions.

"Emergency room" or **"emergency facility"** means an organized, distinct hospital-based facility available twenty-four hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and capable of providing emergency services including trauma.

"Emergency services" mean medical services, including maternity services, required by and provided to a patient

after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

"Equivalency factor" means a conversion factor used, in conjunction with two other factors (cost-based conversion factor and the ratable factor), to determine the level of state-only program payment.

"Exempt hospital" means a hospital that is either not located in a selective contracting area or is exempted by the department and is reimbursed for services to MAA clients through methodologies other than those using cost-based or negotiated conversion factors.

"Experimental treatment" means a course of treatment or procedure that:

(1) Is not generally accepted by the medical profession as effective and proven;

(2) Is not recognized by professional medical organizations as conforming to accepted medical practice;

(3) Has not been approved by the federal Food and Drug Administration (FDA) or other requisite government body;

(4) Is still in clinical trials, or has been judged to need further study;

(5) Is covered by the federal law requiring provider institutional review of patient consent forms, and such review did not occur; or

(6) Is rarely used, novel, or relatively unknown, and lacks authoritative evidence of safety and effectiveness.

"Facility triage fee" means the amount the medical assistance administration will pay a hospital for a medical evaluation or medical screening examination, performed in the hospital's emergency department, of a nonemergent condition of a *healthy options* client covered under the primary care case management (PCCM) program. This amount corresponds to the professional care level 1 or level 2 service.

"Fiscal intermediary" means Medicare's designated fiscal intermediary for a region and/or category of service.

"Formula price" means the hospital's payment rate, which is the product of the hospital-specific conversion factor multiplied by the DRG weight for the given hospitalization.

"Global surgery days" mean the number of preoperative and follow-up days that are included in the reimbursement to the physician for the major surgical procedure.

"Graduate medical education costs" mean the direct and indirect costs of providing medical education in teaching hospitals.

"Grouper" - See **"all-patient grouper (AP-DRG)."**

"HCFA 2552" - See **"cost report."**

"Health care team" means a team of professionals and/or paraprofessionals involved in the care of a client.

"High-cost outlier" means a case with extraordinarily high costs when compared to other cases in the same DRG, in which the allowed charges exceed three times the applicable DRG payment or twenty-eight thousand dollars, whichever is greater.

"Hospice" means a medically-directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington state-licensed and Title XVIII-certified Washington state hospice for terminally ill clients and the clients' families.

"Hospital" means an entity which is licensed as an acute care hospital in accordance with applicable state laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

"Hospital admission" means admission as an inpatient to a hospital, for a stay of twenty-four hours or longer.

"Hospital cost report" - See **"cost report."**

"Hospital facility fee" - See **"facility triage fee."**

"Hospital market basket index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services, as measured by Data Resources, Inc., (DRI).

"Hospital peer group" means the peer group categories adopted by the former Washington state hospital commission for rate-setting purposes:

(1) Group A - rural hospitals paid under a ratio-of-costs-to-charges (RCC) methodology;

(2) Group B - urban hospitals without medical education programs;

(3) Group C - urban hospitals with medical education programs; and

(4) Group D - specialty hospitals and/or hospitals not easily assignable to the other three peer groups.

"Indigent patient" means a patient who has exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below two hundred percent of the federal poverty standards (adjusted for family size), or is otherwise not sufficient to enable the individual to pay for his or her care, or to pay deductibles or coinsurance amounts required by a third-party payor.

"Indirect medical education costs" means the indirect costs of providing an approved medical residency program as recognized by Medicare.

"Inflation adjustment" means, for cost inflation, the hospital inflation factor determined by Data Resources, Inc., (DRI) and published in the DRI/McGraw-Hill Report. See also **"hospital market basket index."** For charge inflation, it means the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) standard reports three and four.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.

"Inpatient services" mean all services provided directly or indirectly by the hospital to a patient subsequent to admission and prior to discharge, and includes, but is not limited to, the following services: Bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and services provided by the hospital within twenty-four hours of the patient's admission as an inpatient.

"Institution" - See WAC 388-500-0005, Medical definitions.

"Interdisciplinary group (IDG)" means the team, including a physician, a registered nurse, a social worker, and a pastoral or other counselor, which is primarily responsible for the provision or supervision of care and services for a Medicaid client.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical designations (coding).

"Intervention" means any medical or dental service provided to a client that modifies the medical or dental outcome for that client.

"Length of stay (LOS)" means the number of days of inpatient hospitalization. The phrase more commonly means the average length of hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region.* See also **"professional activity study (PAS)."**

"Length of stay extension request" means a request from a hospital provider for MAA to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

"Lifetime hospitalization reserve" means, under the Medicare Part A benefit, the nonrenewable sixty hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond ninety days per benefit period. See also **"reserve days."**

"Low-cost outlier" means a case with extraordinarily low costs when compared to other cases in the same DRG, in which the allowed charges for the case is less than or equal to ten percent of the applicable DRG payment or four hundred dollars, whichever is greater. Reimbursement in such cases is determined by multiplying the case's allowed charges by the hospital's RCC ratio.

"Low income utilization rate" means a formula represented as (A/B)+(C/D) in which:

(1) The numerator A is the hospital's total patient services revenue under the state plan, plus the amount of cash subsidies for patient services received directly from state and local governments in a period;

(2) The denominator B is the hospital's total patient services revenue (including the amount of such cash subsidies) in the same period as the numerator;

(3) The numerator C is the hospital's total inpatient service charge attributable to charity care in a period, less the portion of cash subsidies described in (1) of this definition in the period reasonably attributable to inpatient hospital services. The amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the state plan); and

(4) The denominator D is the hospital's total charge for inpatient hospital services in the same period as the numerator.

"Major diagnostic category (MDC)" means one of the twenty five mutually exclusive groupings of principal diagnosis areas in the DRG system. The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

"Market basket index" - See **"hospital market basket index."**

"Medicaid cost proxy" means a figure developed to approximate or represent a missing cost figure.

"Medicaid inpatient utilization rate" means a formula represented as X/Y in which:

(1) The numerator X is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan in a period.

(2) The denominator Y is the hospital's total number of inpatient days in the same period as the numerator's. Inpatient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

"Medical care services" - See WAC 388-500-0005, Medical definitions.

"Medical education costs" mean the expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

"Medical screening evaluation" means the service(s) provided by a physician or other practitioner to determine whether an emergent medical condition exists. See also **"facility triage fee."**

"Medical stabilization" means a return to a state of constant and steady function. It is commonly used to mean the client is adequately supported to prevent further deterioration.

"Medically indigent (MI)" - See WAC 388-500-0005, Medical definitions.

"Medically indigent person" means a person certified by the department of social and health services as eligible for the limited casualty program-medically indigent (LCP-MI) program. See also **"indigent patient."**

"Medicare cost report" means the annual cost data reported by a hospital to Medicare on the HCFA form 2552.

"Medicare crossover" means a claim involving a client who is eligible for both Medicare benefits and Medical Assistance.

"Medicare fee schedule (MFS)" means the official HCFA publication of Medicare policies and relative value units for the resource based relative value scale (RBRVS) reimbursement program.

"Medicare Part A" means that part of the Medicare program that helps pay for inpatient hospital services, which may include, but are not limited to:

(1) A semi-private room;
(2) Meals;
(3) Regular nursing services;
(4) Operating room;
(5) Special care units;
(6) Drugs and medical supplies;
(7) Laboratory services;
(8) X-ray and other imaging services; and
(9) Rehabilitation services.

Medicare hospital insurance also helps pay for post-hospital skilled nursing facility care, some specified home health care, and hospice care for certain terminally ill beneficiaries.

"Medicare part B" means that part of the Medicare program that helps pay for, but is not limited to:

(1) Physician services;
(2) Outpatient hospital services;
(3) Diagnostic tests and imaging services;
(4) Outpatient physical therapy;
(5) Speech pathology services;
(6) Medical equipment and supplies;
(7) Ambulance;
(8) Mental health services; and
(9) Home health services.

"Medicare buy-in premium" - See **"buy-in premium."**

"Medicare payment principles" mean the rules published in the federal register regarding reimbursement for services provided to Medicare clients.

"Mentally incompetent" means a client who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the client has been declared competent for purposes which include the ability to consent to sterilization.

"Multiple occupancy rate" means the rate customarily charged for a hospital room with two or more patient beds.

"Negotiated conversion factor (NCF)" means a negotiated hospital-specific dollar amount which is used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"conversion factor"** and **"cost-based conversion factor."**

"Nonallowed service or charge" means a service or charge that cannot be billed to the department or client.

"Noncontract hospital" means a licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the selective contracting hospital program.

"Noncovered service or charge" means a service or charge that is not covered by medical assistance, including, but not limited to, such services or charges as a private room, circumcision, and video recording of the procedure.

"Nonemergent hospital admission" means any inpatient hospitalization of a client who does not have an emergent condition, as defined in WAC 388-500-0005, Emergency services.

"Nonparticipating hospital" means a noncontract hospital, as defined in this section.

"Operating costs" mean all expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

"Orthotic device" means a fitted surgical apparatus designed to activate or supplement a weakened or atrophied limb or bodily function.

"Out-of-state hospital" means any hospital located outside the state of Washington or outside the designated border areas in Oregon and Idaho.

"Outlier set-aside factor" means the amount by which a hospital's cost-based conversion factor is reduced for payments of high cost outlier cases.

"Outlier set-aside pool" means the total amount of payments for high cost outliers which are funded annually based on payments for high cost outliers during the year.

"Outliers" mean cases with extraordinarily high or low costs when compared to other cases in the same DRG.

"Outpatient" means a client who is receiving medical services in other than an inpatient hospital setting.

"Outpatient care" means medical care provided in other than an inpatient hospital setting, such as in a hospital outpatient or emergency department, a physician's office, the patient's own home, or a nursing facility.

"Outpatient hospital" means a hospital authorized by the department of health to provide outpatient services.

"Outpatient stay" means a hospital stay of less than or approximating twenty-four hours, except that cases involving the death of a client, delivery or initial care of a newborn, or transfer to another acute care facility are not deemed outpatient stays.

"Pain treatment facility" means an MAA-approved inpatient facility for pain management, in which a multidisciplinary approach is used to teach clients various techniques to live with chronic pain.

"Participating hospital" means a licensed hospital that accepts MAA clients.

"PAS length of stay (LOS)" means the average length of hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region.* See also **"professional activity study (PAS)"** and **"length of stay."**

"Patient consent" means the informed consent of the client and/or the client's guardian to the procedure(s) to be performed upon or the treatment provided to the client, evidenced by the client's or guardian's signature on a consent form.

"Peer group" - See **"hospital peer group."**

"Peer group cap" means the reimbursement limit set for hospital peer groups B and C, established at the seventieth percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs.

"Per diem charge" means the daily charge per client that a facility may bill or is allowed to receive as payment for its services.

"Personal comfort items" mean items and services which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member.

"Physical medicine and rehabilitation (PM&R)" means a comprehensive inpatient rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for a diagnostic category for which the client shows significant potential functional improvement.

"Physician standby" means physician attendance without direct face-to-face patient contact and does not involve provision of care or services.

"Physician's current procedural terminology (CPT)" - See **"CPT."**

"Plan of treatment" or **"plan of care"** means the written plan of care for a patient which includes, but is not

limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

"Pregnant and postpartum women (PPW)" mean eligible female clients who are pregnant or within the first one hundred sixty days following delivery.

"Principal diagnosis" means the medical condition determined after study of the patient's medical records to be the principal cause of the patient's hospital stay.

"Principal procedure" means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

"Private room rate" means the rate customarily charged by a hospital for a one-bed room.

"Professional activity study (PAS)" means the compilation of inpatient hospital data by diagnosis and age, conducted by the Commission of Professional and Hospital Activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region.*

"Professional component" means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a reimbursement that recognizes the physician's cognitive skill.

"Prognosis" means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.

"Prolonged service" means direct face-to-face patient services provided by a physician, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services.

"Prospective payment system (PPS)" means a system that sets payment rates for a pre-determined period for defined services, before the services are provided. The payment rates are based on economic forecasts and the projected cost of services for the pre-determined period.

"Prosthetic device" - See WAC 388-500-0005, Medical definitions.

"Psychiatric hospitals" mean designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals.

"Public hospital district" means a hospital district established under chapter 70.44 RCW.

"Random claims sample" means a sample in which all of the items are selected randomly, using a random number table or computer program, based on a scientific method of assuring that each item has an equal chance of being included in the sample. See also **"audit claims sample"** and **"stratified random sample."**

"Ratable" means a hospital-specific adjustment factor applied to the cost-based conversion factor (CBCF) to determine state-only program payment rates to hospitals.

"Ratio of costs to charges (RCC)" means the methodology used to pay hospitals for services exempt from the DRG payment method. It also refers to the factor applied to a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services.

"Readmission" means the situation in which a client who was admitted as an inpatient and discharged from the hospital is back as an inpatient within seven days as a result of one or more of the following: A new flair of illness, complication(s) from the first admission, a therapeutic admission following a diagnostic admission, a planned readmission following discharge, or a premature hospital discharge.

"Rebasing" means the process of recalculating the hospital cost-based conversion factors using more current data.

"Recalibration" means the process of recalculating DRG relative weights using more current data.

"Rehabilitation units" mean specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals that meet Medicare criteria for distinct part rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

"Remote hospitals" mean hospitals located outside selective contracting areas (SCAs), or which:

(1) Are more than ten miles from the nearest contract hospital in the SCA; and

(2) Have fewer than seventy five beds; and

(3) Have fewer than five hundred Medicaid admissions in a two-year period.

"Reserve days" mean the days beyond the ninetieth day of hospitalization of a Medicare patient for a benefit period or spell of illness. See also **"lifetime hospitalization reserve."**

"Retrospective payment system" means a system that sets payment rates for defined services according to historic costs. The payment rates reflect economic conditions experienced in the past.

"Revenue code" means a nationally-used three-digit coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" means services provided in a nursing facility, including:

(1) Assistance in the activities of daily living.

(2) Socialization activities.

(3) Administration of medication.

(4) Maintenance of the resident's room.

(5) Supervision and assistance in the use of durable medical equipment and prescribed therapies.

See **"accommodation costs"** for services included in the hospital room and board category.

"Rural health clinic" means a clinic that is located in a rural area designated as a shortage area, and is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

"Rural hospital" means a rural health care facility capable of providing or assuring availability of health services in a rural area.

"Secondary diagnosis" means a diagnosis other than the principal diagnosis for which an inpatient is admitted to a hospital.

"Selective contracting area (SCA)" means an area in which hospitals participate in competitive bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by Medicaid patients.

"Selective hospital contracting program" or **"selective contracting"** means a competitive bidding program for hospitals within a specified geographic area to provide inpatient hospital services to medical assistance clients.

"Semi-private room rate" means a rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Short stay" means a hospital stay of less than or approximating twenty-four hours where an inpatient admission was not appropriate.

"Special care unit" means a Medicare-certified hospital unit where intensive care, coronary care, psychiatric intensive care, burn treatment or other specialized care is provided.

"Specialty hospitals" mean children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of clients or diseases.

"Spenddown" means the amount of excess income MAA has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spenddown requirement.

"Stat laboratory charges" mean the charges by a laboratory for performing a test or tests immediately. "Stat." is the abbreviation for the Latin word "statim" meaning immediately.

"State plan" means the plan filed by the department with the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS), outlining how the state will administer the hospital program.

"Stratified random sample" means a sample consisting of claims drawn randomly, using statistical formulas, from each stratum of a universe of paid claims stratified according to the dollar value of the claims. See also **"audit claims sample"** and **"random claims sample."**

"Subacute care" means care to a patient which is less intrusive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

"Surgery" - The medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.

"Swing-bed days" means a bed day on which an inpatient is receiving skilled nursing services in a swing bed at the hospital's census hour. The hospital bed must be certified by the health care financing administration for both acute care and skilled nursing services.

"Teaching hospital" means, for purposes of the teaching hospital assistance program disproportionate share hospital (THAPDSH), the University of Washington medical center and harborview hospital.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a reimbursement that recognizes the equipment cost and technician time.

"Tertiary care hospital" means a specialty care hospital providing highly specialized services to clients with more complex medical needs than acute care services.

"Total patient days" means all patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" means to move a client from one acute care facility to another.

"Transferring hospital" means the hospital transferring a client to another acute care facility.

"Trauma care facility" means a facility certified by the department of health as a level I, II or III facility.

"UB-92" means the uniform billing document intended for use nationally by hospitals, hospital-based skilled nursing facilities, home health, and hospice agencies in billing third party payers for services provided to clients.

"Unbundled services" mean services which are excluded from the DRG payment to a hospital, including but not limited to, physician professional services and certain nursing services.

"Uncompensated care" - See **"charity care."**

"Uniform cost reporting requirements" means a standard accounting and reporting format as defined by Medicare.

"Uninsured indigent patient" means an individual who receives hospital inpatient and/or outpatient services and who cannot meet the cost of services provided because the individual has no or insufficient health insurance or other resources to cover the cost.

"Usual and customary charge (UCC)" means the charge customarily made to the general public for a procedure or service, or the rate charged other contractors for the service if the general public is not served.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1100 Hospital coverage. (1) Admission of a medical care client to a hospital shall be covered only when the admission is requested by the client's attending physician. For nonemergent hospital admissions, "attending physician" shall mean the client's primary care provider, or the primary provider of care to the patient at the time of hospitalization. For emergent admissions, "attending physician" shall mean the staff member who has hospital privileges who evaluates the client's medical condition upon the client's arrival at the hospital.

(2) In areas where the choice of hospitals is limited by managed care or selective contracting, the department shall not be responsible for payment under fee-for-service for hospital care and/or services:

(a) Provided to managed care clients enrolled in the department's managed care plan, unless the services are excluded from the health carrier's capitation contract with the department and are covered under the medical assistance program; or

(b) Received by a medical care client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WACs 388-550-4600 and 388-550-4700 apply.

(3) The department shall provide chemical-dependent pregnant Medicaid clients up to twenty-six days of inpatient hospital care for hospital-based detoxification, medical stabilization, and drug treatment when:

(a) An alcohol, drug addiction and treatment support act assessment center verifies the need for the inpatient care; and

(b) The hospital chemical dependency treatment unit is certified by the division of alcohol and substance abuse.

See WAC 388-550-6250 for outpatient hospital services for chemical-dependent pregnant Medicaid clients.

(4) The department shall cover medically necessary services provided to eligible clients in a hospital setting for the care or treatment of teeth, jaws, or structures directly supporting the teeth:

(a) If the procedure requires hospitalization; and

(b) A physician or dentist gives or directly supervises such services.

(5) The department shall pay hospitals for services provided in special care units when the provisions of WAC 388-550-2900 (9)(c) are met.

(6) All services shall be subject to review and approval as stated in WAC 388-87-025.

(7) For inpatient psychiatric admissions, whether voluntary or involuntary, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1200 Limitations on hospital coverage. Hospital coverage under the medical assistance program is limited for certain eligible clients, including, but not limited to, the following:

(1) Medical care clients enrolled with the department's managed care carriers as follows:

(a) Comprehensive risk contracts are subject to their respective carriers' policies and procedures regarding hospital services;

(b) Primary care case management contracts are subject to the clients' primary care physicians' approval;

(c) For emergency care exemptions, see WAC 388-538-100.

(2) The department shall limit coverage for clients eligible for the medically indigent (MI) program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, WAC 388-529-2950, and this chapter. The department shall not cover out-of-state hospital or other medical care for clients under the MI program.

(3) The department shall not cover out-of-state medical care for clients under the medical care services program.

(4) See WAC 388-550-1100(3) for chemical-dependent pregnant clients.

(5) The department shall limit care in a state mental institution or an approved psychiatric facility to categorically needy and medically needy clients under twenty-one years of age, or sixty-five years of age or older.

(6)(a) The department shall pay clients eligible for both Medicare and Medicaid only for their deductibles and coinsurance for hospitalization, unless the client has exhausted his or her Medicare part A benefits.

(b) If such benefits are exhausted, the department shall pay for hospitalization for such client subject to MAA rules.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1300 Revenue code categories and subcategories. (1) For reimbursement and audit purposes, hospitals shall report and bill all services provided to a medical care client under the appropriate cost centers or revenue codes, except the following services which are subject to current procedural terminology codes and rates when provided in an outpatient setting:

(a) Laboratory/pathology;

(b) Radiology, diagnostic and therapeutic;

(c) Nuclear medicine;

(d) Computerized tomography scans, magnetic resonance imaging, and other imaging services;

(e) Physical therapy;

(f) Occupational therapy;

(g) Speech/language therapy; and

(h) Other hospital services as identified and published by the department.

(2) Revenue code categories in this chapter shall be as listed in the state of Washington's UB-92 procedure manual, implemented October 1, 1993, which was patterned after the national uniform billing data element specifications adopted by the national uniform billing committee.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1400 Covered revenue codes for hospital services. (1) The department shall cover the following revenue code categories for both inpatient and outpatient hospitalizations:

(a) "Pharmacy," except that:

(i) Subcategories "take-home drugs," "experimental drugs," and "other pharmacy" are not covered; and

(ii) Subcategory "nonprescription" is covered for inpatients only;

(b) "Intravenous (IV) therapy," except subcategory "other IV therapy";

(c) "Medical/surgical supplies and devices," except for the following subcategories:

(i) "Take home supplies";

(ii) "Prosthetic devices";

(iii) "Oxygen - take home"; and

(iv) "Other supplies/devices."

(d) "Oncology," except subcategory "other oncology";

(e) "Respiratory services," except subcategory "other respiratory services";

(f) Subcategories "general classification" and "minor surgery" under the "operating room services" category;

(g) "Anesthesia," except subcategories "acupuncture" and "other anesthesia";

(h) "Blood storage and processing," except subcategory "other blood storage and processing";

(i) "Other imaging services," except subcategory "other image services";

(j) "Emergency room," except subcategory "other emergency room";

(k) "Pulmonary function," except subcategory "other pulmonary function";

(l) "Cardiology," except subcategory "other cardiology";

(m) "Magnetic resonance imaging (MRI)," except subcategory "other MRI";

(n) "Cast room," except subcategory "other cast room";

(o) "Recovery room," except subcategory "other recovery room";

(p) "Labor room/delivery," except for subcategories "circumcision" and "other labor room/delivery";

(q) "EKG/ECG (electrocardiogram)," except subcategory "other EKG/ECG";

(r) "EEG (electroencephalogram)," except subcategory "other EEG";

(s) "Gastrointestinal services," except subcategory "other gastroenteritises";

(t) "Treatment or observation room," except subcategory "other treatment room";

(u) "Lithotripsy," except subcategory "other lithotripsy"; and

(v) "Organ acquisition," except for subcategories "unknown donor" and "other organ."

(2) Except for certain services, such as inpatient hospice services covered by MAA pursuant to other rules, the department shall cover the following revenue code categories and/or subcategories for inpatient hospitalizations only:

(a) "Room and board - private, medical, or general," except subcategory "hospice";

(b) "Semi-private room and board" (two to four beds), except subcategory "hospice";

(c) "Nursery for newborns and premature babies";

(d) "Intensive care," except subcategory "post-ICU";

(e) "Coronary care," except subcategory "post-CCU";

(f) "Laboratory," except subcategory "renal patient (home)";

(g) "Laboratory pathological";

(h) "Radiology," both "diagnostic" and "therapeutic";

(i) "Nuclear medicine";

(j) "Physical therapy," "occupational therapy," and "speech-language therapy";

(k) "CT (computed tomographic) scans";

(l) "Operating room services," subcategories "organ transplant other than kidney" and "kidney transplant only";

(m) "Clinic," subcategory "chronic pain center" only;

(n) "Ambulance," subcategory "neonatal ambulance services (support crews)" only;

(o) "Other donor bank" category, except that subcategories "peripheral blood stem cell harvesting" and "reinfusion" are limited only to facilities approved by the medical assistance administration (MAA).

In addition to specifically excluded subcategories, the subcategory "other" in each category shall not be covered.

(3) Except for certain services, such as inpatient hospice services covered by MAA pursuant to other rules, the department shall cover the following revenue code categories for outpatient hospital services only:

(a) "Ambulatory surgical care";

(b) "Outpatient services";

(c) Subcategories "general classification" and "dental clinic," under "clinic";

(d) Subcategory "rural health clinic," under "free-standing clinic";

(e) "Drugs requiring specific identification," except covered only for certified kidney centers;

(f) "Hospice services";

(g) "Respite care";

(h) "Inpatient renal dialysis";

(i) "Hemodialysis - outpatient or home";

(j) "Peritoneal dialysis - outpatient or home";

(k) "Continuous ambulatory peritoneal dialysis - outpatient or home";

(l) "Continuous cycling peritoneal dialysis - outpatient or home";

(m) "Miscellaneous dialysis";

(n) Subcategories "education/training" and "weight loss," under the "other therapeutic services" category, except limited to facilities approved by MAA.

In addition to specifically excluded subcategories, the subcategory "other" in each category shall not be covered.

(4) The department shall cover the following revenue code categories and/or subcategories subject to the following specific limitations:

(a) The "private (deluxe)" and "room and board - ward" categories shall be reimbursed at the semi-private hospital room rates.

(b) All inpatient psychiatric services shall be subject to the policies and procedures of the mental health division, and reimbursed only to department-approved psychiatric facilities. See chapter 246-318 WAC. Inpatient psychiatric revenue codes include, but are not limited to:

(i) The subcategory "psychiatric" under all "room and board" categories;

(ii) The subcategory "psychiatric" under the "intensive care" category;

(iii) The "psychiatric/psychological treatments" category; and

(iv) The "psychiatric/psychological services" category.

(c) The department shall reimburse the subcategory "detoxification" under all room and board categories only to detoxification facilities approved by the division of alcohol and substance abuse.

(d) The subcategory "rehabilitation" under all "room and board" categories shall be reimbursed only to MAA-approved rehabilitation facilities.

(e) Only the subcategories "chemical-using pregnant women" and "administrative days" shall be covered in the "other room and board" category.

(f) Subcategory "nonprescription drugs" under the category "pharmacy" shall be covered for inpatient hospitalizations only. See WAC 388-550-1400 (1)(a)(ii). Certain exemptions apply for pregnant women as described in WAC 388-86-024 (2)(c). For coverage of nonprescription drugs, see WAC 388-530-110 and 388-530-1150.

(g) The subcategories "renal patient (home)" and "nonroutine dialysis" under category "laboratory" shall be reimbursed in the outpatient setting only to Medicare-certified kidney centers.

(h) Subcategory "chronic pain center" under the "clinic" category shall be reimbursed only to MAA-approved chronic pain treatment facilities.

(i) Only the subcategory "neonatal ambulance services (support crews)" under the "ambulance" category shall be covered, and only for inpatient hospitalizations.

(j) The category "drugs requiring specific identification" shall be reimbursed only for outpatients and only to Medicare-approved kidney centers.

(k) Subcategories "education/training" and "weight loss," under the "other therapeutic service" category, shall be reimbursed only to MAA-approved facilities.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1500 Noncovered revenue codes. (1) Revenue code subcategories titled "other" shall not be covered by the medical assistance administration (MAA), unless otherwise specified.

(2) The department shall not cover the following revenue code categories in either an inpatient or outpatient setting:

(a) "All-inclusive rate";

(b) "Other room and board," except as indicated in WAC 388-550-1400 (4)(e);

(c) "Leave of absence";

(d) "Not assigned" (all such categories);

(e) "Special charges";

(f) "Incremental nursing charge rate";

(g) "All-inclusive ancillary";

(h) "Pharmacy" subcategories for "take home" and "experimental drugs";

(i) "Durable medical equipment (other than renal)";

(j) "Blood" (and blood products);

(k) "Audiology";

(l) "Clinic," except as specified in WAC 388-550-1400 (3)(c);

(m) "Free-standing clinic," except as specified in WAC 388-550-1400 (3)(d);

(n) "Osteopathic services";

(o) "Ambulance," except as specified in WAC 388-550-1400 (4)(i);

(p) "Skilled nursing";

(q) "Medical social services";

(r) "Home health aide (home health)" and "other visits (home health)";

(s) "Units of service (home health)";

(t) "Oxygen (home health)";

(u) "Medicare/surgical supplies";

(v) "Home IV therapy services";

(w) "Preventive care services";

(x) "Other diagnostic services";

(y) "Professional fees" (all such categories); and

(z) "Patient convenience items."

(3) The department shall not cover the following subcategories in the "other therapeutic service" category:

(a) "General classification";

(b) "Recreational therapy";

(c) "Cardiac rehabilitation";

(d) "Drug rehabilitation," except under the chemically-using pregnant (CUP) women program;

(e) "Alcohol rehabilitation," except under the CUP program; and

(f) "Air fluidized support beds."

(4) The department shall not cover the following subcategories under the "free-standing clinic" category:

(a) "General classification";

(b) "Rural health - home";

(c) "Family practice"; and

(d) "Other clinic."

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1600 Specific items/services not covered. The department shall not cover certain hospital items/services for any hospital stay including, but not limited to, the following:

(1) Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up;

(2) Telephone/telegraph services or television/radio rentals;

(3) Medical photographic or audio/videotape records;

(4) Crisis counseling;

(5) Psychiatric day care;

(6) Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit;

(7) Standby personnel and travel time;

(8) Routine hospital medical supplies and equipment such as bed scales;

(9) Handling fees and portable X-ray charges;

(10) Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client;

(11) Cafeteria charges;

(12) Services and supplies provided to nonpatients, such as meals and "father packs"; and

(13) Standing orders. The department shall cover routine tests and procedures only if the department determines such services are medically necessary, according to the following criteria. The procedure or test:

(a) Is specifically ordered by the admitting physician or, in the absence of the admitting physician, the hospital staff having responsibility for the client (e.g., physician, advanced registered nurse practitioner, or physician assistant);

(b) Is for the diagnosis or treatment of the individual's condition; and

(c) Does not unnecessarily duplicate a test available or made known to the hospital which is performed on an outpatient basis prior to admission; or

(d) Is performed in connection with a recent admission.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1700 Hospital services—Prior approval. (1) Providers of hospital-related services to clients not enrolled with the department's managed care carriers shall obtain prior approval from the medical assistance administration (MAA) for hospital services requiring prior approval. For inpatient psychiatric admissions and inpatient treatment for alcohol and other substance abuse, see chapter 246-318 and 246-326 WAC respectively.

(2) The department shall require that for medical care clients not enrolled with the department's managed care carriers, providers receive prior approval from the department for the following hospital-related services:

(a) All nonemergent admissions to or planned inpatient hospital surgeries in nonparticipating hospitals in selective contracting areas;

(b) Inpatient detoxification, medical stabilization, and drug treatment for a pregnant Medicaid client as described under WAC 388-550-1100(3);

(c) Cataract surgery that does not meet requirements in WAC 388-86-030;

(d) The following surgical procedures, regardless of the diagnosis or place of service:

(i) Hysterectomies for clients forty-four years and younger;

(ii) Reduction mammoplasty; and

(iii) Surgical bladder repair.

(e) All physical medicine and rehabilitation (PM&R) inpatient hospital stays, even when provided by MAA-approved PM&R contract facilities (see WAC 388-550-2300);

(f) All outpatient magnetic resonance imaging and magnetic resonance angiography procedures;

(g) All nonemergent inpatient hospital transfers (see WAC 388-550-3600);

(h) All out-of-state non-emergent hospital stays;

(i) Hospital-related services as described in WAC 388-550-1800 when not provided in an MAA-approved facility; and

(j) Services in excess of the department's established limits.

(3) The department shall inform providers which diagnosis codes from the International Classification of Diseases, 9th Revision, Clinical Modification and procedure codes from physicians' current procedural terminology require prior authorization for nonemergent hospital admissions.

(4) When a client's hospitalization exceeds the number of days allowed by WAC 388-550-4300(2):

(a) The hospital shall, within sixty days after discharge, submit to MAA a request for authorization of the extra days with adequate medical justification, to include at a minimum the following:

(i) History and physical examination;

(ii) Social history;

(iii) Progress notes and doctor's orders for the entire length of stay;

(iv) Treatment plan/critical pathway; and

(v) Discharge summary.

(b) The department shall approve or deny a length of stay extension request within fifteen working days of receiving the request.

(5) The department shall require prior approval for out-of-state hospital admissions of clients not enrolled with department's managed care carriers, except for emergent hospitalizations. The department shall inform providers which codes from the current revision of ICD-9CM are designated as emergent diagnosis codes. The nature of the client's emergent medical condition must be fully documented in the client's hospital's records.

(6) The department shall not reimburse ambulance providers for ambulance transports in cases involving hospital transfers without prior authorization by the department.

(7) The department shall require that providers receive prior approval from the department for medical transportation to out-of-state treatment programs or services authorized by the department for clients not enrolled with the department's managed care carriers.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1750 Services requiring approval. (1) The department shall require that for medical services clients not enrolled with the department's managed care carriers, providers receive approval from the department for the following:

(a) Hospital length-of-stay extensions, in order for the provider to receive payment for the additional hospital days;

(b) All hospital readmissions within seven days of discharge; and

(c) All hospitalizations billed under "miscellaneous diagnosis-related group (DRG)," four hundred sixty-eight.

(2) Providers shall obtain approval for:

(a) Length-of-stay extensions, during or immediately after the extension;

(b) Readmissions, immediately after the readmission; and

(c) Hospitalizations under "miscellaneous DRG," four hundred sixty-eight, immediately after the hospitalization.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1750, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1800 Services—Contract facilities. The department shall reimburse certain services without requiring prior authorization when such services are provided in medical assistance administration (MAA)-approved contract facilities. These services include, but are not limited to, the following:

(1) All transplant procedures specified in WAC 388-550-1900(2);

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400;

(3) Polysomnograms and multiple sleep latency tests for clients one year of age and older (allowed only in outpatient hospital settings), as described under WAC 388-550-6350;

(4) Diabetes education (allowed only in outpatient hospital setting), as described under WAC 388-550-6400; and

(5) Weight loss program (allowed only in outpatient hospital setting), as described under WAC 388-550-6450.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1900 Transplant coverage. (1) The department shall pay for transplant procedures only for eligible clients who:

(a) Meet the criteria in WAC 388-550-2000; and

(b) Are not otherwise subject to a managed care plan.

(2) The department shall cover the following transplant procedures:

(a) Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas;

(b) Bone marrow and peripheral stem cell (PSC);

(c) Skin grafts; and

(d) Corneal transplants.

(3) For procedures covered under subsections (2)(a) and (b) of this section, the department shall pay facility charges only to those medical centers that meet the standards and conditions:

(a) Established by the department; and

(b) Specified in WAC 388-550-2100 and 388-550-2200.

(4) The department shall pay facility charges for skin grafts and corneal transplants to any qualified medical facility, subject to the limitations in this chapter.

(5) The department shall deem organ procurement fees included in the reimbursement to the transplant facility. The department may make an exception to this policy and reimburse these fees separately to a transplant facility when an eligible medical care client is covered by a third-party payer which will pay for the organ transplant procedure itself but not for the organ procurement.

(6) The department shall, without requiring prior authorization, pay for up to fifteen matched donor searches per client approved for a bone marrow transplant. The department shall require prior authorization for matched donor searches in excess of fifteen per bone marrow transplant client.

(7) The department shall not pay for experimental transplant procedures. In addition, the department shall consider experimental those services including, but not limited to, the following:

(a) Transplants of three or more different organs during the same hospital stay;

(b) Solid organ and bone marrow transplants from animals to humans; and

(c) Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

(8) The department shall pay for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay. The department shall cover bone marrow, PSC, skin grafts and corneal transplants whenever medically necessary.

(9) In reviewing coverage for transplant services, the department shall consider cost benefit analyses on a case-by-case basis.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2000 Medical criteria—Transplant services. (1) The department shall pay for transplant surgery in accordance with the provisions of this chapter for an eligible client who has:

(a) End-stage organ disease, except end-stage renal disease and diseases treatable with bone marrow or peripheral stem cell (PSC) transplants;

(b) A critical medical need for a transplant and a poor prognosis for survival without one, except for kidney, skin graft, or corneal transplants;

(c) Tried all other appropriate medical and surgical therapies that customarily yield both short and long term survival comparable to that of a transplant;

(d) Been identified by the transplant facility as a candidate for whom the transplant, as a therapy, has a high probability of a successful clinical outcome, defined as a better than sixty percent survival rate after one year; and

(e) Agreed to long-term adherence to a disciplined medical regimen.

(2) Medical care clients enrolled with the department's managed care carriers shall be subject to their respective carriers' criteria and policies.

(3) The department shall not cover transplant procedures for clients with the following medical conditions:

(a) An irreversible terminal state in which the client has had multi-organ system failure, is moribund, or on life support, defined as mechanical systems such as ventilators or heart-lung respirators which are used to supplement or supplant the normal autonomic functions of a person;

(b) Current active and incurable or metastatic malignancy within other organ systems;

(c) An active infection that will interfere with the client's recovery;

(d) Irreversible renal or hepatic disease that substantially affects longevity. MAA shall exempt from this criterion clients requesting a kidney, liver, bone marrow, PSC, skin graft or corneal transplant;

(e) Significant atherosclerotic vascular disease or atherosclerotic coronary disease that substantially affects longevity. MAA shall not apply this criterion to clients requesting a heart, bone marrow, PSC, skin graft or corneal transplant;

(f) Any other major irreversible disease likely to substantially limit life expectancy to three years or less;

(g) Inability to follow a drug regimen or maintain necessary therapies and/or other prescribed health care regimens;

(h) Ventilator dependence, except when used in short-term, acute situations. The department shall not consider ventilator dependence for transplants involving bone marrow, PSC, skin or cornea;

(i) Current use or history within the past year of alcohol or substance abuse and/or smoking, or failure to have abstained for long enough to indicate low likelihood of recidivism; and

(j) A history of behavior pattern or psychiatric illness that has not been assessed, treated or considered stable, that would likely lead to nonconformance or interference with a disciplined medical regimen.

(4) The department may deny coverage for corneal transplants for clients with an associated disease severe enough to prevent visual improvement, such as macular degeneration or diabetic retinopathy.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2100 Requirements—Transplant facilities. (1) The department shall require a transplant facility to meet the following requirements in order to be reimbursed for transplant services provided to medical care clients. The facility shall have:

(a) An approved certificate of need (CON) from the state department of health (DOH) for the type(s) of trans-

plant procedure(s) to be performed, except that MAA shall not require CON approval for peripheral stem cell (PSC), skin graft and corneal transplant facilities;

(b) Approval from the United Network of Organ Sharing (UNOS) to perform transplants, except that MAA shall not require UNOS approval for PSC, skin graft and corneal transplant facilities; and

(c) Been approved by the department as a center of excellence transplant center for the specific organ(s) or procedure(s) the facility proposes to perform. An out-of-state transplant center shall be a Medicare-certified facility participating in that state's Medicaid program.

(2) The department shall consider a facility for approval as a transplant center of excellence when the facility submits to the department a copy of its DOH-approved CON for transplant services, or documentation that it has, at a minimum:

(a) Organ-specific transplant physicians for each organ or transplant team. The transplant surgeon and other responsible team members shall be experienced and board-certified or board-eligible practitioners in their respective disciplines, including, but not limited to, the fields of cardiology, cardiovascular surgery, anesthesiology, hemodynamics and pulmonary function, hepatology, hematology, immunology, oncology, and infectious diseases. The department shall consider this requirement met when the facility submits to the department a copy of its DOH-approved CON for transplant services;

(b) Component teams which are integrated into a comprehensive transplant team with clearly defined leadership and responsibility. Transplant teams shall include, but not be limited to:

(i) A team-specific transplant coordinator for each type of organ;

(ii) An anesthesia team available at all times;

(iii) A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients;

(iv) Pathology resources for studying and reporting the pathological responses of transplantation;

(v) Infectious disease services with both the professional skills and the laboratory resources needed to discover, identify, and manage a whole range of organisms; and

(vi) Social services resources.

(c) An organ procurement coordinator;

(d) A method ensuring that transplant team members are familiar with transplantation laws and regulations;

(e) An interdisciplinary body and procedures in place to evaluate and select candidates for transplantation;

(f) An interdisciplinary body and procedures in place to ensure distribution of donated organs in a fair and equitable manner conducive to an optimal or successful patient outcome;

(g) Extensive blood bank support;

(h) Patient management plans and protocols;

(i) Written policies safeguarding the rights and privacy of patients; and

(j) Satisfied the annual volume and survival rates criteria for the particular transplant procedures performed at the facility, as specified in WAC 388-550-2200(2).

(3) In addition to the requirements of subsection (2) of this section, a facility being considered for approval as a transplant center of excellence shall submit a copy of its approval from the United Network for Organ Sharing (UNOS), or documentation showing that the facility:

(a) Participates in the national donor procurement program and network; and

(b) Systematically collects and shares data on its transplant program(s) with the network.

(4) The department shall apply the following specific requirements to PSC transplant facilities:

(a) A PSC transplant facility may receive approval from the department to do PSC:

(i) Harvesting, if it has its own apheresis equipment which meets federal or American Association of Blood Banks (AABB) requirements;

(ii) Processing, if it meets AABB quality of care requirements for human tissue/tissue banking; and/or

(iii) Reinfusion, if it meets the criteria established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

(b) A hospital may purchase PSC processing and harvesting services from other department-approved processing providers.

(c) The department shall not reimburse a PSC transplant facility for AABB inspection and certification fees related to PSC transplant services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2200 Transplant requirements—COE. (1) The department shall measure the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the department, the department shall apply these criteria to a facility during both initial and periodic evaluations for designation as a transplant COE. The COE performance criteria shall include, but not be limited to:

(a) Meeting annual volume requirements for the specific transplant procedures for which approved;

(b) Patient survival rates; and

(c) Relative cost per case.

(2) A transplant COE shall meet or exceed annually the following applicable volume criteria for the particular transplant procedures performed at the facility, except for cornea transplants which do not have established minimum volume requirements. Annual volume requirements for transplant centers of excellence include:

(a) Twelve or more heart transplants;

(b) Ten or more lung transplants;

(c) Ten or more heart-lung transplants;

(d) Twelve or more liver transplants;

(e) Twenty-five or more kidney transplants;

(f) Eighteen or more pancreas transplants;

(g) Eighteen or more kidney-pancreas transplants;

(h) Ten or more bone marrow transplants; and

(i) Ten or more peripheral stem cell (PSC) transplants.

Dual-organ procedures may be counted once under each organ and the combined procedure.

(3) A transplant facility within the state that fails to meet the volume requirements in subsection (1) of this section may submit a written request to the department for

conditional approval as a transplant center of excellence. The department shall consider the minimum volume requirement met when the requestor submits an approved certificate of need for transplant services from the state department of health.

(4) An in-state facility granted conditional approval by the department as a transplant center of excellence shall meet the department's criteria, as established in this chapter, within one year of the conditional approval. The department shall automatically revoke such conditional approval for any facility which fails to meet the department's published criteria within the allotted one year period, unless:

(a) The facility submits a written request for extension of the conditional approval thirty calendar days prior to the expiration date; and

(b) Such request is granted by the department.

(5) A transplant center of excellence shall meet Medicare's survival rate requirements for the transplant procedure(s) performed at the facility.

(6) A transplant center of excellence shall submit to the department annually, at the same time the hospital submits a copy of its Medicare Cost Report (HCFA 2552 report) documentation showing:

(a) The numbers of transplants performed at the facility during its preceding fiscal year, by type of procedure; and

(b) Survival rates data for procedures performed over the preceding three years as reported on the United Network of Organ Sharing report form.

(7)(a) Transplant facilities shall submit to the department, within sixty days of the date of the facility's approval as a center of excellence, a complete set of the comprehensive patient selection criteria and treatment protocols used by the facility for each transplant procedure it has been approved to perform.

(b) The facility shall submit to the department updates to said documents annually thereafter, or whenever the facility makes a change to the criteria and/or protocols.

(c) If no changes occurred during a reporting period the facility shall so notify the department to this effect.

(8) The department shall evaluate compliance with the provisions of WAC 388-550-2100 (2)(d) and (e) based on the protocols and criteria submitted to the department by transplant centers of excellence in accordance with subsection (7) of this section. The department shall terminate a facility's designation as a transplant center of excellence if a review or audit finds that facility in noncompliance with:

(a) Its protocols and criteria in evaluating and selecting candidates for transplantation; and

(b) Distributing donated organs in a fair and equitable manner that promotes an optimal or successful patient outcome.

(9)(a) The department shall provide transplant centers of excellence it finds in noncompliance with subsection (8) of this section sixty days within which such centers may submit a plan to correct a breach of compliance;

(b) The department shall not allow the sixty-day option as stated in (a) of this subsection for a breach that constitutes a danger to the health and safety of clients as stated in WAC 388-87-005 (3)(d);

(c) Within six months of submitting a plan to correct a breach of compliance, a center shall report to the department showing:

(i) The breach of compliance has been corrected; or

(ii) Measurable and significant improvement toward correcting such breach of compliance.

(10) The department shall periodically review the list of approved transplant centers of excellence. The department may limit the number of facilities it designates as transplant centers of excellence or contracts with to provide services to medical care clients if, in the department's opinion, doing so would promote better client outcomes and cost efficiencies.

(11) The department shall reimburse department-approved centers of excellence for covered transplant procedures using any of the methods identified in chapter 388-550 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2300 Payment—PM&R. (1) The department may pay for acute inpatient physical medicine and rehabilitation (PM&R) evaluation and individualized treatment for a client for a period of up to four weeks when all of the following conditions are met:

(a) The client suffers from severe disabilities including, but not limited to, motor and/or cognitive deficits;

(b) The client's condition is of hospital-level acuity and:

(i) The condition is medically stable;

(ii) The client is able to actively participate in rehabilitation at least three hours per day, five days per week;

(iii) The client is alert, cooperative, and follows commands;

(iv) The client can mobilize out of bed;

(v) The client is ready to participate in rehabilitation; and

(vi) The client must have new deficits or recent loss of his/her previous level of function.

(c) The client must show an impairment in two or more of the following areas:

(i) Mobility and strength;

(ii) Self care/activities of daily living (ADLs);

(iii) Communication;

(iv) Continence, evacuation of bowel and/or bladder;

(v) Kitchen/food preparation, safety and skill;

(vi) Cognitive perceptual functioning; or

(vii) Pathfinding skills and safety.

(d) PM&R treatment would potentially enable the client to obtain a greater degree of self-care and/or independence;

(e) The client's medical condition requires that intensive PM&R services be provided in an inpatient setting;

(f) The department authorizes services; and

(g) The services are provided in a contract facility approved by the department to provide inpatient PM&R services.

(2) The department shall pay a hospital admitting a PM&R client who does not meet the above criteria the administrative day rate set at the statewide average daily nursing home rate as determined by the department.

(3) The department may authorize an extension to the inpatient treatment period specified in subsection (1) of this

section if the PM&R facility submits adequate written medical justification to the department prior to the expiration of the initial approved stay.

(4) The department shall consider only written applications from facilities requesting designation as approved contract facilities for inpatient PM&R services. To be an inpatient PM&R contract facility, a hospital shall be a commission on accreditation of rehabilitation facilities (CARF)-approved level I or level II rehabilitation facility, as approved by the department.

(5) The department may approve a skilled nursing facility or a hospital as a level II PM&R contract inpatient rehabilitation facility if it meets the following criteria. The skilled nursing facility is:

(a) Medicare and Medicaid-certified;

(b) Accredited by the CARF. The facility shall submit to the department documentation showing its CARF accreditation; and

(c) In good standing with the department.

(6) The department may conditionally approve an inpatient rehabilitation facility as a level II PM&R contract rehabilitation facility if it meets the criteria in subsections (5)(a) and (c) above, and provides documentation showing it:

(a) Is actively operating under CARF standards; and

(b) Has begun the process of obtaining full CARF accreditation.

(7) An inpatient rehabilitation facility conditionally approved as a level II contract rehabilitation facility shall obtain full CARF accreditation within twelve months of being granted conditional approval by the department. The department shall automatically revoke conditional approval for any facility which fails to obtain full CARF accreditation within the allotted one year period.

(8) The department shall determine the most appropriate acute inpatient PM&R facility (inpatient hospital or skilled nursing facility) placement which provides clients the least restrictive environment at the least cost to the department.

(9) A level I PM&R contract rehabilitation facility shall be reimbursed by the department according to the individual hospital's current ratio of cost-to-charge, as described in WAC 388-550-4500.

(10)(a) The department shall reimburse an approved level II PM&R contract rehabilitation facility, whether a hospital or skilled nursing facility, according to the all-inclusive contracted reimbursement allowance, except that such allowance shall not be deemed to include customized adaptive appliances or specialized therapeutic bed, wheelchair, ventilator, or orthotics for home use.

(b) Reimbursement for other medical services provided by the facility which are unrelated to the client's PM&R stay shall be determined by the department on a case-by-case basis.

(11) A hospital not approved by the department as a contract PM&R facility may be reimbursed under the diagnosis-related group methodology, using the initial admitting diagnosis, for rehabilitation services it provides to medical assistance clients.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2400 Chronic pain management program. (1)(a) The department shall cover inpatient chronic pain management training to assist eligible clients to manage chronic pain.

(b) The department shall pay for only one inpatient hospital stay, up to a maximum of twenty-one days, for chronic pain management training per eligible client's lifetime.

(c) Refer to WAC 388-550-1700 (2)(i) and 388-550-1800 for prior authorization.

(2) The department shall reimburse approved chronic pain management facilities an all-inclusive per diem facility fee under the revenue code published in the department's chronic pain management fee schedule. MAA shall reimburse professional fees for chronic pain management services to performing providers in accordance with the department's fee schedule.

(3) The department shall not reimburse a contract facility for unrelated services provided during the client's inpatient stay for chronic pain management, unless the facility requested and received prior approval from the department for those services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2500 Inpatient hospice services. (1) The department shall reimburse hospice agencies participating in the medical assistance program for general inpatient and inpatient respite services provided to clients in hospice care, when:

(a) The hospice agency coordinates the provision of such inpatient services; and

(b) Such services are related to the medical condition for which the client sought hospice care.

(2) Hospice agencies shall bill the department for their services using revenue codes. The department shall reimburse hospice providers a set per diem fee according to the type of care provided to the client on a daily basis.

(3) The department shall reimburse hospital providers directly pursuant to this chapter for inpatient care provided to clients in the hospice program for medical conditions not related to their terminal illness.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2600 Inpatient psychiatric services. For psychiatric hospitalizations, including involuntary admissions, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2700 Substance abuse detoxification services. For hospital-based alcohol and/or drug detoxification services, see chapter 246-326 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2750 Hospital discharge planning services. For discharge planning service requirements, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2750, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2800 Establishing inpatient payment rates. (1) Inpatient hospital services shall be reimbursed using the methodologies identified by the department in its approved state plan. In determining a hospital's basic payment rate, the department shall use either:

(a) A negotiated conversion factor, for hospitals participating in the federally waivered Medicaid hospital selective contracting program;

(b) A cost-based conversion factor, for hospitals not located in selective contracting areas and for hospitals and/or services exempt from selective contracting; or

(c) The ratio of cost to charge, for hospitals and services exempt from conversion factor-based payment methods, as described in WAC 388-550-4200 and WAC 388-550-4300.

(2) As required by 42 CFR § 447.271, the department's total annual aggregate Medicaid payments to each hospital for inpatient hospital services provided to Medicaid clients shall not exceed the hospital's customary charges to the general public for the services. The department will recoup amounts of total annual aggregate Medicaid payments in excess of such charges.

(3) The department's annual aggregate payments for inpatient hospital services, including annual aggregate payments to state-operated hospitals, shall not exceed amounts that can reasonably be estimated would have been paid under the Medicare payment principles.

(4) Reimbursement to a hospital shall not increase by more than the amount allowed under 42 U.S.C. Section 1385x (v)(1)(O) as a result of a change of ownership.

(5) Hospitals participating in the medical assistance program shall submit annually to the department:

(a) A copy of their HCFA 2552 uniform cost report; and

(b) A disproportionate share hospital application with the department. Participating providers shall permit the department to conduct periodic audits of their financial and statistical records.

(6) The reports referred to in subsection (5) of this section shall be completed in accordance with Medicare cost reporting requirements, the provisions of this chapter, and such instructions as may be issued by the department from time to time. Unless federally or state-regulated or instructed by the department, providers shall follow generally accepted accounting principles.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2900 Payment limits—Inpatient hospital services. (1) The department shall pay covered inpatient hospital services only to:

(a) General hospitals that meet the definition in RCW 70.41.020;

(b) Inpatient psychiatric facilities and alcohol or drug treatment centers approved by the department; and

(c) Out-of-state hospital providers subject to conditions specified in WAC 388-550-6700.

(2) The department shall not pay for hospital care and/or services provided to a client enrolled with a department-contracted managed care carrier, unless the medical assistance administration (MAA) specifically authorized the provision of and payment for a service not covered by the health carrier's capitation contract with the department but covered under the client's medical assistance program.

(3) The department shall not pay a hospital for care or services provided to a client enrolled in the hospice program, except as provided under WAC 388-550-2500(3).

(4) The department shall not pay hospitals for inpatient ancillary services in addition to the diagnosis-related group (DRG) payment. The DRG payment includes ancillary services which include, but are not limited to, the following:

(a) Laboratory services;

(b) Diagnostic X-ray and other imaging services, including, but not limited to, magnetic resonance imaging, magnetic resonance angiography, computerized axial tomography, and ultrasound;

(c) Drugs and pharmacy services;

(d) Respiratory therapy and related services;

(e) Physical therapy and related services;

(f) Occupational therapy;

(g) Speech therapy and related services;

(h) Durable medical equipment and medical supplies, including infusion equipment and supplies;

(i) Prosthetic devices used during the client's hospital stay or permanently implanted during the hospital stay, such as artificial heart or replacement hip joints; and

(j) Service charges for handling and processing blood or blood derivatives.

(5) Neither the department nor the client shall be responsible for payment for additional days of hospitalization when:

(a) A client exceeds the professional activities study (PAS) length of stay (LOS) limitations; and

(b) The provider has not obtained department approval for the LOS extension, as specified in WAC 388-550-1700 (3)(a).

(6) The LOS limit for a hospitalization shall be the seventy-fifth percentile of the PAS length of stay for that diagnosis code or combination of codes, published in the PAS Length of Stay-Western Region edition, as periodically updated.

(7) Neither the department nor the client shall be responsible for payment of elective or nonemergent inpatient services included in the department's selective contracting program and received in a nonparticipating hospital in a selective contracting area (SCA) unless the provider received prior approval from the department as required by WAC 388-550-1700 (2)(a). The client, however, may be held responsible for payment of such services if he or she contracts in writing with the hospital at least seventy-two hours in advance of the hospital admission to be responsible for payment. See WAC 388-550-4600, Selective contracting program.

(8) The department shall consider hospital stays of twenty-four hours or less short stays, and shall not pay such stays under the DRG methodology, except that stays of

twenty-four hours or less involving the following situations shall be paid under the DRG system:

(a) Death of a client;

(b) Obstetrical delivery;

(c) Initial care of a newborn; or

(d) Transfer of a client to another acute care hospital.

(9)(a) Under the ratio of costs-to-charge (RCC) method, the department shall not pay for inpatient hospital services provided more than one day prior to the date of a scheduled or elective surgery, nor shall these services be charged to the client.

(b) Under the DRG method, the department shall deem all services provided prior to the day before a scheduled or elective surgery included in the hospital's DRG payment for the case.

(c) The department shall not count toward the threshold for hospital outlier status:

(i) Any charges for extra days of inpatient stay prior to a scheduled or elective surgery; and

(ii) The associated services provided during those extra days.

(10) The department shall apply the following rules to RCC cases and high-cost DRG outlier cases for costs over the high-cost outlier threshold:

(a) The department shall pay hospitals for accommodation costs at the multiple occupancy rate even when a private room is provided to the client. The department shall pay accommodation costs at the semi-private or ward room rate, consistent with the type of accommodations provided.

(b) The department shall cover hospital stat charges only for specific laboratory procedures determined and published by the department as qualified stat procedures. The department shall not automatically treat tests generated in the emergency room as justifying a stat order.

(c) The department shall reimburse hospitals for special care charges only when:

(i) The hospital has a department of health (DOH) or Medicare-qualified special care unit;

(ii) The special care service being billed, such as intensive care, coronary care, burn unit, psychiatric intensive care, or other special care, was provided in the special care unit;

(iii) The special care service provided is the kind of service for which the special care unit has been DOH- or Medicare-qualified; and

(iv) The client's medical condition required the care be provided in the special care unit.

(11) The department shall determine its actual payment for a hospital admission by deducting from the basic hospital payment those charges which are the client's responsibility, referred to as spend-down, or a third party's liability.

(12) The department shall reduce reimbursement rates to hospitals for services provided to MI/medical care services clients according to the individual hospital's ratable and/or equivalency factors, as provided in WAC 388-550-4800.

(13) The department shall pay for the hospitalization of a client who is eligible for Medicare and Medicaid only when the client has exhausted his or her Medicare part A benefits, including the nonrenewable lifetime hospitalization reserve of sixty days.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3000 DRG payment system. (1) Except where otherwise specified, the department shall use the diagnosis-related group (DRG) system, which categorizes patients into clinically coherent and homogenous groups with respect to resource use, as the reimbursement method for inpatient hospital services.

(2) The department shall periodically evaluate which all-patient grouper (AP-DRG) version to use.

(3)(a) The department shall calculate the DRG payment for a particular hospital by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, for that admission by the hospital's cost-based conversion factor, as determined in WAC 388-550-3450.

(b) If the hospital is participating in the selective contracting program, the department shall multiply the DRG relative weight for the admission by the hospital's negotiated conversion factor, as specified in WAC 388-550-4600(4).

(4)(a) The department shall pay for a hospital readmission within seven days of discharge for the same client when department review concludes the readmission did not occur as a result of premature hospital discharge.

(b) When a client is readmitted to the same hospital within seven days of discharge, and department review concludes the readmission resulted from premature hospital discharge, the department shall treat the previous and subsequent admissions as one hospital stay and pay a single DRG for the combined stay.

(5) If two different DRG assignments are involved in a readmission as described in subsection (4) of this section, the department shall review the hospital's records to determine the appropriate reimbursement.

(6) The department shall recognize Medicare's DRG payment for a Medicare-Medicaid dually eligible client to be payment in full.

(a) The department shall pay the Medicare deductible and co-insurance related to the inpatient hospital services provided to clients eligible for Medicare and Medicaid.

(b) The department shall ensure total Medicare and Medicaid payments to a provider for such client does not exceed Medicare's maximum allowable charges.

(c) The department shall pay for those allowed charges beyond the threshold using the outlier policy described in WAC 388-550-3700 in cases where:

(i) Such client's Medicare part A benefits including lifetime reserve days are exhausted; and

(ii) The Medicaid outlier threshold status is reached.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3100 Calculating DRG relative weights. (1) The department shall set Washington Medicaid-specific diagnosis-related group (DRG) relative weights, as follows:

(a) The department shall classify Washington Medicaid hospital admissions data and the hospital admissions data in the Washington state department of health's comprehensive

hospital abstract reporting system (CHARS), using the all-patient grouper (AP-DRG).

(b) The department shall test each DRG statistically for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(c) The department shall establish relative weights from Washington Medicaid hospital admissions data. These relative weights may be stable or unstable.

(d) The department shall establish relative weights from CHARS-derived data which include Medicaid data. These relative weights may be stable or unstable.

(e) The department shall test the stability of Washington Medicaid relative weights established in subsection (1)(c) of this section using the null hypothesis test at seventy-five percent confidence interval. The department shall accept as stable and adopt those Washington Medicaid relative weights that pass the null hypothesis test.

(f) The department shall test the stability of CHARS-derived relative weights established in subsection (1)(d) of this section using the same procedure as in subsection (e) of this section. The department shall replace unstable Washington Medicaid relative weights with stable CHARS-derived relative weights.

(g) The department shall replace remaining unstable Washington Medicaid relative weights with New York proxy relative weights. For the purposes of this chapter, remaining unstable Washington Medicaid relative weights are those that fail the null hypothesis test and for which there are no stable CHARS-derived relative weight replacements.

(2) Using ratios with a Washington Medicaid relative weight as base, the department shall:

(a) Standardize the relative weights by adjusting the CHARS and New York proxy relative weights; and

(b) Assure all Medicaid stable and proxy weights equal a statement case mix of 1.0.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3150 Base period costs and claims data. (1) The department shall set a hospital's cost-based conversion factor using base period cost data from its Medicare cost report (Form HCFA 2552) for its fiscal year corresponding with the base period.

(2) The department shall use in rate-setting only base period cost data that have been desk reviewed and/or field audited by the Medicare intermediary.

(3) The department shall, to the extent feasible, factor out of a hospital's base period cost data nonallowable hospital charges associated with the items/services listed in WAC 388-550-1600(1) before calculating the hospital's conversion factor.

(4) The department shall use the figures for total costs, capital costs, and direct medical education costs from a hospital's HCFA 2552 report in calculating that hospital's allowable costs for each of the thirty-eight categories of cost/revenue centers, listed in subsections (5) and (6) below, used to categorize Medicaid claims.

(5) The department shall use nine categories to assign a hospital's accommodation costs and days of care. These accommodation categories are:

(a) Routine;
(b) Intensive care;
(c) Intensive care-psychiatric;
(d) Coronary care;
(e) Nursery;
(f) Neonatal intensive care unit;
(g) Alcohol/substance abuse;
(h) Psychiatric; and
(i) Oncology.

(6) The department shall use twenty-nine categories to assign ancillary costs and charges. These ancillary categories are:

(a) Operating room;
(b) Recovery room;
(c) Delivery/labor room;
(d) Anesthesiology;
(e) Radiology-diagnostic;
(f) Radiology-therapeutic;
(g) Radioisotope;
(h) Laboratory;
(i) Blood storage;
(j) Intravenous therapy;
(k) Respiratory therapy;
(l) Physical therapy;
(m) Occupational therapy;
(n) Speech pathology;
(o) Electrocardiography;
(p) Electroencephalography;
(q) Medical supplies;
(r) Drugs;
(s) Renal dialysis;
(t) Ancillary oncology;
(u) Cardiology;
(v) Ambulatory surgery;
(w) Computerized tomography scan/magnetic resonance imaging;
(x) Clinic;
(y) Emergency;
(z) Ultrasound;
(aa) Neonatal intensive care unit transportation;
(bb) Gastrointestinal laboratory; and
(cc) Miscellaneous.

(7) The department shall:

(a) Extract from the Medicaid Management Information System all Medicaid paid claims data for each hospital's base year;

(b) Assign line item charges from the paid hospital claims to the appropriate accommodation and ancillary cost center categories; and

(c) Use the cost center categories to apportion Medicaid costs.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3200 Medicaid cost proxies. (1) For cases in which a hospital has Medicaid charges (claims) for certain accommodation or ancillary cost centers which are not separately reported on its Medicare cost report, the department shall establish cost proxies to estimate such costs in order to ensure recognition of Medicaid related costs.

(2) The department shall develop per diem proxies for accommodation cost centers using the median value of the hospital's per diem cost data within the affected hospital peer group.

(3) The department shall develop ratio of cost-to-charge (RCC) proxies for ancillary cost centers using the median value of the hospital's RCC data within the affected hospital peer group.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3250 Indirect medical education costs. (1) For a hospital with a graduate medical education program, the department shall remove indirect medical education-related costs from the aggregate operating and capital costs of each hospital in the peer group before calculating a peer group's cost cap.

(2) To arrive at indirect medical education costs for each component, the department shall:

(a) Multiply Medicare's indirect cost factor of 0.579 by the ratio of the number of interns and residents in the hospital's approved teaching programs to the number of hospital beds; and

(b) Multiply the product obtained in subsection (2)(a) of this section by the hospital's operating and capital components.

(3) After the peer group's cost cap has been calculated, the department shall add back to the hospital's aggregate costs its indirect medical education costs. See WAC 388-550-3450(6).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3300 Hospital peer groups and cost caps. (1) For rate-setting purposes the department shall group hospitals into peer groups and establish cost caps for each peer group. The department shall set hospital reimbursement rates at levels that recognize the cost of reasonable, efficient, and effective providers.

(2) The department shall use the Washington state department of health's (DOH) four hospital peer groupings for rate-setting purposes. The four peer groups are:

(a) Group A, rural hospitals;

(b) Group B, urban hospitals without medical education programs;

(c) Group C, urban hospitals with medical education program; and

(d) Group D, specialty hospitals or other hospitals not easily assignable to the other three groups.

(3) The department shall use a cost cap at the seventieth percentile for a peer group.

(a) The department shall cap at the seventieth percentile the costs of hospitals in peer groups B and C whose costs exceed the seventieth percentile for their peer group.

(b) The department shall exempt peer group A hospitals from the cost cap because they are paid under the ratio of cost-to-charge methodology.

(c) The department shall exempt peer group D hospitals from the cost cap because they are specialty hospitals without a common peer group on which to base comparisons.

(4) The department shall calculate a peer group's cost cap based on the hospitals' base period cost after subtracting:

(a) Indirect medical education costs, as determined in WAC 388-550-3250(2), from the aggregate operating and capital costs of each hospital in the peer group; and

(b) The cost of outlier cases from the aggregate costs in accordance with WAC 388-550-3350(1).

(5)(a) The department shall use the lesser of each individual hospital's calculated aggregate cost or the peer group's seventieth percentile cost cap as the base amount in calculating the individual hospital's adjusted cost-based conversion factor.

(b) After the peer group cost cap is calculated, the department shall add back to the individual hospital's base amount its indirect medical education costs and appropriate outlier costs, as determined in WAC 388-550-3350(2).

(6) The department shall recognize in its rate-setting process changes in peer group status as a result of DOH approval or recommendation. However, in cases where corrections or changes in individual hospitals' base-year cost or peer group assignment occur after peer group cost caps are calculated, the department shall update the peer group cost caps involved only if the change in the individual hospital's base-year cost or peer group assignment would result in a five percent or greater change in the seventieth percentile of costs calculated for its peer group.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3350 Outlier costs. (1)(a) The department shall remove the cost of low- and high-cost outlier cases from individual hospitals' aggregate costs before calculating the peer group cost cap.

(b) After this initial step, all subsequent calculations involving outliers in subsections (2) through (5) of this section pertain only to high-cost outliers.

(c) For a definition of outliers see WAC 388-550-1050, Definitions.

(2) After an individual hospital's base period costs and its peer group cost cap are determined, the department shall add the individual hospital's indirect medical education costs and an outlier cost adjustment back to:

(a) The lesser of the hospital's calculated aggregate cost; or

(b) The peer group's seventieth percentile cost cap.

(3) The outlier cost adjustment is determined as follows to reduce the original high-cost outlier amount in proportion to the reduction in the hospital's base period costs as a result of the capping process:

(a) If the individual hospital's aggregate operating, capital, and direct medical education costs for the base period are less than the seventieth percentile costs for the peer group, the entire high-cost outlier amount is added back.

(b) A reduced high-cost outlier amount is added back if:

(i) The individual hospital's aggregate base period costs are higher than the seventieth percentile for the peer group; and

(ii) The hospital is capped at the seventieth percentile.

(iii) The amount of the outlier added back is determined by multiplying the original high-cost outlier amount by the percentage obtained when the hospital's final cost cap, which is the peer group's seventieth percentile cost, is divided by its uncapped base period costs, as determined in WAC 388-550-3300(4).

(4) The department shall pay high-cost outlier claims from the outlier set-aside pool. The department shall calculate an individual hospital's high-cost outlier set-aside as follows:

(a) For each hospital, the department extracts utilization and paid claims data from the Medicaid Management Information System (MMIS) for the most recent twelve-month period for which the department estimates the MMIS has complete payment information.

(b) Using the data in (a) of this subsection, the department determines the projected annual amount above the high-cost DRG outlier threshold that the department paid to each hospital.

(c) The department's projected high-cost outlier payment to the hospital determined in (b) of this subsection is divided by the department's total projected annual DRG payments to the hospital to arrive at a hospital-specific high-cost outlier percentage. This percentage becomes the hospital's outlier set-aside factor.

(5) The department shall use the individual hospital's outlier set-aside factor to reduce the hospital's CBCF by an amount that goes into a set-aside pool to pay for all high-cost outlier cases during the year. The department shall fund the outlier set-aside pool on hospitals' prior high-cost outlier experience. No cost settlements shall be made to hospitals for outlier cases.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3400 Case-mix index. (1)(a) The department shall adjust hospital costs for case mix under the diagnosis-related group (DRG) payment systems.

(b) The department shall calculate a case-mix index (CMI) for each individual hospital to measure the relative cost for treating Medicaid cases in a given hospital.

(2) The department shall calculate the CMI for each hospital using Medicaid admissions data from the individual hospital's base period cost report, as described in WAC 388-550-3150. The hospital-specific CMI is calculated as follows:

(a) The department shall multiply the number of Medicaid admissions to the hospital for a specific DRG by the relative weight for that DRG. The department shall repeat this process for each DRG billed by the hospital.

(b) The department shall add together the products in (a) of this subsection for all of the Medicaid admissions to the hospital in the base year.

(c) The department shall divide the sum obtained in (b) of this subsection by the corresponding number of Medicaid hospital admissions.

(d) Example: If the average case mix index for a group of hospitals is 1.0, a CMI of 1.0 or greater for a hospital in that group means that the hospital has treated a mix of patients in the more costly DRGs. A CMI of less than 1.0 indicates a mix of patients in the less costly DRGs.

(3) The department shall recalculate each hospital's case mix index periodically, but no less frequently than each time rebasing is done.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3450 Payment method—CBCF rate calculation. (1)(a) The department shall use each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the nine accommodation categories described in WAC 388-550-3150(5).

(b) The department shall divide operating, capital, and direct medical education costs by total hospital days per category to arrive at a per day accommodation cost.

(c) The department shall multiply the per day accommodation cost by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

(2)(a) The department shall also use the base period cost data to calculate total operating, capital and direct medical education costs for each of the hospital's twenty-nine ancillary categories.

(b) The department shall divide these costs by total charges per category to arrive at a cost-to-charge ratio per ancillary category.

(c) The department shall multiply these cost-to-charge ratios by Medicaid charges per category, as tracked by the Medicaid Management Information System (MMIS), to arrive at total Medicaid ancillary costs per category for the three components.

(3) The department shall combine Medicaid accommodation and ancillary costs to derive the hospital's operating, capital and direct medical education components for the base year. The department shall divide these components' combined total will be divided by the number of Medicaid cases during the base year to arrive at an average cost per DRG admission for the hospital.

(4) The department shall adjust the average cost per admission for each component to a common fiscal year end using the appropriate McGraw-Hill Data Resources, Inc., (DRI) Prospective Payment System (PPS)-Type Hospital Market Basket update. The department shall standardize these three admission cost components by dividing the average cost by the hospital's case-mix index.

(5)(a) For hospitals with medical education programs, the department shall remove the indirect medical education costs from operating and capital costs before the peer group cost cap is set.

(b) The department shall also remove the cost of outlier cases in accordance with WAC 388-550-3350(1).

(c) For hospitals in peer group B and C, the department shall set aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap.

(6) The department shall add to the lesser of the hospital-specific aggregate cost or the peer group cost cap determined in subsection (5) of this section:

(a) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(b) An outlier cost adjustment in accordance with WAC 388-550-3350(2).

(7)(a) The department shall multiply the sum obtained in subsection (6) of this section by the DRI PPS-type hospital market basket update for the period January 1 of the year after the base year through September 30 of the rebase year.

(b) The department shall then reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted cost-based conversion factor for July 1 of the rebase year.

(8) The department shall multiply the hospital's adjusted cost-based conversion factor determined in subsection (7) of this section by the applicable DRG relative weight to calculate the DRG payment for each admission.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3500 Inflation adjustments. (1) Effective on October 1 of each year, the department shall adjust all cost-based conversion factors for inflation for the federal fiscal year October 1 through September 30.

(2) The department shall use as annual inflation factor the prospective payment system (PPS)-type hospital market-basket index factor from the most recent McGraw-Hill Data Resources, Inc., (DRI) forecast.

(3) The department shall consider adjustments to negotiated conversion factors according to the terms of the individual hospital's contract.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3600 Payment—Hospital transfers. The department shall apply the following payment rules when a client is transferred from one hospital to another:

(1) The department shall deny payment to a hospital that transfers a nonemergent case to another hospital without the department's prior approval.

(2) The department shall pay a hospital transferring a client to another acute care hospital the lesser of:

(a) A per diem rate multiplied by the number of medically necessary days at the transferring hospital. The department shall determine the per diem rate by dividing the hospital's diagnosis-related group (DRG) payment amount for the appropriate DRG by that DRG's average length of stay; or

(b) The appropriate DRG payment.

(3) The department shall use the hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer. The department shall use the medical assistance administration's length of stay data to determine the number of medically necessary days for a hospital stay.

(4) The department shall pay the hospital that ultimately discharges the client to any residence other than a hospital (e.g., home, nursing facility, etc.) the full DRG payment. The department shall apply the outlier payment methodology if a transfer case qualifies as a high- or low-cost outlier.

(5) The department shall not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital which subsequently sends the client back to the original hospital from which the client is discharged.

(6)(a) The extent of the department's payment to the discharging hospital shall be the full DRG payment.

(b) The department shall pay the intervening hospital a per diem payment based on the method described in subsection (2) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3700 DRG outliers and administrative day rates. (1) The department shall calculate high-cost diagnosis-related group (DRG) outlier payments for qualifying cases as follows:

(a) To qualify as a DRG high-cost outlier, the allowed charges for the case must exceed a threshold of three times the applicable DRG payment or twenty-eight thousand dollars, whichever is greater.

(b) Reimbursement for high-cost outlier cases other than those in subsections (1)(c) and (d) of this section shall be the applicable DRG payment amount, plus seventy-five percent of the hospital's ratio of cost-to-charge (RCC) ratio applied to the allowed charges exceeding the outlier threshold.

(c) Reimbursement for psychiatric high-cost outliers for DRGs 424-432 shall be at the applicable DRG rate plus hundred percent of the hospital RCC applied to the allowed charges exceeding the outlier threshold.

(d) Reimbursement for high-cost outlier cases at in-state children's hospitals shall be the applicable DRG payment amount, plus eighty-five percent of the hospital's RCC applied to the allowed charges exceeding the outlier threshold.

(2) The department shall calculate low-cost DRG outlier payments for qualifying cases as follows:

(a) To qualify as a DRG low-cost outlier, the allowed charges for the case shall be less than or equal to ten percent of the applicable DRG payment or four hundred dollars, whichever is greater.

(b) The department's reimbursement for low-cost DRG outlier claims shall be the allowed charges multiplied by the hospital's RCC.

(3) The department shall pay hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client no longer needs an acute inpatient level of care, but is not discharged because an appropriate noninpatient hospital placement is not available.

(a) The department shall set reimbursement for administrative days at the statewide average Medicaid nursing facility per diem rate. The administrative day rate shall be adjusted annually effective October 1.

(b) Ancillary services shall not be reimbursed during administrative days.

(c) For a DRG payment case, the department shall not pay administrative days until the case exceeds the high-cost outlier threshold for that case.

(d) For DRG-exempt cases, the department shall identify administrative days during the length of stay review process after the client's discharge from the hospital.

(e) If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, the department shall reimburse the hospital at the administrative day per diem rate from the date of admission.

(4) The department shall make day outlier payments to hospitals, in accordance with section 1923 (a)(2)(C) of the Social Security Act, for exceptionally long-stay clients. A hospital shall be eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share (DSH) hospital and the client served is under the age of six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The charge for the hospitalization is below the high-cost outlier threshold (three times the DRG rate or twenty-eight thousand dollars, whichever is greater); and

(d) The client's length of stay is over the day outlier threshold for the applicable DRG. The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

(5) The department shall base the day outlier payment on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate.

(6) The department's total reimbursement for day outlier claims shall be the applicable DRG payment plus the day outlier or administrative days payment.

(7) Day outliers shall only be paid for cases that do not reach high-cost outlier status. A client's claim shall be either a day outlier or a high-cost outlier, but not both.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3800 Rebasing and recalibration. (1) The department shall rebase the Medicaid payment system periodically using each hospital's cost report for its fiscal year that ends during the calendar year designated by the department to be used for each update.

(2) The department shall recalibrate diagnosis-related group weights periodically, as described in WAC 388-550-3100, but no less frequently than each time rebasing is done. The department shall make recalibrated weights effective July 1 of that year.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3900 Border area hospitals payment method. (1) Under the diagnosis-related group (DRG) payment method, the department shall calculate the cost-based conversion factor (CBCF) of a border area hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(a) For a border area hospital with insufficient Medicare cost report (HCFA Form 2552) data, the department shall assign a CBCF based on the peer group average final conversion factor for its Washington hospital peer group.

(b) The department shall include in this average final conversion factor all adjustments to the CBCF, including the outlier set-aside factor described in WAC 388-550-3350(3).

(2) Under the ratio of cost-to-charge (RCC) payment method, the department shall calculate a border area hospital's RCC in accordance with WAC 388-550-4500. For a border area hospital with insufficient Medicare cost report (HCFA Form 2552) data, the department shall assign an RCC based on the weighted average of the RCC ratios for in-state Washington hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4000 Out-of-state hospitals payment method. The department shall pay out-of-state hospitals the lesser of billed charges or the amount calculated using the weighted average of ratio of cost-to-charge ratios for in-state Washington hospitals multiplied by the allowed charges for medically necessary services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4100 New hospitals payment method. (1) For rate-setting purposes, the department shall consider as a new hospital an entity which began services after the most recent base period used for calculating cost-based conversion factors (CBCFs).

(2) The department shall base a new hospital's cost-based rates on the peer group average final conversion factor for its Washington hospital peer group. The department shall include in this average final conversion factor all adjustments to the CBCF, including the outlier set aside factor described in WAC 388-550-3350(3).

(3) The department shall base a new hospital's ratio of cost-to-charge (RCC) rates on the statewide weighted average RCC rate.

(4) The department shall not consider a change in ownership as constituting creation of a new hospital.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4200 Change in hospital ownership. (1) For purposes of this section, a change in hospital ownership may involve one or more, but is not limited to, the following events:

(a) A change in the composition of the partnership;

(b) A sale of an unincorporated sole proprietorship;

(c) The statutory merger or consolidation of two or more corporations;

(d) The leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;

(e) The transfer of a government-owned institution to a governmental entity or to a governmental corporation;

(f) Donation of all or part of a provider's facility to another entity if the donation affects licensure or certification of the provider entity;

(g) Disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity; or

(h) A change in the provider's federal identification tax number.

(2) A hospital shall notify the department in writing ninety days prior to the date of an expected change in the hospital's ownership, but in no case later than thirty days after the change in ownership takes place.

(3) When a change in a hospital's ownership occurs, the department shall set the new provider's cost-based conversion factor (CBCF) at the same level as the prior owner's, except as provided in subsection (4) below.

(4) The department shall set for a hospital formed as a result of a merger:

(a) A blended CBCF based on the old hospitals' rates, proportionately weighted by admissions for the old hospitals; and

(b) An RCC rate determined by combining the old hospitals' cost reports and following the process described in WAC 388-550-4500.

(5) The department shall recapture depreciation and acquisition costs as required by section 1861 (V)(1)(0) of the Social Security Act.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4300 Payment—Exempt hospitals. (1) The department shall exempt the following hospitals from the diagnosis-related group (DRG) payment method:

(a) Peer group A hospitals, as defined in WAC 388-550-3300(2);

(b) Rehabilitation units: Rehabilitation services provided in specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals. The department shall use the same criteria employed by the Medicare program to identify exempt hospitals and designated distinct part rehabilitation units;

(c) Out-of-state hospitals: Those facilities located outside of Washington and outside designated border areas as described in WAC 388-501-0175. The department shall pay these hospitals according to WAC 388-550-4000; and

(d) Military hospitals: Military hospitals may individually elect to get reimbursed a negotiated per diem rate, or the DRG or RCC reimbursement method. The department shall exempt military hospitals from the DRG payment method if no other specific arrangements have been made.

(2) The department shall limit inpatient hospital stays in hospitals identified in subsection (1) above to the number of days established at the seventy-fifth percentile in the current edition of the publication, *"Length of Stay by Diagnosis and Operation, Western Region,"* unless:

(a) The department has a prior arrangement for a specified length of stay; or

(b) The stay is for chemical dependency treatment which is subject to WAC 388-550-1100(3).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4400 Services—Exempt from DRG payment. (1) The department shall exclude the following services from the diagnosis-related group (DRG)-based payment system:

(a) Neonatal services: The department shall exempt DRGs 602-619, 621-628, 630, 635, 637-641 neonatal services from the DRG payment methods. The department shall reimburse DRGs 620 and 629 (normal newborns) by the DRG payment method.

(b) Acquired immunodeficiency syndrome (AIDS)-related inpatient services: AIDS-related inpatient services for those cases with a reported diagnosis of, AIDS-related complex and other human immunodeficiency virus infections.

(c) Alcohol detoxification and treatment services: Alcoholism detoxification and treatment services provided in department-approved alcohol treatment centers.

(d) Detoxification, medical stabilization, and drug treatment for chemically-dependent pregnant women: Hospital-based intensive inpatient care for detoxification, medical stabilization, and drug treatment provided to chemically-dependent pregnant women by a certified hospital.

(e) Physical medicine and rehabilitation: Rehabilitation services provided in department-approved rehabilitation hospitals and general hospital distinct units, and services for physical medicine and rehabilitation patients.

(f) Chronic pain management: Pain management treatment provided in department-approved pain treatment facilities.

(g) Inpatient services for managed care plan enrollees: The department shall reimburse hospitals for these enrollees according to the contract between the hospital and the managed care plan.

(h) Long-term care administrative day services: The department shall reimburse long-term care services based on the statewide average Medicaid nursing facility per diem rate, which is adjusted annually each October 1. The department shall apply this rate to patient days identified as administrative days on the hospital's notice of rates. Hospitals must request a long-term care administrative day designation on a case-by-case basis.

(2) Except when otherwise specified, the department shall reimburse hospitals and services exempt from the DRG payment method under the RCC method, as described in WAC 388-550-4500.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4500 Payment method—RCC. (1)(a) The department shall calculate a hospital's ratio of cost to charge (RCC) by dividing allowable operating costs by patient revenues associated with these allowable costs.

(b) The department shall base these figures on the annual Medicare cost report data provided by the hospital.

(c) The department shall update hospitals' RCC ratios annually with the submittal of new HCFA 2552 Medicare

cost report data. Prior to computing the ratio, the department shall exclude increases in operating costs or total rate-setting revenue attributable to a change in ownership.

(2) The department shall limit a hospital's RCC to one hundred percent of its allowable charges. The department shall recoup payments made to a hospital in excess of its customary charges to the general public.

(3) The department shall establish the basic hospital payment by multiplying the hospital's assigned RCC ratio by the allowed charges for medically necessary services. The department shall deduct client responsibility (spend-down) or third-party liability (TPL) as identified on the billing invoice or by the department from the basic payment to determine the actual payment due from the department for that hospital admission.

(4) The department shall use the RCC payment method to reimburse:

(a) Peer group A hospitals;

(b) Other DRG-exempt hospitals identified in WAC 388-550-4300; and

(c) Any hospital for DRG-exempt services described in WAC 388-550-4400.

(5) The department shall deem the RCC for in-state and border area hospitals lacking sufficient HCFA 2552 Medicare cost report data the weighted average of the RCC ratios for in-state hospitals.

(6) The department shall calculate an outpatient ratio of cost-to-charge by dividing the projected costs by the projected charge multiplied by the average RCC.

(a) In no case shall the outpatient adjustment factor exceed 1.0.

(b) The factor shall be updated each October 1.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4600 Hospital selective contracting program. (1) The department shall designate selective contracting areas (SCA) in which hospitals participate in competitive bidding to provide hospital services to medical care clients. Selective contracting areas are based on historical patterns of hospital use by Medicaid clients.

(2) The department shall require medical care clients in a selective contracting area obtain their elective (nonemergent) inpatient hospital services from participating or exempt hospitals in the SCA. Elective (nonemergent) inpatient hospital services provided by nonparticipating hospitals in an SCA shall not be reimbursed by the department, except as provided in WAC 388-550-4700.

(3) The department shall exempt from the selective contracting program those hospitals that are:

(a) In an SCA but designated by the department as remote. The department shall designate as remote hospitals meeting the following criteria:

(i) Located more than ten miles from the nearest hospital in the SCA;

(ii) Having fewer than seventy-five beds; and

(iii) Having fewer than five hundred Medicaid admissions in a two-year period.

(b) Owned by health maintenance organizations (HMOs) and providing inpatient services to HMO enrollees only;

(c) Children's hospitals;

(d) State psychiatric hospitals or separate (freestanding) psychiatric facilities; and

(e) Out-of-state hospitals in nonborder areas, and out-of-state hospitals in border areas not designated as selective contracting areas.

(4)(a) The department shall negotiate with selectively contracted hospitals a negotiated conversion factor (NCF) for inpatient hospital services.

(b) The department shall calculate its maximum financial obligation for a client under the hospital selective contract in the same manner as DRG payments using cost-based conversion factors (CBCFs).

(c) The department shall apply NCFs to Medicaid clients only. The department shall use CBCFs in calculating payments for MI/medical care services clients.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4700 Payment—Non-SCA participating hospitals. (1) In a selective contracting area (SCA), the department shall pay any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) The department shall pay any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the department to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest contracting hospital exceeds the client's county travel distance standard, as follows:

County	Community Travel Distance Norm
Adams	25 miles
Asotin	15 miles
Benton	15 miles
Chelan	15 miles
Clallam	20 miles
Clark	15 miles
Columbia	19 miles
Cowlitz	15 miles
Douglas	20 miles
Ferry	27 miles
Franklin	15 miles
Garfield	30 miles
Grant	24 miles
Grays Harbor	23 miles
Island	15 miles
Jefferson	15 miles
King	15 miles
Kitsap	15 miles
Kittitas	18 miles
Klickitat	15 miles
Lewis	15 miles
Lincoln	31 miles
Mason	15 miles
Okanogan	29 miles
Pacific	21 miles

Pend Oreille	25 miles
Pierce	15 miles
San Juan	34 miles
Skagit	15 miles
Skamania	40 miles
Snohomish	15 miles
Spokane	15 miles
Stevens	22 miles
Thurston	15 miles
Wahkiakum	32 miles
Walla Walla	15 miles
Whatcom	15 miles
Whitman	20 miles
Yakima	15 miles

(b) If a client must travel outside his/her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client shall obtain such services from a contracting hospital appropriate to the client's condition.

(3) The department shall require prior authorization for all nonemergent admissions to nonparticipating hospitals in an SCA. See WAC 388-550-1700 (2)(a).

(4) The department shall pay a licensed hospital all applicable Medicare deductible and coinsurance amounts for inpatient services provided to Medicaid clients who are also beneficiaries of Medicare part A.

(5) The department shall pay any licensed hospital DRG-exempt services as listed in WAC 388-550-4400.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4800 Hospital payment method—State-only programs. (1) (a) The department shall calculate payments to hospitals for state-only MI/medical care services clients according to the:

(i) Diagnosis-related group (DRG); or

(ii) Ratio of cost-to-charge (RCC) methodologies; and

(b) The department shall reduce hospitals' Title XIX rates by their ratable and/or equivalency (EQ) factors, as applicable.

(2) The department shall calculate ratables as follows:

(a) A hospital's Medicare and Medicaid revenues are added together, along with the value of the hospital's charity care and bad debts. The hospital's low-income disproportionate share (LIDSH) revenue is deducted from this total to arrive at the hospital's community care dollars.

(b) Revenue generated by hospital-based physicians, as reported in the hospital's HCFA 2552 report, is subtracted from total hospital revenue, also as reported in the hospital's cost report.

(c) The amount derived in step (2)(a) is divided by the amount derived in step (2)(b) to obtain the ratio of community care dollars to total revenue.

(d) The result of step (2)(c) is subtracted from 1.000 to derive the hospital's ratable. The hospital's Title XIX cost-based conversion factor (CBCF) or RCC rate is multiplied by (1-ratable) for an MI or medical care services client.

(e) The reimbursements for MI/medical care services clients are mathematically represented as follows:

MI/medical care services RCC = Title XIX RCC x (1-Ratable)

MI/medical care services CBCF = Title XIX Conversion Factor x (1-Ratable) x EQ

(3) The department shall update each hospital's ratable annually on July 1.

(4)(a) The department shall use the equivalency factor (EQ) to hold the DRG reimbursement rates for the MI/medical care services programs at their current level prior to any rebasing. The department shall apply the EQ only to the Title XIX DRG CBCFs. The department shall not apply the EQ when the DRG rate change is due to the application of the annual DRI inflation adjustment.

(b) The department shall calculate a hospital's equivalency factor as follows:

EQ = (Current MI/medical care services conversion factor)/(Title XIX DRG rate x (1-ratable))

(5) Effective for hospital admissions on or after December 1, 1991, the department shall reduce its payment for MI (but not medical care services) clients further by multiplying it by ninety-seven percent. The department shall apply this payment reduction adjustment to the MIDSH methodology in accordance with section 3(b) of the "Medicaid Voluntary Contributions and Provider-Specific Tax Amendment of 1991."

(6) When the MI/medical care services client has a trauma severity factor of nine or more, the department shall pay the full Medicaid Title XIX amount when care has been provided in a nongovernmental hospital designated by DOH as a trauma center. The department shall apply the reduction in MI cases where the trauma severity factor is less than nine. The department shall give an annual grant to governmental hospitals certified by DOH.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4900 Disproportionate share payments. (1) As required by section 1902 (a)(13)(A) of the Social Security Act, the department shall give consideration to hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment to eligible hospitals. The department shall deem this adjustment a disproportionate share payment.

(2) The department shall deem a hospital a disproportionate share hospital if:

(a) The hospital's Medicaid inpatient utilization rate (MIPUR), as defined in WAC 388-550-1050, is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or its low-income utilization rate (LIUR), as defined in WAC 388-550-1050, exceeds twenty-five percent; and

(b) The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals, except that this requirement shall not apply to a hospital:

(i) The inpatients of which are predominantly individuals under eighteen years of age; or

(ii) Which did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(3) For hospitals located in rural areas, "obstetrician" shall mean any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(4) The department may define or deem a hospital a disproportionate share hospital if:

(a) The hospital has a Medicaid inpatient utilization rate (MIPUR) of not less than one percent; and

(b) The hospital meets the requirement of subsection (2)(c) of this section.

(5) The department shall administer the following disproportionate share programs:

(a) Low-income disproportionate share hospital;

(b) Medically-indigent disproportionate share hospital;

(c) General assistance-unemployable disproportionate share hospital;

(d) Small rural hospital assistance program disproportionate share hospital;

(e) Teaching hospital assistance program disproportionate share hospital;

(f) State teaching hospital financing program disproportionate share hospital;

(g) County teaching hospital financing program disproportionate share hospital; and

(h) Public hospital district disproportionate share hospital.

(6) The department shall allow a hospital to receive any one or all of the disproportionate share hospital (DSH) payment adjustments discussed in subsection (5) of this section if:

(a) The hospital applies to the department; and

(b) Meets the eligibility requirements for the particular DSH payment program, as discussed in WAC 388-550-5000 through 388-550-5400.

(7) The department shall ensure each hospital's total DSH payments do not exceed the individual hospital's DSH limit, defined as the cost to the hospital of providing services to Medicaid patients, including patients served under Medicaid managed care programs, less the amount paid by the state under the non-DSH payment provision of the state plan, plus the cost to the hospital of providing services to uninsured patients, less any cash payments made by uninsured patients.

(8)(a) The department's total annual DSH payments shall not exceed the state's DSH allotment for the federal fiscal year.

(b) If the DSH statewide allotment is exceeded, the department shall recoup overpayments from hospitals in the following program order:

(i) Public hospital district disproportionate share hospital;

(ii) Teaching hospital assistance program disproportionate share hospital;

(iii) County teaching hospital financing program disproportionate share hospital;

(iv) State teaching hospital financing program disproportionate share hospital;

(v) Small rural hospital assistance program disproportionate share hospital;

(vi) Medically-indigent disproportionate share hospital;

(vii) General assistance-unemployable disproportionate share hospital; and

(viii) Low-income disproportionate share hospital.

(9) The department shall make periodic DSH payments to eligible hospitals. The department shall have sole discretion regarding the timing of DSH payments.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5000 Payment method—LIDSH. (1) The department shall deem a hospital serving the department's clients eligible for a low-income disproportionate share hospital (LIDSH) payment adjustment if the hospital meets the requirements of WAC 388-550-4900(2).

(2) The department shall pay hospitals deemed eligible under the criteria in subsection (1) of this section DSH payment amounts which in total equal the funding set by the state's appropriations act for LIDSH. The amount appropriated for LIDSH may vary from year to year.

(3) The department shall apportion LIDSH payments to individual hospitals as follows:

(a) For each LIDSH-eligible hospital, the department shall determine the standardized Medicaid inpatient utilization rate (MIPUR). The MIPUR is standardized by dividing the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals.

(b) The hospital's standardized MIPUR is multiplied by the hospital's most recent fiscal year case mix index, and then by the hospital's most recent fiscal year Title XIX admissions. The product is then multiplied by an initial random base amount.

(c) The annual LIDSH payment so calculated for individual hospitals shall be added and compared to the appropriated amount. If the amounts differ, a new base amount shall be selected progressively by trial and error until the sum of the LIDSH payments to hospitals equals the appropriated amount.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5100 Payment method—MIDSH. (1) The department shall deem a hospital eligible for the medically indigent disproportionate share hospital (MIDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is an in-state or border area hospital;

(c) Provides services to clients under the medically indigent program; and

(d) Has a low-income utilization rate of one percent or more.

(2) The department shall determine the MIDSH payment for each eligible hospital in accordance with WAC 388-550-4800.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5150 Payment method—GAUDSH. (1) The department shall deem a hospital eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is an in-state or border area hospital;

(c) Provides services to clients under the medical care services program; and

(d) Has a low-income utilization rate (LIUR) of one percent or more.

(2) The department shall determine the GAUDSH payment for each eligible hospital in accordance with WAC 388-550-4800, except that the payment shall not be reduced by the additional three percent specified in WAC 388-550-4800(4).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5200 Payment method—SRHAPDSH. (1) The department shall deem a hospital eligible for the small rural hospital assistance program disproportionate share hospital (SRHAPDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is an in-state hospital;

(c) Is a small, rural hospital, defined as a hospital with fewer than seventy-five licensed beds and located in a city or town with a nonstudent population of thirteen thousand or less; and

(d) Provides at least one percent of its services to low-income patients in rural areas of the state.

(2)(a) The department shall pay hospitals qualifying for SRHAPDSH payments from a legislatively appropriated pool.

(b) The department shall determine each individual hospital's SRHAPDSH payment as follows: The total dollars in the pool will be multiplied by the percentage derived from dividing the Medicaid payments to the individual hospital during the fiscal year that is two years previous to the state fiscal year immediately preceded by the total Medicaid payments to all SRHAPDSH hospitals during the same hospital fiscal year.

(3) The department's SRHAPDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid and uninsured indigent patients. The department shall reallocate dollars not allocated because a hospital would otherwise exceed this ceiling to the remaining hospitals in the SRHAPDSH pool.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5250 Payment method—THAPDSH. (1) The department shall deem a hospital eligible for the teaching hospital assistance program disproportionate share hospital (THAPDSH) program if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is a Washington State University hospital; and

(c) Has a Medicaid inpatient utilization rate (MIPUR) of twenty percent or more.

(2) The department shall fund THAPDSH payments with legislatively appropriated monies. The department shall divide the legislatively appropriated THAPDSH amount equally between qualifying hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5300 Payment method—STHFPDSH. (1) The department shall deem a hospital eligible for the state teaching hospital financing program disproportionate share hospital (STHFPDSH) if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is a state-owned university or public corporation hospital (border area hospitals are excluded);

(c) Provides a major medical teaching program, defined as a hospital with more than one hundred residents and/or interns; and

(d) Has a Medicaid inpatient utilization rate (MIPUR) of at least twenty percent.

(2)(a) The department shall pay hospitals deemed eligible under the criteria in subsection (1) of this section a STHFPDSH payment from the legislatively appropriated pool specifically designated for DSH payments to state and county teaching hospitals.

(b) The department shall limit STHFPDSH payments to eligible hospitals to seventy percent of the legislatively appropriated pool for DSH payments to state and county teaching hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5350 Payment method—CTHFPDSH. (1) The department shall deem a hospital eligible for the county teaching hospital financing program disproportionate share hospital (CTHFPDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is a county hospital in Washington state (border area hospitals are excluded), so designated by the county in which located;

(c) Provides a major medical teaching program, defined as a hospital with more than one hundred residents and/or interns; and

(d) Has a low-income utilization rate (LIUR) of at least twenty-five percent.

(2)(a) The department shall pay hospitals deemed eligible under the criteria in subsection (1) of this section a CTHFPDSH payment from the legislatively appropriated pool specifically designated for DSH payments to state and county teaching hospitals.

(b) The department shall limit CTHFPDSH payments to eligible hospitals to thirty percent of the legislatively appropriated pool for DSH payments to state and county teaching hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5400 Payment method—PHDDSH. (1) The department shall deem a hospital eligible for the public hospital district disproportionate share hospital (PHDDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is a public district hospital in Washington state or a border area hospital owned by a public corporation; and

(c) Provides at least one percent of its services to low-income patients.

(2) The department shall pay hospitals deemed eligible under the criteria in subsection (1) of this section a PHDDSH payment amount from the legislatively appropriated PHDDSH pool.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5500 Payment—Hospital-based RHCs. (1) The department shall reimburse hospital-based rural health clinics under the prospective payment methods effective July 1, 1994. Under the prospective payment method, the department shall not make reconciliation payments to a hospital-based rural health clinic to cover its costs for a preceding period.

(2) The department shall pay an amount equal to the hospital-based rural health clinic's charge multiplied by the hospital's specific ratio of costs to charges (RCC), not to exceed one hundred percent of the charges.

(3) The department shall determine the hospital-based rural health clinic's RCC from the hospital's annual Medicare cost report, pursuant to WAC 388-550-4500(1).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5600 Hospital rate appeals and disputes. (1) A hospital may appeal any aspect of its Medicaid payment rates by submitting a written notice of appeal and supporting documentation to the medical assistance administration's (MAA) hospital reimbursement section, except that no administrative appeals may be filed challenging the method described herein.

(a) The grounds for rate adjustments include, but are not limited to:

(i) Errors or omissions in the data used to establish rates; and

(ii) Peer group change recommended by the Washington state department of health.

(b) The department may require additional documentation from the provider in order to complete the appeal review. The department may conduct an audit and/or desk review if necessary to complete the appeal review.

(c) Unless the written rate notification specifies otherwise, a hospital shall file an appeal within sixty days after being notified of an action or determination the hospital wishes to challenge. The department shall deem the notification date of an action or determination the date of the written rate notification letter.

(i) A hospital which files an appeal within the sixty-day period described in subsection (1)(c) of this section shall be eligible for retroactive rate adjustments if it prevails.

(ii) The department shall not consider a hospital rate appeal filed after the sixty-day period described in this subsection for retroactive rate adjustments.

(d) When a hospital appeals a rate the department may review all aspects of its rate.

(e) Unless the written rate notification specifies otherwise, the department shall deem rate changes resulting from an appeal effective as follows:

(i) Increases in rates resulting from an appeal filed within sixty days after the written rate notification letter that the hospital is challenging shall be effective retroactive to the date of the rate change specified in the original notification letter.

(ii) Increases in rates resulting from a rate appeal filed after the sixty day period or exception period shall be effective on the date the appeal was filed with the department.

(iii) A rate decrease resulting from an appeal shall be effective on the date specified in the appeal decision notification.

(2)(a) A hospital may request a dispute conference to appeal an administrative review decision. The conference shall be conducted by the assistant secretary for the MAA or his/her designee.

(b) The hospital shall submit a request for a conference within thirty days of receipt of the administrative review decision.

(c) The department shall deem the dispute conference decision its final decision regarding rate appeals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5700 Hospital reports and audits. (1) In-state and border area hospitals shall complete and submit a copy of their annual Medicare cost reports (HCFA 2552) to the department. These hospital providers shall:

(a) Maintain adequate records for audit and review purposes, and assure the accuracy of their cost reports;

(b) Complete their annual Medicare HCFA 2552 cost report according to the applicable Medicare statutes, regulations, and instructions; and

(c) Submit a copy to the department:

(i) Within one hundred fifty days from the end of the hospital's fiscal year; or

(ii) If the hospital provider's contract is terminated, within one hundred fifty days of effective termination date; or

(d) Request up to a thirty day extension of the time for submitting the cost report in writing at least ten days prior to the due date of the report. Hospital providers shall include in the extension request the completion date of the report, and the circumstances prohibiting compliance with the report due date;

(2) If a hospital provider improperly completes a cost report or the cost report is received after the due date or

approved extension date, the department may withhold all or part of the payments due the hospital until the department receives the properly completed or late report.

(3) Hospitals shall submit other financial information required by the department to establish rates.

(4) The department shall periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5800 Outpatient and emergency hospital services. The department shall cover outpatient services, emergent outpatient surgical care, and other emergency care performed on an outpatient basis in a hospital for categorically needy or limited casualty program-medically needy clients. The department shall limit clients eligible for the medically indigent program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5900 Prior authorization—Outpatient services. The department shall require providers to obtain prior authorization for the following selected outpatient hospital services:

(1) Magnetic resonance imaging;

(2) Magnetic resonance angiography;

(3) Sleep studies/polysomnograms for clients over one year old, unless provided in a medical assistance administration (MAA)-approved facility;

(4) Peripheral stem cell transplants, unless provided in an MAA-approved facility;

(5) Positron emission tomography scans, except that the department shall not require prior authorization for brain PET scans;

(6) Evaluation, management and treatment of chronic pain, unless provided in an MAA-approved facility; and

(7) Weight loss program costs, unless provided in a department-approved outpatient weight-loss facility.

(8) See WAC 388-550-1700 for hospital services requiring prior approval and WAC 388-550-1800 for certain prior approval exemptions.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6000 Payment—Outpatient hospital services. (1)(a) The department shall determine allowable costs for hospital outpatient services, excluding nonallowable revenue codes, by the application of the hospital-specific outpatient ratio of costs to charges (RCC), except as specified in subsection (2) below.

(b) The department shall not pay separately for ancillary hospital services which are included in the hospital's RCC reimbursement rate.

(2) The department shall pay the lesser of billed charges or the department's published maximum allowable fees for the following outpatient services:

(a) Laboratory/pathology;

(b) Radiology, diagnostic and therapeutic;

(c) Nuclear medicine;

(d) Computerized tomography scans, magnetic resonance imaging, and other imaging services;

(e) Physical therapy;

(f) Occupational therapy;

(g) Speech/language therapy; and

(h) Other hospital services as identified and published by the department.

(3) The department shall not be responsible for payment of hospital care and/or services provided to a client enrolled in a department-contracted, prepaid medical plan when the client fails to use:

(a) For a nonemergent condition, a hospital provider under contract with the plan;

(b) In a bona fide emergent situation, a hospital provider under contract with the plan; or

(c) The provider whom the department has authorized to provide and receive payment for a service not covered by the prepaid plan but covered under the client's medical assistance program.

(4) The department shall consider a hospital stay of twenty-four hours or less as an outpatient short stay. The department shall not reimburse an outpatient short stay under the diagnosis-related group system except when it involves one of the following situations:

(a) Death of a client;

(b) Obstetrical delivery;

(c) Initial care of a newborn; or

(d) Transfer of a client to another acute care hospital.

(5) The department shall not pay for patient room and ancillary services charges beyond the twenty-four period for outpatient stays.

(6) The department shall not cover short stay unit, emergency room facility charges, and labor room charges in combination when the billed periods overlap.

(7) The department shall require that the hospital's bill to the department shows the admitting, principal, and secondary diagnoses, and include the attending physician's name.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6100 Outpatient hospital physical therapy. (1) The department shall pay for physical therapy as an outpatient hospital service when:

(a) The attending physician prescribes physical therapy;

(b) A licensed physical therapist or physiatrist or a physical therapist assistant supervised by a licensed physical therapist provides the treatment; and

(c) The therapy assists the client:

(i) In avoiding hospitalization or nursing facility care; or

(ii) In becoming employable; or

(iii) Who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(iv) As part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(2) The hospital shall bill outpatient hospital physical therapy services to the department using the appropriate current procedural terminology or department-assigned codes. The department shall not pay outpatient hospitals a facility fee for such services.

(3) The department shall pay for outpatient hospital physical therapy for clients eligible under the:

(a) Categorically needy, general assistance unemployable and ADATSA programs;

(b) Medically needy program only when the client is:

(i) Twenty years of age and under and referred by a screening provider under the early and periodic screening, diagnosis, and treatment program; or

(ii) Receiving home health care services.

(4) The department shall not pay for physical therapy programs for clients under the limited casualty program-medically indigent program.

(5)(a) For clients who are twenty years of age or under, the department shall not require prior authorization or limit the number of physical therapy sessions payable per client per calendar year, subject to the provision of subsection (8) below, provided the services are medically necessary.

(b) Providers shall fully document in the client's medical record the medical justification for continued therapy.

(6)(a) Except as provided in subsection (7) below, the department shall pay for categorically needy, medically needy and medical care services clients who are twenty-one years of age or older a total of eighteen hours of physical therapy in a calendar year, in any combination of modalities and procedures, for:

(i) Acute conditions; or

(ii) Following joint surgery.

(b) The department shall set time unit equivalents for each physical therapy procedure or modality, and publish such schedules periodically.

(7) For a client twenty-one years of age or older who has a medical diagnosis specified in the outpatient hospital billing instructions as normally requiring more intensive physical therapy treatment, the department shall cover up to twenty-four hours of physical therapy in a calendar year, in any combination of modalities and procedures.

(8)(a) Notwithstanding the hours per calendar year limit, the department shall reimburse a maximum of one hour of physical therapy session per day, except that a maximum of two hours shall be allowed when a client assessment/evaluation is performed on the same date.

(b) The physical therapy provider shall document in each client's record the amount of time spent on services to the client.

(9)(a) The department shall require that physical therapy begin within thirty days of the date the therapy was prescribed.

(b) The department may deny payment for therapy started more than thirty days after the date of the prescription, unless medical justification for the delay is presented to the department.

(c) The hospital shall include the prescription for physical therapy services in the client's medical record.

(10) The department shall not pay for physical therapy services under fee-for-service when physical therapy is already included in other reimbursement methodologies applied to the case, including but not limited to DRG payment for inpatient hospital services and nursing facility per diem.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6150 Outpatient hospital occupational therapy. (1) The department shall pay for occupational therapy as an outpatient hospital service when:

(a) The service is provided by a licensed occupational therapist or a licensed occupational therapy assistant supervised by a licensed occupational therapist;

(b) The provider obtains approval from the department before services are performed, for services requiring prior approval as designated in the department's billing instructions; and

(c) The occupational therapy is provided:

(i) As part of an outpatient program when identified in the early and periodic screening, diagnosis, and treatment program of a recipient twenty years of age and younger; or

(ii) As part of the physical medicine and rehabilitation program.

(2)(a) The hospital shall bill outpatient hospital occupational therapy services to the department using the appropriate current procedural terminology or department-assigned codes.

(b) The department shall not pay outpatient hospitals a facility fee for these services.

(3) The department shall pay for occupational therapy provided to clients eligible under the:

(a) Categorically needy, general assistance unemployable and ADATSA programs;

(b) Medically needy program only when the client is:

(i) Twenty years of age and younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program; or

(ii) Receiving home health care services.

(4) The department shall reimburse for occupational therapy as part of an outpatient program when identified in the early and periodic screening, diagnosis, and treatment program of an eligible client.

(5) The department shall cover one assessment, two durable medical equipment needs assessments, and twelve sessions of outpatient hospital occupational therapy per year.

(6) The department shall pay for up to twenty-four additional therapy visits for clients under the children with special health care needs program when the therapy visits are related to the approved list of diagnoses as published by the department.

(7) The department shall not pay for occupational therapy when payment for occupational therapy is included in the reimbursement of other treatment programs including, but not limited to the hospital inpatient diagnosis related group and inpatient physical medicine and rehabilitation services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6200 Outpatient hospital speech therapy services. (1) The department shall cover speech therapy services for eligible medical care clients who have a medically recognized disease or defect which requires speech therapy services, except as limited below:

(a) Under the medically needy program the department shall limit therapy to clients twenty years of age and under.

(b) The department shall not pay for specialized speech therapy under the medically indigent program.

(2) The department shall cover speech therapy when provided under a written plan of treatment:

(a) Established by a speech pathologist who has been granted a certificate of clinical competence by the American Speech, Language and Hearing Association; or

(b) An individual who has completed the equivalent educational and work experience necessary for such a certificate; and

(c) That is periodically reviewed by the client's primary care physician.

(3) The department shall cover one medical diagnostic evaluation and twelve speech therapy sessions in a calendar year per client. The department may cover up to twenty-four additional speech therapy sessions only when associated with the specific diagnoses listed in the department's outpatient hospital billing instructions. The department shall make such instructions available to the public.

(4) The department shall require a provider to submit an authorization request to the office of children with special health care needs on the appropriate form for a child with special health care needs who needs more than twelve speech therapy sessions or the additional twenty-four sessions, but does not have any of the specific diagnoses identified in subsection (3) of this section.

(5) The department shall require swallowing (dysphagia) evaluations to be performed by a speech/language pathologist who holds a master's degree in speech pathology and who has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

(6) The department shall require a swallowing evaluation to include:

(a) An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;

(b) Dietary recommendations for oral food and liquid intake therapeutic or management techniques;

(c) Therapeutic or management techniques; and

(d) Videofluoroscopy, when necessary, for further evaluation of swallowing status and aspiration risks.

(7) The provider shall bill outpatient hospital speech therapy services to the department using the appropriate current procedural terminology or department-assigned codes. The department shall not pay the outpatient hospital a facility fee for these services.

(8) The department shall not pay for speech therapy when payment for speech therapy is included in the reimbursement as part of other treatment programs including, but not limited to the hospital inpatient diagnosis-related group and nursing facility services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6250 Pregnancy—Enhanced outpatient benefits. The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 440-25 WAC and certified under chapter 440-22 WAC or its successor.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6300 Outpatient nutritional counseling. (1) The department shall cover nutritional counseling services only for eligible Medicaid clients twenty years of age and under referred during an early and periodic screening, diagnosis and treatment screening to a certified dietitian.

(2) Except for children under the children's medical program, the department shall not cover nutritional counseling for clients under the medically indigent and other state-only funded programs.

(3) The department shall pay for nutritional counseling for the following conditions:

(a) Inadequate or excessive growth such as failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile, and obesity;

(b) Inadequate dietary intake, such as formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite;

(c) Infant feeding problems, such as poor suck/swallow reflex, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited caregiver knowledge and/or skills;

(d) Chronic disease requiring nutritional intervention, such as congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, and gastrointestinal disease;

(e) Medical conditions requiring nutritional intervention, such as iron-deficiency anemia, familial hyperlipidemia, and pregnancy;

(f) Developmental disability, such as increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings; or

(g) Psycho-social factors, such as behavior suggesting eating disorders.

(4) The department shall pay for maximum of twenty sessions, in any combination, of assessment/evaluation and/or nutritional counseling in a calendar year.

(5) The department shall require each assessment/evaluation or nutritional counseling session be for a period of twenty-five to thirty minutes of direct interaction with a client and/or the client's caregiver.

(6) The department shall pay the provider for a maximum of two sessions per day per client.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6350 Outpatient sleep apnea/sleep study programs. (1) The department shall pay for

polysomnograms or multiple sleep latency tests only for clients one year of age or older with obstructive sleep apnea or narcolepsy.

(2) The department shall pay for polysomnograms or multiple sleep latency tests only when performed in outpatient hospitals approved by the medical assistance administration (MAA) as centers of excellence for sleep apnea/sleep study programs.

(3) The department shall not require prior authorization for sleep studies as outlined in WAC 388-550-1800.

(4) Hospitals shall bill the department for sleep studies using current procedural terminology codes. The department shall not reimburse hospitals for these services when billed under revenue codes.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6400 Outpatient hospital diabetes education. (1) The department shall pay for outpatient hospital-based diabetes education for an eligible client when:

(a) The facility is approved by the department of health (DOH) as a diabetes education center, and

(b) The client is referred by a licensed health care provider.

(2) The department shall require the diabetes education teaching curriculum to have measurable, behaviorally-stated educational objectives. The diabetes education teaching curriculum shall include all the following core modules:

(a) An overview of diabetes;

(b) Nutrition, including individualized meal plan instruction that is not part of the Women, Infants, and Children program;

(c) Exercise, including an individualized physical activity plan;

(d) Prevention of acute complications, such as hypoglycemia, hyperglycemia, and sick day management;

(e) Prevention of other chronic complications, such as retinopathy, nephropathy, neuropathy, cardiovascular disease, foot and skin problems;

(f) Monitoring, including immediate and long term diabetes control through monitoring of glucose, ketones, and glycosylated hemoglobin; and

(g) Medication management, including administration of oral agents and insulin, and insulin start-up.

(3) The department shall pay for a maximum of six hours of individual core survival skills outpatient diabetes education per lifetime per client.

(4) The department shall require DOH-approved centers to bill the department for diabetes education services on the UB92 billing form using the specific revenue codes assigned and published by the department.

(5) The department shall reimburse for outpatient hospital-based diabetes education based on the individual hospital's current specific ratio of costs-to-charges, or the hospital's customary charge for diabetes education, whichever is less.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6450 Outpatient hospital weight loss program. The department may pay for an outpatient weight loss program only when provided through an outpatient weight loss facility approved by the medical assistance administration. The department shall deny payment for services provided by nonapproved providers.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6450, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6500 Blood and blood products. (1) The department shall limit Medicaid reimbursement to a hospital for blood derivatives to blood bank service charges for processing the blood and blood products.

(2) Other than payment of blood bank service charges, the department shall not pay for blood and blood derivatives.

(3) The department shall not separately reimburse blood bank service charges for handling and processing blood and blood derivatives provided to an individual who is hospitalized when the hospital is reimbursed under the diagnosis-related group (DRG) system. The department shall bundle these service charges into the total DRG payment.

(4) The department shall reimburse a hospital, which is paid under the cost to charge method, separately for processing blood and blood products.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6600 Hospital-based physician services. See chapter 388-531 WAC regarding rules for inpatient and outpatient physician services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6700 Hospital services provided out-of-state. (1) The department shall reimburse only emergency care for an eligible Medicaid client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC 388-501-0175 for a list of border cities.

(2) The department shall authorize and provide comparable medical care services to a Medicaid client who is temporarily outside the state to the same extent that such medical care services are furnished to an eligible Medicaid client in the state, subject to the exceptions and limitations in this section.

(3) The department shall not authorize payment for out-of-state medical care furnished to state-funded clients (medically indigent/medical care services), but may authorize medical services in designated bordering cities.

(4) The department shall cover hospital care provided to Medicaid clients in areas of Canada as described in WAC 388-501-0180 (1)(b).

(5) The department shall review all cases involving out-of-state medical care to determine whether the services are within the scope of the medical assistance program.

(6)(a) If the client can claim deductible or coinsurance portions of Medicare, the provider shall submit the claim to

the intermediary or carrier in the provider's own state on the appropriate Medicare billing form.

(b) If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For reimbursement for out-of-state inpatient hospital services, see WAC 388-550-4000.

(8) The department shall reimburse out-of-state outpatient hospital services billed under the physician's current procedural terminology codes at an amount that is the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX Medicaid program.

(9) Out-of-state providers shall present final charges to MAA within three hundred sixty-five days of the date of service. In no case shall the state of Washington be liable for payment of charges received beyond one year from the date services were rendered.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6700, filed 12/18/97, effective 1/18/98.]

Title 390 WAC
PUBLIC DISCLOSURE COMMISSION

Chapters

Chapter 390-16 WAC
FORMS FOR CAMPAIGN FINANCING REPORTING—CONTRIBUTIONS

WAC

WAC 390-16-041 Forms—Summary of total contributions and expenditures. (1) The official form for reports of contributions and expenditures by candidates and political committees who use the "full" reporting option is designated "C-4," revised 3/97, and includes Schedule A, revised 11/93, Schedule B, revised 11/93, Schedule C, revised 3/93, and Schedule L, revised 11/93.

(2) The official form for reports of contributions and expenditures by candidates and political committees who use the "abbreviated" reporting option is designated "C-4abb," revised 11/93.

(3) Copies of these forms are available at the Commission Office, Room 403, Evergreen Plaza Building, Olympia, Washington 98504. Any attachments shall be on 8-1/2" x 11" white paper.