WAC 388-97-33540 Seating in a resident room. The nursing home must provide comfortable seating for residents and visitors, not including resident care equipment, that provides proper body alignment and support.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33540, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33550 Lighting in resident rooms. The nursing home must provide a permanently mounted or equivalent light suitable for any task the resident chooses to do or any task the staff must do.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33550, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33560 Call signal device in resident rooms. The nursing home must provide a resident call signal device that complies with WAC 388-97-32530.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33560, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33570 Cubicle curtains in resident rooms. The nursing home must provide:

(1) Flame-retardant cubicle curtains in multi-bed rooms that ensures full visual privacy for each resident;

(2) **In a new building or addition**, the cubicle curtain or enclosed space ensures full visual privacy for each bed in a multi-bed room with enclosed space containing at least sixty-four square feet of floor area with a minimum dimension of seven feet. "Full visual privacy" in a multi-bed room prevents staff, visitors and other residents from seeing a resident in bed, while allowing staff, visitors, and other residents access to the toilet room, handwashing sink, exterior window, and the entrance door;

(3) For exceptions to cubicle curtain requirements refer to WAC 388-97-310.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33570, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33580 Miscellaneous equipment in resident rooms in a new building or addition. The nursing home must provide:

(1) A phone jack for each bed in each room;

(2) A handwashing sink in each multi-bed room and a handwashing sink in each single room that does not have an adjoining toilet room containing a handwashing sink. A handwashing sink located in a resident bedroom must be located between the corridor entry door and the nearest resident bed; and

(3) Storage that meets the requirements of WAC 388-97-357, 388-97-35710, and 388-97-35720.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33580, filed 2/24/00, effective 3/26/00.]

RESIDENT TOILET AND BATHING FACILITIES

WAC 388-97-340 Resident toilet facilities or rooms. The nursing home must ensure that:

(1) Each resident room is equipped with or located convenient to toilet facilities.

(2) **For new construction**, a toilet room must:

(a) Be directly accessible from each resident room and from each bathing facility without going through or entering a general corridor while maintaining resident dignity;

(b) Serve two bedrooms or less;

(c) Be designed to accommodate a person in a wheelchair;

(d) Contain at least one handwashing sink; and

(e) Provide a properly located and securely mounted grab bar at each side and the back of each toilet fixture in each toilet room and stall. Grab bars on the open side must be located twelve to eighteen inches from the center line of the toilet. Grab bars on the open side must be able to swing up.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-340, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-340, filed 9/15/94, effective 10/16/94.]

WAC 388-97-34010 Resident bathing facilities or rooms. The nursing home must ensure:

(1) Each resident room is equipped with or located near bathing facilities;

(2) At least one bathing unit for no more than thirty residents that is not located in a room served by an adjoining bathroom;

(3) At least one bathing device for immersion per floor;

(4) At least one roll in shower or equivalent on each resident care unit:

(a) Designed and equipped for unobstructed ease of shower chair entry and use; and

(b) With a spray attachment equipped with a backflow prevention device.

(5) Resident bathing equipment is smooth, cleanable, and able to be disinfected after each use.

(6) **For new construction**, in each bathing unit containing more than one bathing facility:

(a) Each bathtub, shower, or equivalent, is located in a separate room or compartment with three solid walls;

(b) The entry wall may be a "shower" type curtain or equivalent;

(c) The area for each bathtub and shower is sufficient to accommodate a shower chair, an attendant, and provide visual privacy for bathing, drying, and dressing;

(d) Shower and tub surfaces are slip-resistant;

(e) Bathing areas are constructed of materials that are impervious to water and cleanable; and

(f) Grab bars are installed on all three sides of a shower with the shower head grab bar being "L" shaped.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-34010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-34020 Locks in toilet and bathing facilities. The nursing home must ensure:

(1) All lockable toilet facilities and bathrooms have a readily available means of unlocking from the outside; and

(2) Locks are operable from the inside with a single motion.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-34020, filed 2/24/00, effective 3/26/00.]

DINING, DAYROOMS, AND RESIDENT ACTIVITY AREAS

WAC 388-97-345 Dining, dayrooms, and resident activity areas. (1) The nursing home must provide one or more rooms designated for resident dining and activities that are:

(a) Well lighted;

(b) Well ventilated;

(c) Adequately furnished; and

(d) Large enough to accommodate all activities.

(2) **In a new building or addition**, the nursing home must design space for dining rooms, dayrooms, and activity areas for resident convenience and comfort and to provide a homelike environment. These areas must be located on the same floor as the residents who will use the areas. The nursing home must:

(a) Ensure these rooms or areas are exterior rooms with windows that have a maximum sill height of thirty-six inches;

(b) Provide space for dining, day use, and activities with a minimum combined total of thirty square feet for each licensed bed;

(c) Design any multi-purpose rooms to prevent program interference with each other;

(d) Locate a day room on each resident care unit;

(e) Provide storage spaces for all activity and recreational equipment and supplies, adjoining or adjacent to the facilities provided; and

(f) Locate a common use toilet facility, with handwashing sink and accessories, providing direct access from the hallway and within a maximum of forty feet from these spaces.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-345, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-345, filed 9/15/94, effective 10/16/94.]

LAUNDRY SERVICES

WAC 388-97-347 Laundry services and storage. The nursing home must comply with WAC 388-97-205 and ensure:

(1) Sufficient laundry washing and drying facilities to meet the residents' care and comfort needs without delay.

(2) The temperature and time of the hot water cycle to disinfect nursing home linen is in accordance with the following table:

Water temperature	Cycle length
160 degrees F	At least 5 minutes
140 degrees F	At least 15 minutes

(3) **In new construction**, soiled linens and soiled clothing are stored and sorted in a room ventilated according to Table 5, WAC 388-97-47020. The room must:

(a) Have self-closing doors;

(b) Be separated from the washing and drying facilities;

(c) Contain a handwashing sink;

(d) Have a floor drain; and

(e) Contain a clinic service sink.

(4) **In new construction**, clean linen is stored in a room ventilated according to Table 5, WAC 388-97-47020. The room must:

(a) Be separated from the washing and drying facilities; and

(b) Have self closing doors.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-347, filed 2/24/00, effective 3/26/00.]

DEMENTIA CARE UNIT

WAC 388-97-350 Dementia care unit. A nursing home that began operating a dementia care unit at any time after November 13, 1989, must meet all requirements of this section, WAC 388-97-35010 through 388-97-35060, and the resident care unit requirements of WAC 388-97-325 through 388-97-32580. Refer to WAC 388-97-097, for program requirements.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-350, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-350, filed 9/15/94, effective 10/16/94.]

WAC 388-97-35010 Dining areas on a dementia care unit. (1) The nursing home must provide dining areas in the dementia care unit which may also serve as day areas for the unit.

(2) **In a new building or addition**, the dining, dayroom, and activity area or areas on the unit must provide a minimum of thirty square feet per resident.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35020 Outdoor areas on a dementia care unit. The nursing home must provide the dementia care unit with:

(1) Secured outdoor space and walkways;

(2) An ambulation area with accessible walking surfaces that:

(a) Are firm, stable, and free from cracks and abrupt changes with a maximum of one inch between sidewalk and adjoining landscape areas;

(b) Have slip-resistant surfaces if subject to wet conditions; and

(c) Sufficient space and outdoor furniture with flexibility in arrangement of the furniture to accommodate residents who use wheelchairs and mobility aids; and

(3) Nontoxic outdoor plants in areas accessible to residents.

(4) **In new construction** the outdoor areas must also meet the requirements of WAC 388-97-45510.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35030 Indoor areas on a dementia care unit. The nursing home must provide the dementia care unit with:

(1) Indoor ambulation areas that meet the needs of the residents and are maintained free of equipment; and

(2) Nontoxic indoor plants in areas accessible to residents.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35040 Ambulation route on a dementia care unit in a new building or addition. The nursing home must ensure that the dementia care un it has a continuous ambulation route which may include outdoor ambulation areas and allows the resident to return to the resident's starting point without reversing direction.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35050 Physical plant on a dementia care unit. The nursing home must:

(1) Provide a staff toilet room with a handwashing sink;

(2) Ensure that floors, walls, and ceiling surfaces display contrasting color for identification:

(a) Surfaces may have a disguise design to obscure or conceal areas that residents should not enter, except for exit doors and doorways; and

(b) Exit doors must be marked so that they are readily distinguishable from adjacent construction and the way of exit travel is obvious and direct;

(3) Ensure that door thresholds are one-half inch high or less;

(4) Provide a signal device adapted:

(a) To meet residents' needs; and

(b) For staff and family use, if necessary;

(5) Ensure that the public address system is used only for emergency use; and

(6) Refer to WAC 388-97-470(2) for dementia care unit exceptions to individual temperature controls.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35050, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35060 Special egress control devices on a dementia care unit. In dementia care units the nursing home must:

(1) Have proof that required approvals for any special egress control devices were obtained from the state fire marshal, department of social and health services, and the local official who enforces the uniform building code and uniform fire code; and

(2) **In a new building or addition, or when adding** special egress control devices to be used on doors and gates which are a part of the exit system, the building must:

(a) Have obtained approval from department of health construction review and the local official who enforces the Uniform Building Code and Uniform Fire Code;

(b) Have an approved automatic fire alarm system;

(c) Have an approved supervised automatic fire sprinkler system which is electrically interconnected with the fire alarm system; and

(d) Have a system which must:

(i) Automatically release if power to the system is lost;

(ii) Automatically release with activation of the building's fire alarm system;

(iii) Release with an override switch installed at each staff work station or at a constantly staff attended location within the building; and

(iv) Have directions for releasing the device at each egress controlled door and gate; and

(e) Prohibit the use of keyed locks at all doors and gates in all egress pathways.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35060, filed 2/24/00, effective 3/26/00.]

SPECIALIZED AND OUTPATIENT REHABILITATION

WAC 388-97-352 Specialized rehabilitation. (1) If nursing homes initially licensed after October 1, 1981 provide inpatient specialized rehabilitation, they must ensure that those services provide:

(a) Easy access in general service areas;

(b) Exercise, treatment, and supportive equipment as required by the narrative program in the construction documents;

(c) Adequate space for exercise equipment and treatment tables with sufficient work space on each side;

(d) Privacy cubicle curtains on tracks or the equivalent around treatment areas;

(e) A sink in the treatment area and a toilet and handwashing sink in a toilet room nearby;

(f) Space and a desk or equivalent for administrative, clerical, interviewing, and consultative functions;

(g) Adequate enclosed storage cabinets for clean linen and supplies and locked storage for cleaning chemicals in the rehabilitation room or nearby janitor's closet;

(h) Adequate storage space for large equipment;

(i) A janitor's closet close to the area;

(j) Soiled linen storage; and

(k) A separate room or area for hydrotherapy tanks, or the equivalent, if provided.

(2) **For any new construction** under WAC 388-97-29560, nursing homes licensed before October 1, 1981, must comply with the requirements in subsection (1) of this section.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-352, filed 2/24/00, effective 3/26/00.]

WAC 388-97-353 Outpatient rehabilitation. The nursing home must ensure that facilities with outpatient programs provide:

(1) A designated reception and waiting room or area and space for interviewing or counseling individual outpatients and their families;

(2) Adequate space for the program so that disruption to designated resident care units is minimized;

(3) Accessible toilet and shower facilities nearby;

(4) Lockers or a safe place to store outpatient personal belongings;

(5) A separate room or area for hydrotherapy tanks, or the equivalent, if provided; and

(6) **In new construction**, required access must come from the exterior without passing through the interior of the facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-353, filed 2/24/00, effective 3/26/00.]

FOOD SERVICE AREAS

WAC 388-97-355 Food service areas. The nursing home must ensure food service areas are in compliance with chapter 246-215 WAC, state board of health rules governing food service sanitation. The nursing home must:

(1) Ensure food service areas are provided for the purpose of preparing, serving, and storing food and drink unless food service is provided from another licensed food service facility;

(2) Ensure food service areas are located to facilitate receiving of food supplies, disposal of kitchen waste, and transportation of food to dining and resident care areas;

(3) Locate and arrange the kitchen to avoid contamination of food, to prevent heat and noise entering resident care areas, and to prevent through traffic;

(4) Locate the receiving area for ready access to storage and refrigeration areas;

(5) Conveniently locate a handwashing sink near the food preparation and dishwashing area, and include a waste receptacle and dispensers stocked with soap and paper towels;

(6) Adequately ventilate, light, and equip the dishwashing room or area for sanitary processing of dishes;

(7) Locate the garbage storage area in a well-ventilated room or an outside area;

(8) Provide hot and cold water and a floor drain connected to the sanitary sewage system in a can wash area, unless located in outside covered area;

(9) Provide space for an office or a desk and files for food service management located central to deliveries and kitchen operations; and

(10) Include housekeeping facilities or a janitor's closet for the exclusive use of food service with a service sink and storage of housekeeping equipment and supplies.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-355, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-355, filed 9/15/94, effective 10/16/94.]

STORAGE

WAC 388-97-357 Storage of equipment. The nursing home must:

(1) Provide adequate storage space for wheelchairs and other ambulation equipment;

(2) Ensure stored equipment does not impinge upon the required corridor space; and

(3) **In new construction**, provide adequate storage of four square feet or more of storage space per bed which does not impinge upon required corridor space.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-357, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35710 Storage of resident room equipment in a new building or addition. The nursing home must provide separate storage for extra pillows and blankets for each bed. This may be in a location convenient to the resident room or combined with the wardrobe or closet if it does not impinge upon the required space for clothing.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35710, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35720 General storage in new construction. A nursing home must have general storage space of not less than five square feet per bed in addition to the closets and storage required in WAC 388-97-33520.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35720, filed 2/24/00, effective 3/26/00.]

LIGHTING AND ELECTRICAL

WAC 388-97-360 Lighting. The nursing home must ensure that lighting and lighting levels:

(1) Are adequate and comfortable for the functions being conducted in each area of the nursing home;

(2) Are suitable for any task the resident chooses or any task the staff must do;

(3) Support the independent functioning of the resident;

(4) Provide a homelike environment; and

(5) Minimize glare.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-360, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-360, filed 9/15/94, effective 10/16/94.]

WAC 388-97-36010 Natural or artificial light. (1) The nursing home must ensure that adequate natural or artificial light for inside illumination is provided in every useable room area, including but not limited to storerooms, attic and basement rooms, hallways, stairways, inclines, and ramps.

(2) **In new buildings and additions**, the nursing home must utilize:

(a) Windows and skylights to minimize the need for artificial light and to allow a resident to experience the natural daylight cycle; and

(b) Windows and skylights near entrances/exits in order to avoid difficulty in adjusting to light levels when entering or leaving the facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36020 Outside lighting. The nursing home must ensure:

(1) Lighting levels in parking lots and approaches to buildings are appropriate for resident and visitor convenience and safety; and

(2) All outside areas where nursing home equipment and machinery are stored have proper lighting.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36030 Light shields. The nursing home must ensure that light shields are provided in food prepara-

tion and serving areas, utility rooms, medication rooms, exam rooms, pool enclosures, laundry areas, and on ceiling mounted fluorescent lights in resident rooms.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36040 Illumination levels in new buildings and additions. The nursing home must ensure:

(1) Lighting fixtures and circuitry provide at least the illumination levels shown within Table B;

(2) Design takes into consideration that lighting systems normally decrease in output with age and dirt accumulation; and

(3) Light fixture locations and switching arrangements are appropriate for the needs of the occupants of the spaces and follow Illuminating Engineering Society (IES) recommendations for health care facilities.

TABLE B

Average Maintained Footcandles

Area	Ambient Light[1]	Task Light[2]
Adm and lobby, day	30	NA
Adm and lobby, night	20	NA
Barber, beautician	50	NA
Chapel, quiet area	30	NA
Corridors, interior ramps	30	NA
Corridors, at night		20
Dining areas	50	NA
Doorways, exterior	20	NA
Exam, treatment table	NA	100
Exam, treatment room	30	50
Exit stairways and landings	30	NA
Food preparation areas	50	75
Janitor's closet	30	NA
Laundry	30	50
Medicine prep area	30	100
Nurses' desk	30	70
Nurses' station, day	30	50
Nurses' station, night	20	50
Physical therapy	30	50
Resident room	30	50
Resident reading light	NA	75
Recreation area	30	50
Toilet, hand washing sinks, and mirrors	30	50
Toilet and bathing facilities, general	30	NA
Utility room, general	30	
Utility room, work counter	NA	50
Worktable, course work	30	70
Worktable, fine work	50	100

1/ Ambient light measurements are taken two and one-half feet from the floor (plus or minus six inches). Minimum footcandles are based upon average measurement. A minimum of three measurements should be taken, including a measurement at the center of each area, near the outer perimeter, and at a point equidistant from the center and the perimeter measurement.

2/ Task light measurements are taken at the work surface. Minimum footcandles for task light are based upon average measurement. A minimum of three measurements should be taken, including a measurement at the center of each work surface, near the outer perimeter of the work surface, and at a point equidistant from the center and the perimeter measurement.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36050 Night lights in new construction. The nursing home must install in each resident room a night light that is:

(1) Flush mounted on the wall;

(2) Designed to prevent viewing the light source from thirty inches or more above the floor;

(3) Designed to provide a maximum illumination level of 10 footcandles;

(4) Located to provide safe pathway lighting for the staff and residents; and

(5) Controlled by a switch at each resident room entrance door or by a master switch.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36050, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36060 Switches in new construction. The nursing home must install quiet operating switches for general illumination adjacent to doors in all areas and accessible to residents in resident rooms.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36060, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36070 Electrical outlets. (1) The nursing home must provide enough electrical outlets to meet the care and personal appliance needs of each resident. An approved power tap may be used only for portable appliances with specific overcurrent protection needs, such as a computer. A "power tap" is a device for indoor use consisting of an attachment plug on the end of a flexible cord and two or more receptacles on the opposite end, with overcurrent protection. A power tap must be:

(a) Polarized or grounded;

(b) UL listed; and

(c) Directly connected to a permanently installed electrical outlet.

(2) **In new construction**, the nursing home must ensure:

(a) There are a minimum of seven outlets:

(i) Four hospital grade electrical outlets located convenient to each residents' bed and centered at forty to forty-four inches above the floor, with a minimum of:

(ii) Two additional electrical outlets at separate, convenient locations in each resident room; and

(iii) One duplex electrical outlet located adjacent to each handwashing sink intended for resident use.

(b) All electrical outlets located within five feet of any sink, toilet, bath, or shower must be protected by a ground fault circuit interrupter.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36070, filed 2/24/00, effective 3/26/00.]

SAFETY

WAC 388-97-365 Safety. The nursing home must provide:

(1) A safe, functional, sanitary, and comfortable environment for the residents, staff, and the public; and

(2) Signs to designate areas of hazard.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-365, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-365, filed 9/15/94, effective 10/16/94.]

WAC 388-97-36510 Safety—Poisons and nonmedical chemicals. The nursing home must ensure that poisons and nonmedicinal chemicals are stored in containers identified with warning labels. The containers must be stored:

(1) In a separate locked storage when not in use by staff; and

(2) Separate from drugs used for medicinal purposes.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36510, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36520 Safety—Storage of equipment and supplies. The nursing home must ensure that the manner in which equipment and supplies are stored does not jeopardize the safety of residents, staff, or the public.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36520, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36530 Safety—Handrails. The nursing home must:

(1) Provide handrails on each side of all corridors and stairwells accessible to residents; and

(2) **In new construction** ensure that:

(a) Ends of handrails are returned to the walls;

(b) Handrails are mounted thirty to thirty-four inches above the floor and project not more than three and three-quarters inches from the wall; and

(c) Handrails terminate not more than six inches from a door.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36530, filed 2/24/00, effective 3/26/00.]

WATER SUPPLY

WAC 388-97-370 Water supply. The nursing home must comply with the requirements of the group A, Public Water Systems, chapter 246-290 WAC or group B, Public Water Systems, chapter 246-291 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-370, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-370, filed 9/15/94, effective 10/16/94.]

WAC 388-97-37010 Hot water. The nursing home must ensure:

(1) The hot water system maintains water temperatures at one hundred ten degrees Fahrenheit, plus or minus ten degrees Fahrenheit, at fixtures used by residents and staff.

(2) For laundry temperatures, refer to WAC 388-97-347.

(3) For dishwashing temperatures, refer to chapter 246-215 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-37010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-37020 Cross connections. The nursing home must:

(1) Prohibit all cross connections between potable and nonpotable water;

(2) Use backflow prevention devices on plumbing fixtures, equipment, facilities, buildings, premises or areas which are actual or potential cross-connections to prevent the backflow of water or other liquids, gases, mixtures or substances into a water distribution system or other fixtures, equipment, facilities, buildings or areas; and

(3) Follow guidelines, practices, procedures, interpretations and enforcement as outlined in the manual titled "Accepted Procedure and Practice in Cross-Connection Control; Pacific NW Edition; American Waterworks Association," or any successor manual, referenced in chapter 246-290 WAC for public water supply.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-37020, filed 2/24/00, effective 3/26/00.]

PEST CONTROL AND SEWAGE AND WASTE DISPOSAL

WAC 388-97-375 Pest control. The nursing home must:

(1) Maintain an effective pest control program so that the facility is free of pests such as rodents and insects;

(2) Construct and maintain buildings to prevent the entrance of pests such as rodents and insects; and

(3) Provide mesh screens or equivalent with a minimum mesh of one-sixteenth inch on all windows and other openings that can be left open.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-375, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-375, filed 9/15/94, effective 10/16/94.]

WAC 388-97-385 Sewage and liquid waste disposal. The nursing home must ensure:

(1) All sewage and liquid wastes are discharged into an approved public sewage system where such system is available; or

(2) Sewage and liquid wastes are collected, treated, and disposed of in an on-site sewage system in accordance with chapter 246-272 WAC and meets with the approval of the local health department and/or the state department of health.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-385, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-385, filed 9/15/94, effective 10/16/94.]

NEW CONSTRUCTION DOCUMENTS

WAC 388-97-400 General new construction documents. (1) The project sponsor must submit plans for all new construction to the department of health, construction review, for review and approval. Documents must be approved before the work begins. The project sponsor must also submit documents to department of health, certificate of need for review and applicable determination.

(2) The nursing home may request exemptions to new construction requirements as described in WAC 388-97-405.

(3) If the proposed project is not extensive enough to require professional architectural or engineering services, the project sponsor must submit a written description to the department of health, construction review, to determine if WAC 388-97-401 applies.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-400, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-400, filed 9/15/94, effective 10/16/94.]

WAC 388-97-40010 Preliminary new construction documents. If preliminary documents and specifications are submitted, they must:

(1) Include a narrative program with drawings. Copies of these documents must be sent to the department of health, certificate of need and construction review, and to aging and adult services administration. The narrative program must identify:

(a) How the design promotes a homelike environment and facilitates resident-centered care and services;

(b) Functional space requirements;

(c) Staffing patterns;

(d) Each function to be performed;

(e) Types of equipment required; and

(f) Services that will not be provided directly, but will instead be provided through contract.

(2) Refer to WAC 388-97-400(3), if the proposed project is not extensive enough to require professional architectural or engineering services.

(3) Be drawn to scale and include:

(a) A site plan showing streets, entrance ways, driveways, parking, design statements for adequate water supply, sewage and disposal systems, space for the storage of recycled materials, and the arrangement of buildings on the site noting handicapped accessible parking and entrances;

(b) Floor plans showing existing and proposed arrangements within the building, including the fixed and major movable equipment; and

(c) Each room, space, and corridor identified by function and number.

(4) Include a general description of construction and materials, including interior finishes.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-40010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-401 Final new construction documents. (1) Construction must not start until at least two sets of final construction documents drawn to scale with complete specifications have been submitted to and approved by the department of health, construction review, in coordination with aging and adult services administration and the department of health, certificate of need.

(2) An architect or engineer licensed by the state of Washington must prepare, stamp, sign, and date the final construction documents.

(3) Construction documents that are changed after approval by the department of health, construction review, require resubmission before any construction on the proposed change is started.

(4) The construction of the facility must follow the final approved construction documents.

(5) These drawings and specifications must show complete details to be furnished to contractors for construction of the buildings, including:

(a) Site plan;

(b) Drawings of each floor of the building, including fixed equipment;

(c) Elevations, sections, and construction details;

(d) Schedule of floor, wall, and ceiling finishes, door and window sizes and types, and door finish hardware;

(e) Mechanical and electrical systems;

(f) Provision for noise, dust, smoke, and draft control, fire protection, safety and comfort of the residents if construction work takes place in or near occupied areas; and

(g) Landscape plans and vegetation planting schedules for dementia care units.

(6) A reduced set of the final construction floor plans on eight and one half by eleven inch or eleven by seventeen inch sheets showing each room function and number must be submitted.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-401, filed 2/24/00, effective 3/26/00.]

WAC 388-97-402 Pre-installation submissions for new construction. The department of health, construction review, must receive and approve pre-installation submissions prior to installation. Pre-installation submissions may include any or all of the following:

(1) Stamped shop drawings, hydraulic calculations, and equipment information sheets for fire sprinkler system(s);

(2) Shop drawings, battery calculations, and equipment information sheets for fire detection and alarm systems;

(3) Shop drawings and equipment information sheets for a kitchen hood and duct automatic fire extinguishing system;

(4) Drawings and equipment information sheets for special egress control devices; and

(5) Drawings and/or a finish schedule denoting areas to be carpeted with:

(a) A coding system identifying type of carpet in each area;

(b) A copy the manufacturer's specifications for each type of carpet; and

(c) A copy of a testing laboratory report of the radiant panel and smoke density tests for each type of carpet.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-402, filed 2/24/00, effective 3/26/00.]

WAC 388-97-403 New construction timelines. (1) Construction documents must be resubmitted for review as a new project according to current requirements if construction:

(a) Has not started within one year from the date of approval; or

(b) Is not completed within two years from the date of approval.

(2) To obtain an extension beyond two years, a written request must be submitted and approved thirty days prior to the end of the two-year period.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-403, filed 2/24/00, effective 3/26/00.]

WAC 388-97-405 Exemptions to new construction requirements. (1) The director of residential care services, aging and adult services administration, may grant exemptions to new construction requirements for:

(a) Alterations when the applicant demonstrates the proposed alterations will serve to correct deficiencies or will upgrade the nursing home in order to better serve residents; and

(b) Substitution of procedures, materials, or equipment for requirements specified in this chapter when such procedures, materials, or equipment have been demonstrated to the director's satisfaction to better serve residents.

(2) The nursing home must ensure requests for exemptions are in writing and include any necessary approvals from the local code enforcement authority and the state fire marshal.

(3) The nursing home must ensure all exemptions granted under the foregoing provisions are kept on file at the nursing home.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-405, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-405, filed 9/15/94, effective 10/16/94.]

CODES AND STANDARDS IN NEW CONSTRUCTION

WAC 388-97-410 State building code in new construction. The nursing home must through its design, construction and necessary permits demonstrate compliance with the following codes and local jurisdiction standards:

(1) The Uniform Building Code, and Uniform Building Code Standards, as published by the International Conference of Building Officials as amended and adopted by the Washington state building code council and published as chapter 51-40 WAC, or successor laws;

(2) The Uniform Mechanical Code, including chapter 22, Fuel Gas Piping, Appendix B, as published by the International Conference of Building Officials and the International Association of Plumbing and Mechanical Officials as amended and adopted by the Washington state building code council and published as chapter 51-42 WAC, or successor laws;

(3) The Uniform Fire Code, and Uniform Fire Code Standards, as published by the International Conference of Building Officials and the Western Fire Chiefs Association as amended and adopted by the Washington state building code council and published as chapters 51-44 and 51-45 WAC, or successor laws;

(4) The Uniform Plumbing Code, and Uniform Plumbing Code Standards, as published by the International Association of Plumbing and Mechanical Officials, as amended and adopted by the Washington state building code council and published as chapters 51-46 and 51-47 WAC, or successor laws;

(5) The Washington state ventilation and indoor air quality code, as adopted by the Washington state building code council and filed as chapter 51-13 WAC, or successor laws; and

(6) The Washington state energy code, as amended and adopted by the Washington state building code council and filed as chapter 51-11 WAC, or successor laws.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-410, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-410, filed 9/15/94, effective 10/16/94.]

WAC 388-97-415 Electrical codes and standards in new construction. The nursing home must ensure that all electrical wiring complies with state and local electrical codes including chapter 296-46 WAC, and the National Electric Code of the National Fire Protection Association (NFPA-70) as adopted by the Washington state department of labor and industry.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-415, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-415, filed 9/15/94, effective 10/16/94.]

WAC 388-97-420 Elevator codes in new construction. The nursing home must ensure that elevators are installed in accordance with chapter 296-81 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-420, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-420, filed 9/15/94, effective 10/16/94.]

WAC 388-97-425 Local codes and ordinances in new construction. The nursing home must:

(1) Follow all local ordinances relating to zoning, building, and environmental standards; and

(2) Obtain all local permits before construction and keep permits on file at the nursing home.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-425, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-425, filed 9/15/94, effective 10/16/94.]

ADMINISTRATION AND PUBLIC AREAS IN NEW CONSTRUCTION

WAC 388-97-430 Entrances and exits in new construction. The nursing home must have the main entrances and exits sheltered from the weather and barrier free accessible in accordance with chapter 51-40 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-430, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-430, filed 9/15/94, effective 10/16/94.]

WAC 388-97-43010 Lobbies in new construction. The nursing home must have a lobby or area in close proximity to the main entrance that is barrier free accessible and includes:

(1) Waiting space with seating accommodations;

(2) A reception and information area;

(3) Space to accommodate persons in wheelchairs;

(4) A public restroom;

(5) A drinking fountain; and

(6) A public telephone.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-43020 Interview space in new construction. The nursing home must have interview spaces for private interviews relating to social service and admission.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-43030 Offices in new construction. The nursing home must provide:

(1) Office space convenient to the work area for the administrator, the director of nursing services, medical records staff, social services staff, activities director, and other personnel as appropriate;

(2) Work space for physicians and outside consultants;

(3) Space for locked storage of health records which provides for fire and water protection; and

(4) Space for the safe storage and handling of financial and business records.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-43040 Inservice education space in new construction. The nursing home must provide space for employee inservice education that will not infringe upon resident space.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-43050 Staff areas in new construction. The nursing home must ensure a lounge, lockers, and toilets are provided convenient to the work areas for employees and volunteers.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43050, filed 2/24/00, effective 3/26/00.]

VISITING, PRIVATE, AND OUTDOOR RECREATION SPACE AND WALKWAYS IN NEW CONSTRUCTION

WAC 388-97-455 Visiting and private space in new construction. The nursing home must design a separate room or areas for residents to have family and friends visit and for residents to spend time alone. The nursing home must ensure these areas provide:

(1) Space which facilitates conversation and privacy; and

(2) Access to a common-use toilet facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-455, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-455, filed 9/15/94, effective 10/16/94.]

WAC 388-97-45510 Outdoor recreation space and walkways in new construction. A nursing home must provide a safe, protected outdoor area for resident use. The nursing home must ensure the outdoor area has:

(1) Shaded and sheltered areas to meet residents needs;

(2) Accessible walking surfaces which are firm, stable, and free from cracks and abrupt changes with a maximum of one inch between sidewalk and adjoining landscape areas;

(3) Sufficient space and outdoor furniture provided with flexibility in arrangement of the furniture to accommodate residents who use wheelchairs and mobility aids;

(4) Shrubs, natural foliage, and trees; and

(5) If used as a resident courtyard, the outdoor area must not be used for public or service deliveries.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-45510, filed 2/24/00, effective 3/26/00.]

POOLS AND PHARMACIES IN NEW CONSTRUCTION

WAC 388-97-460 Pools in new construction. The nursing home must ensure swimming pools, spas, and tubs which remain filled between uses meet the requirements in chapter 246-260 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-460, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-460, filed 9/15/94, effective 10/16/94.]

WAC 388-97-46010 Pharmacies in new construction. The nursing home must ensure that an on-site pharmacy meets the requirements of the Washington State board of pharmacy per chapters 18.64 RCW and 246-865 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46010, filed 2/24/00, effective 3/26/00.]

GENERAL DESIGN REQUIREMENTS IN NEW CONSTRUCTION

WAC 388-97-465 Elevators in new construction. The nursing home must:

(1) Ensure that all buildings having residential use areas or service areas that are not located on the main entrance floor, have an elevator; and

(2) Have at least one elevator sized to accommodate a resident bed and attendant for each sixty beds on floors other than the main entrance floor.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-465, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-465, filed 9/15/94, effective 10/16/94.]

WAC 388-97-46510 Stairways, ramps, and corridors in new construction. The nursing home must ensure stairways, ramps and corridors conform with the Uniform Building Code.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46510, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46520 Walking surfaces in a new building or addition. The nursing must ensure that:

(1) An abrupt change in the walking surface level including at door thresholds which are greater than one quarter inch are beveled to a one vertical in two horizontal; and

(2) Changes in the walking surface level greater than one half inch are accomplished by means of a ramp with a maximum slope of one vertical in twelve horizontal.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46520, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46530 Doors in new construction. The nursing home must ensure doors to:

(1) Resident rooms provide a minimum of forty-four inches clear width;

(2) Resident bathrooms and toilet rooms are a minimum of thirty-two inches clear width for wheelchair access;

(3) All resident toilet rooms and bathing facilities open outward except if doors open directly into a resident occupied corridor;

(4) Toilet rooms and bathrooms have single action locks, and a means of unlocking doors from the outside;

(5) Occupied areas do not swing into corridors; and

(6) All passages are arranged so that doors do not open onto or obstruct other doors while maintaining resident dignity.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46530, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46540 Floor finishes in new construction. The nursing home must ensure:

(1) Floors at all outside entrances have slip resistant finishes both inside and outside the entrance even when wet; and

(2) All uncarpeted floors are smooth, nonabsorbent and easily cleanable.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46540, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46550 Carpets in new construction. The nursing home must ensure that department of health, construction review approves of all carpet installation.

(1) Carpets may be used in all areas except: toilet rooms, bathrooms, kitchen, laundry, utility rooms, medication rooms, maintenance, isolation rooms if provided, and areas subject to high moisture or flooding. Specifications for acceptable carpeting are:

(a) Pile yarn fibers are easily cleanable;

(b) Pile is looped texture in all resident use areas. Cut pile may be used in nonresident use areas;

(c) Average pile density of five thousand ounces per cubic yard in resident use areas and four thousand ounces per cubic yard in nonresident areas. The formula for calculating the density of the carpet is: Yarn weight in ounces times 36, divided by pile height in inches equals ounces per cubic yard of density; and

(d) A maximum pile height of .255 inches in resident use areas and .312 inches in nonresident use areas.

(2) Carpets must:

(a) Be cemented to the floor; and

(b) Have the edges covered and top set base with toe at all wall junctures.

(3) When recarpeting, the safety of residents must be assured during and after recarpeting installation within the room or area. The nursing home must ensure the room or area is:

(a) Well ventilated;

(b) Unoccupied; and

(c) Unavailable for use until room is free of volatile fumes and odors.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46550, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46560 Coving in new construction. The nursing home must ensure:

(1) Kitchens, restrooms, laundry, utility rooms, and bathing areas have integral coves of continuous commercial grade sheet vinyl, bullnose ceramic tile or sealed bullnose quarry tile at least six inches in height; and

(2) All other wall junctions have either integral coving or top set base with toe.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46560, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46570 Walls in new construction. The nursing home must ensure:

(1) Wall finishes are easily cleanable;

(2) A water-resistant finish extends above the splash line in all rooms or areas subject to splash or spray, such as bathing facilities with tubs only, toilet rooms, janitors' closets, and can-wash areas; and

(3) Bathing facilities with showers have a water-resistant finish extending to the ceiling.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46570, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46580 Accessories in new construction. The nursing home must provide the following accessories with the necessary backing, if required, for mounting:

(1) Usable countertop area and mirror at each handwashing sink in toilet rooms and resident rooms;

(2) Towel or robe hooks at each handwashing sink in resident rooms and at each bathing facility;

(3) A robe hook at each bathing facility, toilet room and in examination room or therapy area, including outpatient therapy rooms;

(4) A securely mounted toilet paper holder properly located within easy reach of the user at each toilet fixture;

(5) Sanitary seat covers at each public and employee use toilet;

(6) Open front toilet seats on all toilets;

(7) Dispensers for paper towels and handwashing soap at each handwashing sink, and bathing facility;

(8) Sanitary napkin dispensers and disposers in public and employee women's toilet rooms; and

(9) Grab bars that are easily cleanable and resistant to corrosion and securely mounted.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46580, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46590 Miscellaneous in new construction. The nursing home must ensure:

(1) Rooms and service areas are identified by visible and tactile signs, refer to WAC 388-97-35050(2) for possible exceptions; and

(2) Equipment and casework is designed, manufactured and installed for ease of proper cleaning and maintenance, and suitable for the functions of each area.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46590, filed 2/24/00, effective 3/26/00.]

HEATING, VENTILATION, AND AIR CONDITIONING SYSTEMS IN NEW CONSTRUCTION

WAC 388-97-470 Heating systems in new construction. The nursing home must ensure:

(1) The heating system is capable of maintaining a temperature of seventy-five degrees Fahrenheit for areas occupied by residents and seventy degrees Fahrenheit for nonresident areas;

(2) Resident rooms have individual temperature control, except in a dementia care unit controls may be covered, locked, or placed in an inconspicuous place;

(3) The following is insulated within the building:

(a) Pipes conducting hot water which are exposed to resident contact; and

(b) Air ducts and casings with outside surface temperatures below ambient dew point.

(4) Insulation on cold surfaces includes an exterior vapor barrier; and

(5) Electric resistant wall heat units are prohibited in new construction.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-470, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-470, filed 9/15/94, effective 10/16/94.]

WAC 388-97-47010 Cooling systems in new construction. The nursing home must have:

(1) A mechanical cooling system capable of maintaining a temperature of seventy-five degrees Fahrenheit for areas occupied by residents; and

(2) A cooling system that has mechanical refrigeration equipment to provide summer air conditioning to resident areas, food preparation areas, laundry, medication rooms, and therapy areas by either a central system with distribution ducts or piping, or packaged room or zonal air conditioners.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-47010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-47020 Ventilation systems in new construction. The nursing home must ensure:

(1) Ventilation of all rooms is designed to prevent objectionable odors, condensation, and direct drafts on the residents;

(2) All habitable space is mechanically ventilated including:

(a) Air-supply and air-exhaust systems;

(b) Installation of air-handling duct systems according to the requirements of the Uniform Mechanical Code and chapter 51-42 WAC;

(c) Corridors not used to supply air to, or exhaust air from, any room except that infiltration air from corridors may be used to ventilate bathrooms, toilet rooms, janitors' closets, and small electrical or telephone closets opening directly on corridors;

(d) Installation of supply registers and return air grilles at least three inches above the floor;

(e) Installation of exhaust grilles on or near the ceiling; and

(f) Outdoor air intakes located a minimum of twenty-five feet from the exhaust from any ventilating system, combustion equipment, or areas which may collect vehicular exhaust and other noxious fumes, and a minimum of ten feet from plumbing vents. The nursing home must locate the bottom of outdoor air intakes serving central systems a minimum of three feet above adjoining grade level or, if installed through the roof, three feet above the highest adjoining roof level.

TABLE 5

PRESSURE RELATIONSHIPS AND VENTILATION OF CERTAIN AREAS OF NURSING HOMES

FUNCTION AREA	Pressure Relationship To Adjacent Areas[1,2]	Minimum Air Changes of Outdoor Air Per Hour Supplied To Room	Minimum Total Air Changes Per Hour Supplied To Room	All Air Exhausted Directly To Outdoors	Air Recirculated Within Room Units
PATIENT CARE					
Isolation Room	N	2	12	Yes	No
Patient area corridor	±	Optional	2	Optional	Optional
Patient room	±	2	2	Optional	Optional
Toilet room	N	Optional	10	Yes	No
DIAGNOSTIC AND TREATMENT					
Clean workroom or clean holding	P	2	4	Optional	Optional
Examination room	±	2	6	Optional	Optional
Occupational therapy[3]	N	2	3	Optional	Optional
Physical therapy[3]	N	2	3	Optional	Optional
Soiled workroom or soiled holding	N	2	10	Yes	No
STERILIZING AND SUPPLY					
Clean linen storage	P	Optional	2	Yes	No
Laundry, general[3]	±	2	10	Yes	No

TABLE 5
PRESSURE RELATIONSHIPS AND VENTILATION OF CERTAIN AREAS OF NURSING HOMES

FUNCTION AREA	Pressure Relationship To Adjacent Areas[1,2]	Minimum Air Changes of Outdoor Air Per Hour Supplied To Room	Minimum Total Air Changes Per Hour Supplied To Room	All Air Exhausted Directly To Outdoors	Air Recirculated Within Room Units
Linen and trash chute room	N	Optional	10	Yes	No
Soiled linen sorting and storage	N	Optional	10	Yes	No
Sterilizer equipment room	N	Optional	10	Yes	No
SERVICE					
Bathroom	N	Optional	10	Yes	No
Dietary day storage	±	Optional	2	Yes	No
Food preparation center[3]	±	2	10	Yes	No
Janitor's closet	N	Optional	10	Yes	No
Warewashing room[3]	N	Optional	10	Yes	No

1/ P=Positive N=Negative ±=Continuous directional control not required.

2/ Whether positive or negative, pressure must be a minimum of seventy cubic feet per minute (CFM).

3/ The volume of air may be reduced up to fifty percent in these areas during periods of nonuse. The soiled holding area of the general laundry must maintain its full ventilation capacity at all time.

(3) Minimum ventilation requirements. Meet the pressure relationship and ventilation rates per ASHRAE 95 HVAC Applications Chapter 7.11 Table 5 Pressure Relationships and Ventilation of Certain Areas of Nursing Homes. The nursing home must ensure:

(a) Exhaust hoods in food preparation areas comply with the Uniform Mechanical Code;

(b) All hoods over commercial type cooking ranges are equipped with fire extinguishing systems and heat actuated fan controls;

(c) Kitchen ventilation is adequate to provide comfortable working temperatures;

(d) Boiler rooms, elevator equipment rooms, laundry rooms, and any other heat-producing spaces are provided with sufficient outdoor air to maintain combustion rates of equipment and to limit temperatures at the ceiling to ninety-seven degrees Fahrenheit; and

(e) Individual toilet rooms and bathrooms are ventilated either by individual mechanical exhaust systems or by a central mechanical exhaust system.

(4) Individual exhaust systems.

(a) Where individual mechanical exhaust systems are used to exhaust individual toilet rooms or bathrooms, the individual ventilation fans are interconnected with room lighting to ensure ventilation while room is occupied. The ventilation fan must have a time delay shutoff to ensure that the exhaust continues for a minimum of five minutes after the light switch is turned off; and

(b) The volume of air removed from the space by exhaust ventilation is replaced directly or indirectly by an equal amount of tempered/conditioned air.

(5) Central exhaust systems. The nursing home must ensure:

(a) All fans serving central exhaust systems are located to prevent a positive pressure in the duct passing through an occupied area; and

(b) Fire and smoke dampers are located and installed in accordance with the Uniform Building Code chapter 51-40 WAC.

(6) Air filters.

(a) All central ventilation or air-conditioning systems are equipped with filters having efficiencies of at least eighty percent if the system supplies air to resident rooms, therapy areas, food preparation areas, or laundry areas;

(b) Central ventilation or air conditioning systems means any system serving more than a single room used by residents or by any group of rooms serving the same utility function (i.e., the laundry);

(c) Filter efficiency is warranted by the manufacturer and is based on atmospheric dust spot efficiency per ASHRAE Standard 52-76;

(d) The filter bed is located upstream of the air-conditioning equipment, unless a prefilter is employed. In which case, the prefilter is upstream of the equipment and the main filter bed may be located downstream; and

(e) The nursing home must ensure:

(i) Filter frames are durable and provide an airtight fit with the enclosing duct work. All joints between filter segments and enclosing duct work are gasketed or sealed;

(ii) All central air systems have a manometer installed across each filter bed with an alarm to signal high pressure differential; and

(iii) Humidifiers, if provided, are a steam type.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-47020, filed 2/24/00, effective 3/26/00.]

PLUMBING AND FIXTURES IN NEW CONSTRUCTION

WAC 388-97-480 Handwashing sinks in new construction. The nursing home must provide a handwashing sink in each toilet room and exam room.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-480, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-480, filed 9/15/94, effective 10/16/94.]

WAC 388-97-48010 Drinking fountains in new construction. Where drinking fountains are installed, the nursing home must ensure the fountains are of the inclined jet, sanitary type.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-48010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-48020 Mixing valves or mixing faucets in new construction. The nursing home must provide each fixture, except toilet fixtures and special use fixtures, with hot and cold water through a mixing valve or mixing faucet.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-48020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-48030 Spouts in new construction. The nursing home must ensure all lavatories and sinks in resident rooms, resident toilet rooms, and utility and medication areas have gooseneck spouts, without aerators in areas requiring infection control.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-48030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-48040 Faucet controls in new construction. The nursing home must provide wrist blade, single-lever controls or their equivalent at all sinks and lavatories. The nursing home must:

(1) Provide at least four inch wrist blades and/or single-levers;

(2) Provide sufficient space for full open and closed operation; and

(3) Color-code and label faucet controls to indicate "hot" and "cold."

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-48040, filed 2/24/00, effective 3/26/00.]

SUBCHAPTER III
NURSING HOME LICENSE

INITIAL LICENSE APPLICATION

WAC 388-97-550 Initial nursing home license. (1) A complete nursing home license application must be:

(a) Submitted at least sixty days prior to the proposed effective date of the license on forms designated by the department;

(b) Signed by the proposed licensee or the proposed licensee's authorized representative;

(c) Notarized; and

(d) Reviewed by the department in accordance with this chapter.

(2) All information requested on the license application must be provided. At minimum, the nursing home license application will require the following information:

(a) The name and address of the proposed licensee, and any partner, officer, director, managerial employee, or owner of five percent or more of the proposed licensee;

(b) The names of the administrator, director of nursing services, and, if applicable, the management company;

(c) The specific location and the mailing address of the facility for which a license is sought;

(d) The number of beds to be licensed; and

(e) The name and address of all nursing homes that the proposed licensee or any partner, officer, director, managerial employee, or owner of five percent or more of the proposed licensee has been affiliated with in the past ten years.

(3) The proposed licensee must be:

(a) The individual or entity responsible for the daily operation of the nursing home;

(b) Denied the license if any individual or entity named in the application is found by the department to be unqualified.

(4) For initial licensure of a new nursing home, the proposed licensee must submit the annual license fee with the initial license application. The nonrefundable nursing home license fee is one hundred twenty-seven dollars per bed per year.

(5) If any information submitted in the initial license application changes before the license is issued, the proposed licensee must submit a revised application containing the changed information.

(6) If a license application is pending for more than six months, the proposed licensee must submit a revised application containing current information about the proposed licensee or any other individuals or entities named in the application.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-550, filed 2/24/00, effective 3/26/00.]

LICENSE RENEWAL

WAC 388-97-555 Nursing home license renewal. (1) All nursing home licenses must be renewed annually.

(2) License renewals must be:

(a) Submitted at least thirty days prior to the license's expiration date on forms designated by the department;

(b) Signed by the current licensee or the current licensee's authorized representative;

(c) Notarized; and

(d) Reviewed by the department in accordance with this chapter.

(3) The current licensee must provide all information on the license renewal form or other information requested by the department.

(4) The application for a nursing home license renewal must be:

(a) Made by the individual or entity currently licensed and responsible for the daily operation of the nursing home;

(b) Denied if any individual or entity named in the renewal application is found by the department to be unqualified.

(5) The nursing home license renewal fee must be submitted at the time of renewal. The nonrefundable fee is one hundred twenty-seven dollars per bed per year.

(6) In unusual circumstances, the department may issue an interim nursing home license for a period not to exceed three months. The current licensee must submit the prorated

nursing home license fee for the period covered by the interim license. The annual date of license renewal does not change when an interim license is issued.

(7) A change of nursing home ownership does not change the date of license renewal and fee payment.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-555, filed 2/24/00, effective 3/26/00.]

DEPARTMENT REVIEW OF LICENSE APPLICATIONS AND APPEALS

WAC 388-97-560 Department review of initial nursing home license applications. (1) All initial nursing home license applications must be reviewed by the department under this chapter.

(2) The department will not begin review of an incomplete license application.

(3) The proposed licensee must respond to any department request for additional information within five working days.

(4) When the application is determined to be complete, the department will consider the proposed licensee or any partner, officer, director, managerial employee, or owner of five percent or more of the proposed licensee, separately and jointly, in its review. The department will review:

(a) The information contained in the application;

(b) Survey and complaint investigation findings in every facility each individual and entity named in the application has been affiliated with during the past ten years;

(c) Compliance history;

(d) Financial assessments;

(e) Actions against the proposed licensee (i.e., revocation, suspension, refusal to renew, etc.);

(f) All criminal convictions, and relevant civil or administrative actions or findings including, but not limited to, findings under 42 C.F.R. §488.335, disciplinary findings, and findings of abuse, neglect, exploitation, or abandonment; and

(g) Other relevant information.

(5) The department will notify the proposed licensee of the results of the review.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-560, filed 2/24/00, effective 3/26/00.]

WAC 388-97-565 Department review of nursing home license renewals. (1) All renewal license applications must be reviewed by the department under this chapter.

(2) The department will not begin review of an incomplete license renewal application.

(3) The proposed licensee must respond to any department request for additional information within five working days.

(4) When the application is determined to be complete, the department will review:

(a) The information contained in the application;

(b) Actions against the license (i.e., revocation, suspension, refusal to renew, etc.);

(c) All criminal convictions, and relevant civil or administrative actions or findings including, but not limited to, findings under 42 C.F.R. §488.335, disciplinary findings, and findings of abuse, neglect, exploitation, or abandonment; and

(d) Other relevant information.

(5) The department will notify the current licensee of the results of the review.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-565, filed 2/24/00, effective 3/26/00.]

WAC 388-97-570 Reasons for denial, suspension, modification, revocation of, or refusal to renew a nursing home license. (1) The department may deny, suspend, revoke, or refuse to renew a nursing home license if the proposed or current licensee, or any partner, officer, director, managing employee, or owner of five percent or more of the proposed or current licensee of the nursing home has:

(a) Not complied with all the requirements established by chapters 18.51, 74.42, or 74.46 RCW and rules adopted thereunder;

(b) A history of significant noncompliance with federal or state regulations in providing nursing home care;

(c) No credit history or a poor credit history;

(d) Engaged in the illegal use of drugs or the excessive use of alcohol or been convicted of "crimes relating to drugs" as defined in RCW 43.43.830;

(e) Unlawfully operated a nursing home, or long term care facility as defined in RCW 70.129.010, without a license;

(f) Previously held a license to operate a hospital or any facility for the care of children or vulnerable adults, and that license has been revoked, or suspended, or the licensee did not seek renewal of the license following written notification of the licensing agency's initiation of revocation or suspension of the license;

(g) Obtained or attempted to obtain a license by fraudulent means or misrepresentation;

(h) Permitted, aided, or abetted the commission of any illegal act on the nursing home premises;

(i) Failed to meet financial obligations as the obligations fall due in the normal course of business;

(j) Been convicted of a felony, other than a felony that is a "crime against children or other persons," or a "crime relating to financial exploitation" as defined in RCW 43.43.830, if the crime reasonably relates to the competency of the individual to own or operate a nursing home;

(k) Failed to provide any authorization, documentation, or information the department requires in order to verify information contained in the application; or

(l) Failed to verify additional information the department determines relevant to the application.

(2) In determining whether there is a history of significant noncompliance with federal or state regulations under subsection (1)(b), the department may, at a minimum, consider:

(a) Whether the violation resulted in a significant harm or a serious and immediate threat to the health, safety, or welfare of any resident;

(b) Whether the proposed or current licensee promptly investigated the circumstances surrounding any violation and took steps to correct and prevent a recurrence of a violation;

(c) The history of surveys and complaint investigation findings and any resulting enforcement actions;

(d) Repeated failure to comply with regulations;

(e) Inability to attain compliance with cited deficiencies within a reasonable period of time; and

(f) The number of violations relative to the number of facilities the proposed or current licensee, or any partner, officer, director, managing employee, or owner of five percent or more of the proposed or current licensee of the nursing home, has been affiliated with in the past ten years.

(3) The department must deny, suspend, revoke, or refuse to renew a proposed or current licensee's nursing home license if the proposed or current licensee or any partner, officer, director, managing employee, or owner of five percent or more of the assets of the nursing home, has been:

(a) Convicted of a "crime against children or other persons" as defined under RCW 43.43.830;

(b) Convicted of a "crime relating to financial exploitation" as defined under RCW 43.43.830;

(c) Found by a court in a protection proceeding under chapter 74.34 RCW, or any comparable state or federal law, to have abandoned, abused, neglected or financially exploited a vulnerable adult;

(d) Found in any final decision issued by a disciplinary board to have sexually or physically abused or exploited any minor or an individual with a developmental disability or to have abused or financially exploited any vulnerable adult;

(e) Found in any dependency action to have sexually assaulted or exploited any minor or to have physically abused any minor;

(f) Found by a court in a domestic relations proceeding under Title 26 RCW, or any comparable state or federal law, to have sexually abused or exploited any minor or to have physically abused any minor; or

(g) Found to have abused, neglected, or mistreated residents or misappropriated their property, and that finding has been entered on a nursing assistant registry.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-570, filed 2/24/00, effective 3/26/00.]

WAC 388-97-575 Appeal of the department's licensing decision. (1) A proposed or current licensee contesting a department licensing decision must file a written request for an adjudicative proceeding within twenty days of receipt of the decision.

(2) Adjudicative proceedings will be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 18.51.065, 43.20A.205, WAC 388-98-750, and chapters 388-08 and 388-97 WAC. If any provision in this chapter conflicts with chapter 388-08 WAC, the provision of this chapter will govern.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-575, filed 2/24/00, effective 3/26/00.]

MANAGEMENT AGREEMENTS AND CHANGES OF OWNERSHIP

WAC 388-97-580 Management agreements. (1) If the responsibilities given to the manager by the management agreement are so extensive that the licensee is relieved of responsibility for the daily operations of the facility, then the department must determine that a change of ownership has occurred.

(2) The proposed licensee or the current licensee must notify the residents and their representatives sixty days before entering into a management agreement.

(3) The department must receive a written management agreement, including an organizational chart showing the relationship between the proposed or current licensee, management company, and all related organizations:

(a) Sixty days before the proposed change of ownership date as part of the initial license application or any change of ownership;

(b) Sixty days before the effective date when submitted by the current licensee; or

(c) Thirty days before the effective date of any amendment to an existing management agreement.

(4) Management agreements, at minimum must:

(a) Create a principal/agent relationship between the licensee and the manager;

(b) Describe the responsibilities of the licensee and manager, including items, services, and activities to be provided;

(c) Require the licensee's governing body, board of directors, or similar authority to appoint the facility administrator;

(d) Provide for maintenance and retention of all records as applicable according to rules and regulations;

(e) Allow unlimited access by the department to documentation and records according to applicable laws or regulations;

(f) Require the licensee to participate in monthly oversight meetings and quarterly on-site visits to the facility;

(g) Require the manager to immediately send copies of surveys and notices of noncompliance to the licensee;

(h) State that the licensee is responsible for ensuring all licenses, certifications, and accreditations are obtained and maintained;

(i) State that the manager and licensee will review the management agreement annually and notify the department of changes according to applicable rules and regulations; and

(j) Acknowledge that the licensee is the party responsible for meeting state and federal licensing and certification requirements.

(5) Upon receipt of a proposed management agreement, the department may require:

(a) The licensee or manager to provide additional information or clarification;

(b) Any changes necessary to:

(i) Bring the management agreement into compliance with this section; and

(ii) Ensure that the licensee has not been relieved of the responsibility for the daily operations of the facility; and

(c) More frequent contact between the licensee and manager under subsection (4)(f).

(6) The department may monitor the licensee's and manager's compliance with the terms of the management agreement and take any action deemed appropriate.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-580, filed 2/24/00, effective 3/26/00.]

WAC 388-97-585 Change of ownership. (1) A change of ownership occurs when there is a substitution of the operator or operating entity responsible for the daily operational decisions of the nursing home, or a substitution of control of such operating entity. Events which constitute a change of ownership include, but are not limited to, the following:

(a) The form of legal organization of the licensee is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) The licensee transfers ownership of the nursing home business enterprise to another party regardless of whether ownership of some or all of the real property and/or personal property assets of the facility is also transferred;

(c) Dissolution or consolidation of the entity, or merger if the licensee does not survive the merger;

(d) If, during any continuous twenty-four month period, fifty percent or more of the entity is transferred, whether by a single transaction or multiple transactions, to:

(i) A different party (e.g., new or former shareholders); or (ii) An individual or entity that had less than a five percent ownership interest in the nursing home at the time of the first transaction; or

(e) Any other event or combination of events that results in a substitution or substitution of control of the operator or the operating entity responsible for the daily operational decisions of the nursing home.

(2) Ownership does not change when the following, without more, occur:

(a) A party contracts with the licensee to manage the nursing home enterprise as the licensee's agent (i.e., as provided in WAC 388-97-580); or

(b) The real property or personal property assets of the nursing home are sold or leased, or a lease of the real property or personal property assets is terminated, as long as there is not a substitution or substitution of control of the operator or operating entity.

(3) When a change of ownership is contemplated, the current licensee must notify the department and all residents and their representatives at least sixty days prior to the proposed date of transfer. The notice must be in writing and contain the following information:

(a) Name of the current licensee and proposed licensee;

(b) Name and address of the nursing home being transferred; and

(c) Date of proposed transfer.

(4) The proposed licensee must comply with license application requirements. The operation or ownership of a nursing home must not be transferred until the proposed licensee has been issued a license to operate the nursing home.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-585, filed 2/24/00, effective 3/26/00.]

LICENSED BED CAPACITY, RELOCATION OF RESIDENTS AND LICENSE RELINQUISHMENT

WAC 388-97-590 Licensed bed capacity. A nursing home must not be licensed for a capacity that exceeds the number of beds permitted under:

(1) This chapter;

(2) Chapter 70.38 RCW and regulations thereunder; or

(3) Applicable local zoning, building or other such regulations.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-590, filed 2/24/00, effective 3/26/00.]

WAC 388-97-595 Relocation of residents. (1) In the event of license revocation or suspension, decertification, or other emergency closures the department must:

(a) Notify residents and, when appropriate, resident representatives of the action; and

(b) Assist with residents' relocation and specify possible alternative living choices and locations.

(2) When a resident's relocation occurs due to a nursing home's voluntary closure, or voluntary termination of its Medicare and/or Medicaid contract:

(a) The nursing home must:

(i) Send written notification, sixty days before closure or contract termination, to the department's designated local office and to all residents and resident representatives; and

(ii) Provide appropriate discharge planning and coordination for all residents.

(b) The department may provide residents assistance with relocation.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-595, filed 2/24/00, effective 3/26/00.]

WAC 388-97-600 License relinquishment. (1) A nursing home licensee must voluntarily relinquish its license when:

(a) The nursing home ceases to do business as a nursing home; and

(b) Within twenty-four hours after the last resident is discharged from the facility.

(2) The license must be returned to the department.

(3) If a nursing home licensee fails to voluntarily relinquish its license, the department will revoke the license.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-600, filed 2/24/00, effective 3/26/00.]

Chapter 388-98 WAC
NURSING HOME LICENSURE PROGRAM ADMINISTRATION

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-98-005	Receivership. [Statutory Authority: Chapter 18.51 RCW. 88-06-086 (Order 2603), § 388-98-005, filed 3/2/88.] Repealed by 90-01-052 (Order 2917), filed

12/15/89, effective 1/15/90. Statutory Authority: 1989 c 372 § 8.

388-98-800 Applicability of civil fines. [Statutory Authority: 1987 c 476. 87-21-017 (Order 2546), § 388-98-800, filed 10/9/87. Statutory Authority: RCW 18.51.310. 80-08-027 (Order 1515), § 388-98-800, filed 6/25/80.] Repealed by 90-01-052 (Order 2917), filed 12/15/89, effective 1/15/90. Statutory Authority: 1989 c 372 § 8.

388-98-850 Imposition and payment of fines. [Statutory Authority: 1987 c 476. 87-21-017 (Order 2546), § 388-98-850, filed 10/9/87. Statutory Authority: RCW 18.51.310. 80-08-027 (Order 1515), § 388-98-850, filed 6/25/80.] Repealed by 90-01-052 (Order 2917), filed 12/15/89, effective 1/15/90. Statutory Authority: 1989 c 372 § 8.

WAC 388-98-001 Definitions. (1) For purposes of this section, the following words or phrases shall have the following meanings unless the context clearly indicates otherwise:

(2) "Applicant" means an individual, partnership, corporation, or other legal entity seeking a license to operate a nursing home.

(3) "Deficiency" means a finding by the department of a violation of professional standards of practice, the requirements of chapters 18.51 or 74.42 RCW, or the standards, rules, and regulations established under them or in the case of a Medicaid contractor, violation of Medicaid requirements of Title XIX of the Social Security Act, as amended, and regulations promulgated thereunder.

(4) "Denial of payment" means a department decision not to pay for new Medicaid admissions to a nursing home.

(5) "Department" means the nursing home licensing agency of the state department of social and health services.

(6) "Director" means an individual elected or appointed as director of a corporation.

(7) "Emergency closure" means a department order to immediately close a nursing home.

(8) "Emergency transfer" means a department order to immediately transfer specified residents or all residents from a nursing home to safe settings.

(9) "Highest practicable physical, mental, or psychosocial well being" means the highest level of functioning and well being possible to be achieved for a resident limited by the resident's presenting functional status and potential for improvement or reduced rate of degeneration. Highest practicable is not a diagnostic, prospective, delineating determination made without aggressive, competent efforts to halt degenerative processes and to achieve or restore independent free choice functioning. It is achieved through functional assessment and aggressive, competent addressing of the individual's physical, mental, and psychosocial needs.

(10) "Licensed nursing home" means a nursing home licensed under chapter 18.51 RCW.

(11) "Licensee" means an individual, partnership, corporation, or other legal entity licensed to operate a nursing home or a person subject to licensure as determined by the department. This does not include an employee of a licensee or person unless that employee is an owner of five percent or more of the licensed entity assets.

(12) "Licensee's agent" means the designated nursing home administrator, or an individual designated to perform managerial functions in the administrator's absence.

(13) "Officer" means an individual appointed as an officer of a corporation.

(14) "Owner of five percent or more of the assets of a nursing home" means:

(a) In the case of a sole proprietorship, the owner, or if owned as community property, the owner and owner's spouse;

(b) In the case of a corporation, the owner of at least five percent of the capital stock of a corporation; or

(c) In the case of other types of business entities, the owner of a beneficial interest in at least five percent of the capital assets of an entity.

(15) "Partner" means an individual in a partnership owning or operating a nursing home.

(16) "Plan of correction" means a written statement specifying:

(a) How the nursing home will correct the cited deficiencies;

(b) The date by which the correction will be made; and

(c) Who is responsible for assuring the correction.

(17) "Reasonable time" means a period of time determined by the department and noted in the plan of correction. In determining the length of time for correction of each deficiency, the department considers:

(a) The gravity of the deficiency, including the severity and immediacy of the actual or potential harm to residents;

(b) The required financial and personnel resources necessary to correct the deficiency; and

(c) The minimum amount of time practicably required to correct the deficiency.

(18) "Receivership" means a court action resulting in the removal of a nursing home's current operator and the appointment of a substitute operator to temporarily manage and operate the nursing home.

(19) "Retaliate":

(a) Retaliate against a resident means an act including, but not limited to:

(i) Verbal or physical harassment or abuse;

(ii) Nonmedically indicated social, dietary, or mobility restriction;

(iii) Lessening of the level of care not medically appropriate;

(iv) A nonvoluntary relocation within a nursing home without appropriate medical, psychosocial, or nursing justification;

(v) Neglect or negligent treatment;

(vi) Withholding of privileges; or

(vii) Infringement on a resident's rights as described in WAC 248-14-247 and chapter 74.42 RCW.

(b) Retaliate against an employee means an act including, but not limited to, harassment, firing, demotion, disciplinary action, or nonvoluntary reassignment or rescheduling occurring as a result of employee actions described in section 220, chapter 18.51 RCW.

(c) A rebuttable presumption is raised that retaliation has occurred if a condition described in subsection 388-98-001 (14)(a) of this section definition occurs within one year of the resident's actions described in WAC 388-98-800 (2)(i).

(20) "Severity" means the seriousness of a deficiency as determined by the:

(a) Actual or potential negative outcomes for residents or resident rights violations; or

(b) Extent to which the resident's highest practicable physical, mental, or psychosocial well being is compromised or threatened.

(21) "Scope" means the frequency, incidence, or extent of the occurrence of a deficiency.

(22) "Stop placement" means action instituted by the department prohibiting nursing home admissions, readmissions, and transfers of patients.

(23) "Temporary management" means the department temporarily appoints a substitute manager or operator with authority to hire, terminate, or reassign staff, obligate current facility revenues, alter procedures as appropriate, or otherwise manage the facility as necessary to:

(a) Correct deficiencies; or

(b) Close the facility in a safe and orderly manner.

(24) "Termination" means a department decision to:

(a) Terminate or not renew a nursing home's Medicaid certification and contract; or

(b) Recommend the federal Health Care Financing Administration terminate or not renew a nursing home's Medicaid and/or Medicare certification and contracts.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-001, filed 12/15/89, effective 1/15/90. Statutory Authority: 1987 c 476. 87-21-017 (Order 2546), § 388-98-001, filed 10/9/87. Statutory Authority: RCW 18.51.070. 83-24-030 (Order 2052), § 388-98-001, filed 12/1/83. Statutory Authority: RCW 18.51.310. 80-08-027 (Order 1515), § 388-98-001, filed 6/25/80.]

WAC 388-98-003 Remedies. (1) The department may suspend, revoke, or refuse to renew a license, and/or assess civil monetary penalties when the department finds the licensee or partner, officer, director, or owner of five percent or more of the assets of the nursing home, licensee's agent, employee or individual providing nursing home care or services:

(a) Operates or operated a nursing home without a license or under a revoked or suspended license;

(b) Knowingly or with reason to know makes a false statement of a material fact in the application for license, in attached data, or in matters under department investigation;

(c) Refuses to allow department representatives or agents to inspect required books, records, and files or portions of the nursing home premises;

(d) Willfully prevents, interferes with, or attempts to impede the work of authorized department representatives and the lawful enforcement under provisions of this chapter or chapter 74.42 RCW;

(e) Willfully prevents or interferes with department representatives in the preservation of evidence of violations of provisions under this chapter or chapter 74.42 RCW;

(f) Fails to report patient abuse or neglect in violation of chapter 70.124 RCW;

(g) Fails to pay a civil monetary penalty the department assesses under this chapter within ten days after assessment becomes final;

(h) Retaliates against a patient or employee participating in proceedings specified under RCW 18.51.220; or

(i) Discriminates against Medicaid recipients as prohibited under RCW 74.42.055.

(2) When the department finds:

(a) A licensee or partner, officer, director, or owner of five percent or more of the assets of the nursing home, licensee's agent, employee, or individual providing nursing home care or services fails or refuses to comply with the requirements under chapter 18.51 or 74.42 RCW; or

(b) A Medicaid contractor licensee fails or refuses to comply with the Medicaid requirements of Title XIX of the Social Security Act, as amended; then

(c) The department may impose any or all of the following remedies:

(i) Suspend, revoke, or refuse to renew a license;

(ii) Order stop placement;

(iii) Assess civil monetary penalties;

(iv) Deny payment to a nursing home for Medicaid residents admitted after notice to deny payment. Medicaid recipient residents shall not assume responsibility for payment when the department takes action under this subsection;

(v) Appoint temporary management as provided under section 300 of this chapter; and

(vi) Petition the court to establish receivership.

(3) The criteria set forth in this subsection implement the requirement under section 8, chapter 372, Laws of 1989, that the department establish criteria for the imposition of remedies. These criteria apply to the imposition of remedies under subsection (2) of this section for deficiencies directly impacting a nursing home resident's well being. The criteria do not substitute for standards set forth in section 8, chapter 372, Laws of 1989 for the mandatory imposition of stop placement and denial of payment.

CRITERIA

	Deficiency		
(a)	Actual or threatened harm or injury exists which minimally compromises or could compromise resident well being:		
	(i)	Limited or isolated in scope	Required Remedy Plan of Correction Optional Remedy Civil fine of $500-$1000
	(ii)	Moderate to systemic in scope	Required Remedy Plan of Correction Optional Remedy Civil fine of $500-$1500
(b)	Actual or threatened harm or injury exists which moderately compromises or could compromise resident well being:		
	(i)	Limited or isolated in scope	Required Remedy Plan of Correction Optional Remedy Civil fine of $1000-$2000
	(ii)	Moderate in scope	Required Remedy Civil fine of $1000-$3000
	(iii)	Systemic in scope	Required Remedies Stop Placement Termination Optional Remedies Civil fine of $1000-$3000 per day License Revocation Denial of payment for new Medicaid admissions Dept. on-site monitoring

CRITERIA		
Deficiency		
(iv)	Uncorrected; or repeated after correction within 15-months:	
(A)	Limited or isolated in scope	Required Remedy Civil fine of $1500-$2000 Optional Remedy Civil fine of $1500-$2000 per day
(B)	Moderate in scope	Required Remedy Civil fine of $2000-$3000 Optional Remedies Stop Placement Termination Denial of payment for new Medicaid admissions Civil fine of $1000 per day Dept. on-site monitoring
(C)	Systemic in scope	Required Remedies Stop Placement Termination Civil fine of $2000-$3000 Optional Remedies Civil fine of $2000-$3000 per day License Revocation Denial of payment for new Medicaid admissions Dept. on-site monitoring
(c)	Actual or threatened harm or injury existed which seriously compromised resident well being. The threat has been removed.	Required Remedy Civil fine of $1500-3000 Optional Remedy Civil fine of $1500-$3000 per day
(d)	Actual or threatened harm or injury exists which seriously compromises or could compromise resident well being:	
(i)	Limited or isolated in scope	Required Remedies Termination Stop Placement Optional Remedies Civil fine of $1500-$3000 per day Denial of payment for new Medicaid admissions Emergency transfer of individual residents Temporary management or receivership Dept. on-site monitoring License Revocation
(ii)	Moderate to systemic in scope	Required Remedies Termination Stop Placement License Revocation Optional Remedies Civil fine of $2500-$3000 per day License Suspension Emergency closure or patient transfer Temporary management or receivership

CRITERIA		
Deficiency		
		Denial of payment for new Medicaid admissions Dept. on-site monitoring
(iii)	Uncorrected; or repeated after correction within 15 months:	
(A)	Limited or isolated in scope	Required Remedies Termination Stop Placement License Revocation Civil fine of $2000-$3000 Optional Remedies Civil fine of $2000-$3000 per day More severe optional remedies listed in (d)(i) may also be selected.
(B)	Moderate to systemic in scope	Required Remedies Termination Stop Placement License Revocation Civil fine of $3000 Optional Remedies Civil fine of $3000 per day More severe optional remedies listed in (d)(ii) may also be selected.
(e)	Emergency Crisis Health and safety of a large percentage of the population is imminently threatened due to events such as: Structural damage Staff Walkout Natural disaster (not subject to optional remedies)	Required Remedies Emergency closure or emergency resident transfer Optional Remedies A civil fine of $3000 per day Termination License Revocation or suspension

(4) Civil monetary penalties shall become due twenty days after the licensee is served with a notice of the penalty, unless the licensee requests a hearing. If a hearing is requested, the penalty becomes due ten days after a final decision in the department's favor is issued. Interest accrues beginning thirty days after the department serves the licensee with notice of the penalty.

[Statutory Authority: 1989 c 372. 90-06-031 (Order 2943), § 388-98-003, filed 3/1/90, effective 4/1/90.]

WAC 388-98-010 List of qualified receivers. (1) The department may recruit individuals, partnerships, and corporations interested in serving as a receiver of a nursing home. Recruitment may be by personal letters, telephone, radio or television announcements, or advertisements in publications determined suitable by the department.

(2) Individuals, partnerships, or corporations interested in being appointed as a receiver shall complete designated sections of a nursing home license application.

(3) Individuals, partnerships, or corporations with experience in providing long-term health care and a history of satisfactory nursing home operation may submit a receiver application to the department at any time. Applicants shall be

subject to the criteria established for licensees found in WAC 248-14-080, except the department may waive the requirement for having sixty days to review the application.

(4) The department shall maintain a list of potential receivers. The department shall add names of applicants to the list upon receipt of applications properly completed by applicants.

(5) The department shall not consider as a receiver any person, partnership, or corporation which:

(a) Is the licensee, administrator, or partner, officer, director, managing employee, or owner of five percent or more of the assets of the nursing home subject to receivership;

(b) Is affiliated with the nursing home subject to receivership;

(c) Has a financial interest in the nursing home before the time of appointment; or

(d) Has owned or operated a nursing home ordered into receivership or temporary management in any state.

(6) The department may recommend a receiver to the court. In making the recommendation, one or more of the following factors may be considered:

(a) Potential receiver's willingness to serve as a receiver for the nursing home in question;

(b) Amount and quality of the potential receiver's experience in long term care;

(c) Quality of care, as determined by prior survey reports, provided under the potential receiver's supervision or management;

(d) Potential receiver's prior performance as a receiver;

(e) How soon potential receiver is available to act as a receiver;

(f) Potential receiver's familiarity and past compliance with state and federal regulations applicable to nursing homes;

(g) Potential receiver's economic potential and interest in operating the nursing home on a permanent basis; and

(h) Preference may be given to potential receivers expressing an interest in the permanent operation of the nursing home.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-010, filed 12/15/89, effective 1/15/90. Statutory Authority: Chapter 18.51 RCW. 88-06-086 (Order 2603), § 388-98-010, filed 3/2/88.]

WAC 388-98-015 Duties and powers of receiver. (1) The receiver shall protect the health, security, and welfare of the residents for the duration of the receivership. The receiver shall perform all acts reasonably necessary to ensure residents' needs are met. Such acts may include, but are not limited to:

(a) Correcting deficiencies cited by the department;

(b) Hiring, directing, managing, and discharging all consultants and employees for just cause, discharging the administrator of the nursing home, recognizing collective bargaining agreements, and settling labor disputes;

(c) Receiving and expending in a prudent and business-like manner all revenues and financial resources of the home, provided that priority shall be given to debts and expenditures directly related to providing care and meeting residents' needs;

(d) Making necessary purchases, repairs, and replacements, provided that expenditures for purchases, repairs, or replacements in excess of five thousand dollars are approved by the court;

(e) Entering into contracts necessary for the operation of the nursing home: Provided That, contracts extending beyond the period of receivership shall be approved by the court;

(f) Preparing all reports required by the department;

(g) Planning with residents and their guardians, family, or significant others, required relocation;

(h) Meeting regularly with staff, residents, and residents' families to inform them of:

(i) Plans for correcting the deficiencies;

(ii) Progress achieved in correction;

(iii) Plans for facility closure and relocation; or

(iv) Plans for continued operation of the nursing home including the identity of the permanent operator.

(2) The receiver shall consult the court in cases of extraordinary or questionable debts incurred prior to the receiver's appointment and shall not have the power to close the home or sell any of the nursing home's assets without prior court approval.

(3) The receiver shall comply with applicable state and federal laws and regulations. If the nursing home is certified and is providing care to medical assistance clients, the receiver shall become the Medicaid contractor for the duration of the receivership period.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-015, filed 12/15/89, effective 1/15/90. Statutory Authority: Chapter 18.51 RCW. 88-06-086 (Order 2603), § 388-98-015, filed 3/2/88.]

WAC 388-98-020 Termination of receivership. (1) After receivership is established, the department may recommend to the court that all residents be relocated and the nursing home closed when:

(a) Problems exist in the physical condition of the premises which cannot be corrected in an economically prudent manner; or

(b) The department determines the former operator or owner:

(i) Is unwilling or unable to manage the nursing home in a manner ensuring residents' health, safety, and welfare; and

(ii) Has not entered into an enforceable agreement to sell the nursing home within three months of the court's decision to grant receivership.

(2) The department may recommend to the court an alternate receiver be appointed:

(a) When the receiver is no longer willing to serve as a receiver; or

(b) If a receiver is not making acceptable progress in correcting the deficiencies in the nursing home.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-020, filed 12/15/89, effective 1/15/90. Statutory Authority: Chapter 18.51 RCW. 88-06-086 (Order 2603), § 388-98-020, filed 3/2/88.]

WAC 388-98-300 Temporary management. (1) When the department appoints a temporary manager, the:

(a) Department shall order the licensee to cease operating the nursing home:

(b) Department shall order the licensee to turn over to the temporary manager possession and control of the nursing home including, but not limited to, all patient care records, financial records, and other records necessary for continued operation of the nursing home while temporary management is in effect; and

(c) Temporary manager shall have authority to temporarily relocate some or all residents if the:

(i) Temporary manager determines the resident's health, security, or welfare is jeopardized; and

(ii) Department concurs with the temporary manager's determination that relocation is necessary.

(2) The department's authority to order temporary management is discretionary in all cases.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-300, filed 12/15/89, effective 1/15/90.]

WAC 388-98-320 Temporary managers—Application. (1) The department may recruit individuals, partnerships, and corporations interested in serving as a temporary nursing home manager.

(2) Individuals, partnerships, or corporations interested in being appointed as a temporary manager shall complete and submit to the department designated sections of a nursing home license application.

(3) Individuals, partnerships, or corporations with experience in providing long-term health care and a history of satisfactory nursing home operation may submit an application to the department at any time. Applicants shall be subject to the criteria established for licensees found in WAC 248-14-080, except the department may waive the requirement for having sixty days to review the application.

(4) The department shall not consider as a temporary manager a person, partnership, or corporation which:

(a) Is the licensee, administrator, or partner, officer, director, managing employee, or owner of five percent or more of the assets of the nursing home subject to temporary management;

(b) Is affiliated with the nursing home subject to temporary management; or

(c) Has owned or operated a nursing home ordered into temporary management or receivership in any state.

(5) The department, in appointing a temporary manager, may consider one or more of the following factors:

(a) Potential temporary manager's willingness to serve as a temporary manager for the nursing home in question;

(b) Amount and quality of the potential temporary manager's experience in long-term care;

(c) Quality of care, as determined by prior survey reports, provided under the potential temporary manager's supervision or management;

(d) Potential temporary manager's prior performance as a temporary manager or receiver;

(e) How soon the potential temporary manager is available to act as a temporary manager;

(f) Potential temporary manager's familiarity and past compliance with state and federal regulations applicable to nursing homes.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-320, filed 12/15/89, effective 1/15/90.]

WAC 388-98-330 Duties and powers of temporary manager. (1) The temporary manager shall protect the health, security, and welfare of the residents for the duration of the temporary management. The temporary manager shall perform all acts reasonably necessary to ensure residents' needs are met. Such acts may include, but are not limited to:

(a) Correcting department-cited deficiencies;

(b) Hiring, directing, managing, and discharging all consultants and employees for just cause, discharging the administrator of the nursing home, recognizing collective bargaining agreements, and settling labor disputes;

(c) Receiving and expending in a prudent and business-like manner all current revenues of the home provided priority shall be given to debts and expenditures directly related to providing care and meeting residents' needs;

(d) Making necessary purchases, repairs, and replacements, provided such expenditures in excess of five thousand dollars are approved by the department;

(e) Entering into contracts necessary for the operation of the nursing home;

(f) Preparing all department-required reports;

(g) Planning required relocation with residents and residents' guardians, family, or significant others;

(h) Meeting regularly with and informing staff, residents, and residents' families of:

(i) Plans for correcting the deficiencies;

(ii) Progress achieved in correction;

(iii) Plans for facility closure and relocation; or

(iv) Plans for continued operation of the nursing home including the identity of the permanent operator.

(2) The temporary manager shall make a detailed monthly accounting of all expenditures and liabilities to the department and to the owner of the nursing home.

(3) The temporary manager shall comply with all applicable state and federal laws and regulations. If the nursing home is certified and is providing care to medical assistance clients, the temporary manager shall become the Medicaid contractor for the duration of the temporary management period.

(4) The temporary manager shall be responsible and liable only for the temporary manager's gross negligence, intentional wrongdoing, or breach of fiduciary duty to either the nursing home residents or the current or former licensee or nursing home owner.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-330, filed 12/15/89, effective 1/15/90.]

WAC 388-98-340 Termination of temporary management. (1) The department shall terminate temporary management:

(a) After three months unless good cause is shown to continue the temporary management. Good cause for continuing the temporary management exists when returning the nursing home to its former operator would subject residents to a threat to health, safety, or welfare;

(b) When all residents are transferred and the nursing home is closed;

(c) When deficiencies threatening residents' health, safety, or welfare are eliminated and the former operator or

owner agrees to department-specified conditions regarding the continued facility operation; or

(d) When a new, licensed operator assumes control of the nursing home.

(2) The department may appoint an alternate temporary manager:

(a) When the temporary manager is no longer willing to serve as a temporary manager;

(b) If a temporary manager is not making acceptable progress in correcting the nursing home deficiencies or in closing the nursing home; or

(c) If the department determines the temporary manager is not operating the nursing home in a financially responsible manner.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-340, filed 12/15/89, effective 1/15/90.]

WAC 388-98-700 Stop placement—Informal review. A nursing home licensee shall have the right to an informal review to present written evidence refuting the deficiencies cited as the basis for a stop placement. If an informal review is desired, the nursing home shall request the informal review, in writing, within ten days of the effective date of the stop placement. The request shall be made to the director, nursing home services, aging and adult services administration. The right to an informal review is in addition to the licensee's right to a hearing, as provided in section 750.

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-700, filed 12/15/89, effective 1/15/90. Statutory Authority: 1987 c 476. 87-21-017 (Order 2546), § 388-98-700, filed 10/9/87. Statutory Authority: RCW 18.51.070. 83-24-030 (Order 2052), § 388-98-700, filed 12/1/83.]

WAC 388-98-750 Notice and hearing rights. (1) This subsection shall apply to the department's imposition of the following remedies:

(a) License suspension, revocation, or nonrenewal;

(b) Stop placement;

(c) Civil monetary penalty;

(d) Denial of payment;

(e) Appointment of a temporary manager;

(f) Emergency transfer of residents; and

(g) Emergency closure.

(2) The department's notice of a decision to impose a remedy is governed by RCW 18.51.065 and 43.20A.XXX and section 96, chapter 175, laws of 1989. The licensee's or agent's right to an adjudicative proceeding is in the same law.

(a) A person contesting any decision described in subsection (1) of this section shall within twenty days of receipt of the decision:

(i) File a written application for an adjudicative proceeding by a method showing proof of receipt with the Office of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(ii) Include in or with the application:

(A) A specific statement of the issue and law involved;

(B) The grounds for contesting the department decision; and

(C) A copy of the contested department decision.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW); RCW 18.51.065 and 43.20A.XXX; and section 96, chapter 175, Laws of 1989; this section; and chapter 388-08 WAC. If any provision in this section conflicts with chapter 388-08 WAC, the provision in this section governs.

(3) When a licensee fails to pay a fine when due under this chapter, the department may:

(a) Withhold an amount equal to the fine plus interest, if any, from the licensee's Medicaid payment;

(b) Suspend the licensee's nursing home license. Such license suspension shall continue until the fine is paid; or

(c) Impose an additional civil monetary penalty, under WAC 388-98-003 (1)(g).

[Statutory Authority: 1989 c 372 § 8. 90-01-052 (Order 2917), § 388-98-750, filed 12/15/89, effective 1/15/90.]

WAC 388-98-810 Civil penalty fund. The department shall use civil penalties, collected under RCW 18.51.060 (4)(a) or chapter 74.42 RCW, for the following purposes listed in order of priority:

(1) Issue a relocation allowance to the Medicaid-funded nursing home resident who must relocate because the department finds the resident's nursing home deficient to the point decertification occurs. The department may issue the resident a relocation allowance for the following purposes:

(a) Transportation to review potential relocation sites, including a nursing home, a congregate care facility, an adult family home, or independent housing;

(b) Cost of sending personal belongings to the resident's new location, including a residential setting or the resident's own residence; and

(c) Cost of obtaining or reestablishing independent housing when the resident is able to relocate to the resident's own residence. The department shall issue a relocation allowance if the resident meets the conditions for issuing a nursing home discharge allowance, as described under WAC 388-15-145. If the discharge allowance maximum of four hundred dollars does not sufficiently cover relocation costs, the department shall issue the relocation allowance in addition to the discharge allowance.

(2) Reimburse the Medicaid-funded nursing home resident for personal funds lost due to negligence or malfeasance by nursing home staff where the resident resides. The department shall use the civil penalty fund only if the resident's personal funds cannot be recovered from the nursing home or other responsible party; and

(3) Pay the cost of maintaining the Medicaid-funded nursing home resident in the resident's nursing home which lost its Medicaid certification until the:

(a) Resident is relocated; or

(b) Nursing home corrects the deficiencies causing the facility's decertification; and

(c) Department reinstates the nursing home Medicaid certification.

[Statutory Authority: RCW 18.51.070. 90-12-048 (Order 2990), § 388-98-810, filed 5/31/90, effective 7/1/90.]

WAC 388-98-830 Notification of response time. (1) Department findings shall be documented in writing and presented to the licensee or licensee's agent.

(2) The department shall obtain a plan of correction from the licensee or licensee's agent.

(a) The department may require the licensee or licensee's agent to submit an acceptable plan of correction during the survey or complaint investigation for a specific deficiency presenting an immediate danger of death or serious physical harm to any resident in the nursing home or a substantial probability that death or serious physical harm would result. Such deficiency shall be abated or eliminated as soon as possible within twenty-four hours from notification to the licensee or licensee's agents.

(b) A licensee or licensee's agent participating in the Medicare or Medicaid program shall submit a complete and acceptable plan of correction during the exit interview when there are fewer than sixty days from the exit interview to the Medicare or Medicaid certification expiration date.

(c) All licensees or licensees' agents choosing to submit a complete plan of correction during the exit interview may do so.

(d) The licensee or licensee's agent not submitting a plan of correction at the exit interview shall submit a complete plan of correction by the time and date specified by the department. The department may allow the licensee or licensee's agent up to ten calendar days from the exit conference to submit an acceptable plan of correction for deficiencies presenting neither an immediate danger nor a substantial probability of death or serious physical harm. Such deficiency shall be corrected within a reasonable time determined by the department. In no event shall the time for correction exceed sixty days.

(e) When deficiencies involve facility alterations, physical plant plan development, construction review, or certificate of need, an interim plan of correction stating the steps planned and approximate time schedule is acceptable. Updated plans shall be submitted as agreed to and as progress occurs.

(3) Upon licensee's or licensee's agent's written petition, the department shall determine whether or not to grant a request for an extended correction time. Such a petition must be received by the department at the earliest possible date prior to the expiration of the correction time originally approved. The burden of proof is on the licensee or licensee's agent to show good cause for not being able to comply with the original correction time.

(4) The department shall notify the licensee or licensee's agent when the plan of correction is unacceptable. The licensee or licensee's agent shall return the revised plan of correction to the department by the date specified by the department.

[Statutory Authority: 1987 c 476. 87-21-017 (Order 2546), § 388-98-830, filed 10/9/87. Statutory Authority: RCW 18.51.310. 80-08-027 (Order 1515), § 388-98-830, filed 6/25/80.]

WAC 388-98-870 Separate violations. (1) Each separate finding of a violation of a statute, rule, or regulation shall constitute a separate violation.

(2) Following the notification of a deficiency described in WAC 388-98-800 (4), (5), or (6), each day upon which the same deficiency is present, or a substantially similar action occurs, shall constitute a separate violation subject to the assessment of a separate penalty.

[Statutory Authority: 1987 c 476. 87-21-017 (Order 2546), § 388-98-870, filed 10/9/87. Statutory Authority: RCW 18.51.310. 80-08-027 (Order 1515), § 388-98-870, filed 6/25/80.]

WAC 388-98-890 Reporting. All civil fines assessed against a nursing home which relate to the activities and responsibilities of a licensed nursing home administrator as defined in WAC 248-14-235 shall be reported to the professional licensing division, business and professions administration. The report shall include the name of the person, name of the facility, amount of fine, and date of fine.

[Statutory Authority: RCW 18.51.310. 80-08-027 (Order 1515), § 388-98-890, filed 6/25/80.]

Chapter 388-110 WAC

CONTRACTED RESIDENTIAL CARE SERVICES: ASSISTED LIVING SERVICES, ENHANCED ADULT RESIDENTIAL CARE, AND ADULT RESIDENTIAL CARE

WAC

PART I
ALL CONTRACTED RESIDENTIAL CARE SERVICES

WAC 388-110-005 Authority. The following rules are adopted under RCW 74.39A.010, 74.39A.020, 74.39A.060,

74.39A.070, 74.39A.080, 74.39A.170, and 18.88A.210 through 18.88A.240.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-005, filed 5/8/96, effective 6/8/96.]

WAC 388-110-010 Scope and applicability. (1) These rules apply only to boarding homes licensed under chapter 18.20 RCW, or boarding homes located within the boundaries of a federally recognized Indian reservation and licensed by a tribe, that contract with the department to provide assisted living services, enhanced adult residential care, or adult residential care.

(2) Only services provided to or on behalf of the assisted living services, enhanced adult residential care, or adult residential care resident, and paid for fully or partially by the department shall be subject to these rules.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-010, filed 5/8/96, effective 6/8/96.]

WAC 388-110-020 Definitions. (1) "Adult residential care" is a package of services, including personal care services, that the department contracts with a licensed boarding home to provide in accordance with Parts I and IV of this chapter.

(2) "Aging in place" means being in a care environment that can accommodate a resident's progressive disability or changing needs without relocating. For aging in place to occur, needed services are adjusted to meet the changing needs of the resident.

(3) "Applicant" means the individual, partnership, corporation or other entity which has applied for a contract with the department to provide assisted living services, enhanced adult residential care, or adult residential care to state funded residents in a licensed boarding home.

(4) "Assisted living services" is a package of services, including personal care and limited nursing services, that the department contracts with a licensed boarding home to provide in accordance with Parts I and II of this chapter. Assisted living services include housing for the resident in a private apartment-like unit.

(5) "Boarding home" means the same as the definition found in RCW 18.20.020(2), or a boarding home located within the boundaries of a federally recognized Indian reservation and licensed by the tribe.

(6) "Caregiver" means any person responsible for providing direct personal care services to a resident and may include but is not limited to the contractor, employee, volunteer, or student.

(7) "Case manager" means the department staff person or designee assigned to negotiate, monitor, and facilitate a service plan for residents receiving services fully or partially paid for by the department.

(8) "Contractor" means the individual, partnership, corporation, or other entity which contracts with the department to provide assisted living services, enhanced adult residential care, or adult residential care to state funded residents in a licensed boarding home.

(9) "Department" means the Washington state department of social and health services (DSHS).

(10) "Dignity" means the quality or condition of being esteemed and respected in such a way as to validate the self-worth of the resident.

(11) "Enhanced adult residential care" is a package of services, including personal care and limited nursing services, that the department contracts with a licensed boarding home to provide in accordance with Parts I and III of this chapter.

(12) "Frail elder or vulnerable adult" means the same as the definition found in RCW 74.34.020 or 43.43.830.

(13) "Homelike" means an environment having the qualities of a home, including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences. A homelike environment provides residents with an opportunity for self-expression, and encourages interaction with the community, family and friends.

(14) "Independence" means free from the control of others and being able to assert one's own will, personality and preferences.

(15) "Individuality" means the quality of being unique; the aggregate of qualities and characteristics that distinguishes one from others. Individuality is supported by modifying services to suit the needs or wishes of a specific individual.

(16) "Limited nursing services" means the same as the definition found in WAC 246-316-265.

(17) "Personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident's needs as defined in WAC 388-15-202(38). Personal care services do not include assistance with tasks that must be performed by a licensed health professional.

(18) "Resident" means a person residing in a boarding home for whom services are paid for, in whole or in part, by the department under a contract for assisted living services, enhanced adult residential care, or adult residential care. "Resident" includes former residents when examining complaints about admissions, re-admissions, transfers or discharges. For decision-making purposes, the term "resident" includes the resident's surrogate decision maker in accordance with state law or at the resident's request.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-020, filed 5/8/96, effective 6/8/96.]

WAC 388-110-030 Contract application. (1) In order to apply for a contract with the department to provide assisted living services, enhanced adult residential care, or adult residential care, an applicant shall:

(a) Have a valid boarding home license for the facility at which the contracted services will be provided;

(b) Complete and submit a contract application on department provided forms at least sixty days before the requested effective date for the contract; and

(c) Provide information regarding any facilities the applicant, and any partner, officer, director, managerial employee, or owner of five percent or more of the applicant has been affiliated with in the last ten years.

(2) Within sixty days of the receipt of the application the department shall approve a contract, refuse to enter into a contract, or request additional information the department deems relevant from the applicant. The department may extend the sixty days to allow the applicant to supply or clarify information requested by the department. The department shall conduct an on-site review of the contracting facility before issuing a contract.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-030, filed 5/8/96, effective 6/8/96.]

WAC 388-110-040 Contract qualifications. (1) The department shall consider separately and jointly as applicants each person and entity named in the application for a contract for assisted living services, enhanced adult residential care, or adult residential care. If the department finds any person or entity unqualified, the department shall deny the contract.

(2) In making a determination whether to grant a contract, the department shall review:

(a) The information in the application; and

(b) Other documents and information the department deems relevant, including inspection and complaint investigation findings for each facility with which the applicant or any partner, officer, director, managerial employee, or owner of five percent or more of the entity applicant has been affiliated.

(3) The applicant and the facility for which a contract is sought shall comply with all requirements established by chapter 74.39A RCW and this chapter. The department may deny a contract for noncompliance with any such requirements.

(4) The department shall deny a contract if an applicant or any partner, officer, director, managerial employee, or owner of five percent or more of the entity applicant applying for a contract has a history of significant noncompliance with federal or state regulations in providing care or services to frail elders, vulnerable adults or children. The department shall consider, at a minimum, the following as a history of significant noncompliance requiring denial of a contract:

(a) Revocation or suspension of a license for the care of children, frail elders or vulnerable adults;

(b) Enjoined from operating a facility for the care of children, frail elders or vulnerable adults; or

(c) Termination, cancellation, suspension, or nonrenewal of a Medicaid or Medicare provider agreement, or any other agreement with a public agency for the care or treatment of children, frail elders or vulnerable adults.

(5) The department shall deny, terminate, or refuse to renew a contract if an applicant or any partner, officer, director, managerial employee, an owner of fifty percent or more of the entity applicant, or an owner who exercises control over daily operations has been:

(a) Convicted of a crime against a person as defined under RCW 43.43.830 or 43.43.842;

(b) Convicted of a crime related to financial exploitation as defined under RCW 43.43.830 or 43.43.842;

(c) Found by a court in a protection proceeding or in a civil damages lawsuit under chapter 74.34 RCW to have abused, neglected, abandoned or exploited a vulnerable adult;

(d) Found in any final decision issued by a disciplinary board to have sexually or physically abused, neglected, or exploited any minor or vulnerable adult;

(e) Found in any dependency action under chapter 13.34 RCW to have sexually assaulted, neglected, exploited, or physically abused any minor; or

(f) Found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused, exploited, or physically abused any minor.

(6) The department may deny, terminate, or refuse to renew a contract if an applicant or any partner, officer, director, managerial employee, an owner of fifty percent or more of the entity applicant, or an owner who exercises control over daily operations has:

(a) Obtained or attempted to obtain a license or contract by fraudulent means or misrepresentation;

(b) Been convicted of a felony or a crime against a person if the conviction reasonably relates to the competency of the person to contract with the department;

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

(d) A poor credit history;

(e) Engaged in the illegal use of drugs or the excessive use of alcohol;

(f) Operated a facility for the care of children or adults without a license;

(g) Failed to meet financial obligations as the obligations fell due in the normal course of business;

(h) Misappropriated property of residents;

(i) Filed for bankruptcy, reorganization, or receivership;

(j) Been denied a license or license renewal to operate a facility that was licensed for the care of children, frail elders or vulnerable adults;

(k) Relinquished or returned a license in connection with the operation of any facility for the care of children, frail elders or vulnerable adults, or did not seek the renewal of such license, following written notification of the licensing agency's initiation of denial, suspension, cancellation or revocation of the license; or

(l) Had resident trust funds or assets of an entity providing care to children, frail elders or vulnerable adults seized by the IRS or a state entity for failure to pay income or payroll taxes.

[Statutory Authority: RCW 74.39A.010, 74.39A.020 and 74.39A.080. 96-21-050, § 388-110-040, 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-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-040, filed 5/8/96, effective 6/8/96.]

WAC 388-110-050 Change of contractor. (1) A change of contractor occurs when there is a substitution of the individual contractor or contracting entity ultimately responsible for the daily operational decisions of the assisted living service, enhanced adult residential care, or adult residential care, or a substitution of control of such contracting entity.

(a) Events which constitute a change of contractor include but are not limited to the following:

(i) The form of legal organization of the contractor is changed (e.g., a sole proprietor forms a partnership or corporation);

(ii) Assisted living services, enhanced adult residential care, or adult residential care contract rights and responsibilities are transferred by the initial contractor to another party regardless of whether ownership of some or all of the real property and/or personal property assets of the facility are also transferred;

(iii) If the contractor is a partnership, any event occurs which dissolves the partnership;

(iv) 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;

(v) If the contractor 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:

(A) New or former stockholders; or

(B) Present stockholders each having held less than five percent of the stock before the initial transaction; or

(vi) Any other event or combination of events which results in a substitution or substitution of control of the individual contractor or the contracting entity.

(b) The contractor does not change when the following, without more, occur:

(i) A party contracts with the contractor to manage the assisted living, enhanced adult residential care, or adult residential care facility as the contractor's agent, i.e., subject to the contractor's general approval of daily operating and management decisions; or

(ii) The real property or personal property assets of the facility contractor change ownership or are leased, or a lease of the real property or personal property assets is terminated, without a substitution of individual operator or operating entity and without a substitution of control of the operating entity.

(2) When a change of contractor is contemplated, the current contractor shall notify the department and all residents at least sixty days prior to the proposed date of transfer. The notice shall be in writing and shall contain the following information:

(a) Name of the present contractor and prospective contractor;

(b) Name and address of the facility being transferred; and

(c) Date of proposed transfer.

(3) The operation or ownership of an assisted living services, enhanced adult residential care, or adult residential care contract shall not be transferred until the new operator has entered into a contract with the department. The new contractor shall comply with contract application requirements in WAC 388-110-030.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-050, filed 5/8/96, effective 6/8/96.]

WAC 388-110-060 Resident rights. (1) The contractor shall comply with all requirements of chapter 70.129 RCW, Long-term care resident rights. The contractor shall promote and protect the resident's exercise of all rights granted under that law.

(2) The contractor shall provide care and services in compliance with the federal Patient self determination act and with applicable state statutes related to surrogate and health care decision making, including chapters 7.70, 70.122, 11.88, 11.92 and 11.94 RCW.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-060, filed 5/8/96, effective 6/8/96.]

WAC 388-110-070 General service standards. The contractor shall:

(1) Ensure residents have control over their time, space and lifestyle to the extent that the health, safety and well-being of other residents is not disturbed;

(2) Promote the resident's right to exercise decision making and self-determination to the fullest extent possible;

(3) Follow the informed consent process as required in chapter 7.70 RCW, when applicable, in the development of the negotiated service agreement;

(4) Provide services for residents in a manner and in an environment that encourages maintenance or enhancement of each resident's quality of life, and promotes the resident's privacy, dignity, choice, independence, individuality, and decision-making ability; and

(5) Provide a safe, clean and comfortable homelike environment, allowing residents to use their personal belongings to the extent possible.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-070, filed 5/8/96, effective 6/8/96.]

WAC 388-110-080 Social and recreational activities. (1) The contractor shall provide social and recreational activities that provide and promote opportunities for the resident to participate in ongoing and varied activities based on the resident's choice and consistent with identified resident needs and functional ability.

(2) The contractor shall support the participation of residents and the resident council, if there is one, in the development of recreational and activity programs that reflect the needs and choices of the residents.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-080, filed 5/8/96, effective 6/8/96.]

WAC 388-110-090 Administration. The contractor shall:

(1) Maintain substantial compliance with all requirements of chapter 18.20 RCW, Law for boarding homes and chapter 246-316 WAC, Boarding homes;

(2) Ensure all facility staff are knowledgeable about chapter 70.129 RCW, Long-term care resident rights;

(3) Provide residents, prior to move-in, a copy of the facility's admission agreement which clearly specifies the range of services the facility is able to provide to residents;

(4) Not require a resident to sign any admission contract or agreement that purports to waive any rights of the resident;

(5) Develop and implement a grievance procedure and process which is responsive to resident's complaints;

(6) Post in a place and manner clearly visible to residents and visitors the department's toll-free complaint telephone number;

(7) Comply with all federal and state statutory and regulatory requirements regarding nondiscrimination in all aspects of the facility's operation;

(8) Ensure resident rooms or resident units are not located in a separate unit within a facility that has exiting doors that restrict egress from the unit, such as, but not limited to automatic locking and unlocking exiting doors, unless the contractor is already providing services to residents in such a unit under a contract with the department for assisted living services, adult residential care, or enhanced adult residential care on the effective date of this chapter;

(9) Encourage residents and the resident council, if there is one, to provide input to the facility about residents' preferences for food choices, taking into account the cultural and religious needs of residents;

(10) Ensure all instances of suspected abuse, neglect, exploitation, or abandonment are reported to the department, as required in chapter 74.34 RCW, and to the local law enforcement agency;

(11) Not have any sexual contact with any resident and shall ensure that facility staff and students not have sexual contact with any resident;

(12) Notify the department within five business days when there is a change in the facility administrator; and

(13) Permit department representatives to enter the facility without prior notification in order to monitor the contract requirements under this chapter and to conduct complaint investigations, including but not limited to observing and interviewing residents, and accessing resident records.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-090, filed 5/8/96, effective 6/8/96.]

WAC 388-110-100 Transfer and discharge, social leave, and bed hold. The contractor shall:

(1) Comply with chapter 70.129 RCW and chapter 246-316 WAC pertaining to transfer and discharge (move-out);

(2) Include the department's case manager in the development of a relocation or discharge (move-out) plan, and have the case manager approve the plan before any notice required under subsection (1) of this section is issued to the resident, except in an emergency;

(3) Note an absence in a resident's record when a resident will be absent from the facility for more than seventy-two consecutive hours;

(4) Not be required to discharge (move-out) and readmit a resident for absences less than thirty-one consecutive days;

(5) Obtain department approval for payment for social leave in excess of fifteen consecutive days; and

(6) Retain a bed or unit for a resident hospitalized or temporarily placed in a nursing home for up to thirty days when the resident is likely to return, but if as part of the negotiated service agreement it is determined prior to the end of the thirty days that the resident will not return to the facility, the facility may discharge (move-out) the resident in accordance with subsections (1) and (2) above and release the bed or unit.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-100, filed 5/8/96, effective 6/8/96.]

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, communication 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-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-110, filed 5/8/96, effective 6/8/96.]

WAC 388-110-120 Resident personal funds. (1) Upon the death of a resident, the facility shall promptly convey the resident's personal funds held by the facility with a final accounting of such funds to the department or to the individual or probate jurisdiction administering the resident's estate no later than forty-five calendar days after the date of the resident's death:

(a) When the personal funds of the deceased resident shall be paid to the state of Washington, those funds and the final accounting shall be made payable to the secretary, department of social and health services, and sent to the office of financial recovery, estate recovery unit, P.O. Box 9501, Olympia, Washington 98507-9501, or such address as may be directed by the department in the future;

(b) The check and final accounting accompanying the payment shall contain the name and social security number of the deceased individual from whose personal funds account the monies are being paid; and

(c) The department of social and health services shall establish a release procedure for use of funds necessary for burial expenses.

(2) In situations where the resident is absent from the facility for an extended time without notifying the facility, and the resident's whereabouts is unknown:

(a) The facility shall make a reasonable effort to find the missing resident; and

(b) If the resident cannot be located after ninety days, the facility shall notify the department of revenue of the existence of "abandoned property," outlined in chapter 63.29 RCW. The facility shall deliver to the department of revenue the balance of the resident's personal funds within twenty days following such notification.

(3) Prior to the change of contractor of the facility business, the contractor shall:

(a) Provide each resident with a written accounting of any personal funds held by the facility;

(b) Provide the new contractor with a written accounting of all resident funds being transferred; and

(c) Obtain a written receipt for those funds from the new operator.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-120, filed 5/8/96, effective 6/8/96.]

PART II
ASSISTED LIVING SERVICES

WAC 388-110-140 Assisted living services facility structural requirements. (1) In a boarding home with an assisted living services contract, each resident shall have a private apartment-like unit with a private bathroom. Each unit shall have at least the following:

(a) In an existing facility, an individual unit with a minimum of one hundred eighty square feet including counters, closets and built-ins, and excluding the bathroom. In a new facility, an individual unit with a minimum of two hundred twenty square feet including counters, closets and built-ins, and excluding the bathroom;

(b) A separate private bathroom, which includes a sink, toilet, and a shower or bathtub. In a new facility, a minimum of fifty percent of resident bathrooms shall be wheelchair accessible and have a roll-in shower;

(c) A lockable entry door;

(d) A kitchen area equipped, at a minimum, with a refrigerator, a microwave oven or stovetop, and a counter or table for food preparation. In a new facility, a kitchen area must also be equipped with a sink and counter area, and storage space for utensils and supplies; and

(e) A living area wired for telephone and, where available in the geographic location, wired for television service.

(2) In a new facility, the contractor shall provide a private accessible mailbox in which the resident may receive mail.

(3) The contractor shall provide homelike smoke-free common areas with sufficient space for socialization designed to meet resident needs. Common areas shall be available for resident use at any time provided such use does not disturb the health or safety of other residents. When possible, access to outdoor areas shall be made available to all residents.

(4) The contractor shall provide a space for residents to meet with family and friends outside the resident's living unit.

(5)(a) For purposes of this section, a new facility is:

(i) A new building to be used as a boarding home or part of a boarding home, for which plans are submitted to the department of health for construction review, as required by WAC 246-316-070, on or after the effective date of this chapter; or

(ii) An addition, modification, or alteration to an existing building, for which plans are submitted to the department of health for construction review, as required by WAC 246-316-070, on or after the effective date of this chapter.

(b) All facilities that are not new facilities under subsection (5)(a) of this section, are existing facilities. An existing building, or portion thereof, that is converted to boarding home use shall be considered an existing facility unless there is an addition, modification or alteration to the existing building.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-140, filed 5/8/96, effective 6/8/96.]

WAC 388-110-150 Assisted living service standards. (1) The contractor shall ensure that both the physical environment and the delivery of assisted living services are designed to enhance autonomy in ways which reflect personal and social values of dignity, privacy, independence, individuality, choice and decision-making of residents. The contractor shall provide the resident services in a manner which:

(a) Makes the services available in a homelike environment for residents with a range of needs and preferences;

(b) Facilitates aging in place by providing flexible services in an environment that accommodates and supports the resident's individuality;

(c) Supports managed risk which includes the resident's right to take responsibility for the risks associated with decision-making; and

(d) Develops a formal written, negotiated plan to decrease the probability of a poor outcome when a resident's decision or preference places the resident or others at risk, leads to adverse consequences, or conflicts with other residents' rights or preferences.

(2) Building on the department's assessment and service plan completed before admission, the contractor shall complete a negotiated service agreement within thirty days of move-in. The contractor shall involve the following persons in the negotiation and renegotiation of the agreement:

(a) The resident to the greatest extent practicable;

(b) Appropriate facility staff;

(c) The department's case manager; and

(d) If the resident chooses, the resident's family or any other person the resident wants included.

(3) The contractor shall ensure the negotiated service agreement:

(a) Includes recognition of the resident's capabilities and choices, and defines the division of responsibility in the implementation of services;

(b) Addresses, at a minimum, the following elements: assessed health care needs; social needs and preferences; personal care tasks; and if applicable, limited nursing and medication services, including frequency of service and level of assistance;

(c) Is signed and approved by the resident, the contractor, and the department case manager; and

(d) Includes the date the agreement was approved.

(4) The contractor shall provide the resident and case manager with a copy of the agreement, and place a copy in the resident's record.

(5) The contractor shall update the agreement when there are changes in the services the resident needs and wants to receive. At a minimum, the contractor shall review and update the negotiated service agreement semiannually.

(6) The contractor shall provide personal care services based on the resident's negotiated service agreement.

(7) The contractor shall provide the range of services required to meet the increasing or changing needs of residents as they age in place to the maximum extent permitted by the boarding home regulations.

(8) The contractor shall provide or arrange for limited nursing services to meet the needs of residents who require nursing services, at no additional cost to the resident.

(9) The contractor shall provide written policies and procedures that ensure the facility will provide limited nursing services and will allow additional on-site health care services to the maximum extent allowed under chapter 246-316 WAC, and if requested, shall assist the resident to obtain the additional on-site health care services.

(10) If requested or needed by the resident, the contractor shall assist the resident to obtain, arrange, and coordinate services such as: transportation to medical services and recreational activities; ancillary services for medically related care (e.g., physician, pharmacist, mental health services, physical or occupational therapy, hospice, home health care, podiatry); barber/beauty services; and other services necessary to support and assist the resident in maintaining as much independence as possible.

(11) The contractor shall make available and offer at no additional cost to the resident generic personal care items needed by the resident such as soap, shampoo, toilet paper, toothbrush, toothpaste, deodorant, sanitary napkins, and disposable razors. This does not include items covered by medical coupons or preclude residents from choosing to purchase their own personal care items.

(12) The contractor shall provide all residents with access to an on-site washing machine and dryer for resident use.

(13) The contractor shall make beverages and snacks available to residents.

(14) The contractor shall develop written policies and procedures to be followed by staff and shared with residents which illustrate how employees shall deliver services to residents while ensuring resident's privacy, dignity, choice, independence, individuality and decision-making ability.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-150, filed 5/8/96, effective 6/8/96.]

WAC 388-110-170 Education and training requirements. (1) Any administrator hired after the effective date of this chapter shall have completed forty hours of training regarding assisted living services, resident rights, and the social model of services within the first six months of employment. All administrators shall have ten hours of continuing education credits per calendar year.

(2) The contractor shall provide and document a minimum of five hours of training for all staff regarding assisted living services, resident rights, the social model of services, and service planning for residents.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-170, filed 5/8/96, effective 6/8/96.]

WAC 388-110-180 Nurse delegation training and registration. Before performing any delegated nursing task, facility staff must:

(1) Be a nursing assistant certified or registered under chapter 18.88A RCW; and

(2) Attend and successfully complete department designated core delegation training.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-180, filed 5/8/96, effective 6/8/96.]

WAC 388-110-190 Performance of delegated nursing care tasks. (1) Facility staff who have been delegated a nursing care task in compliance with requirements established by the nursing care quality assurance commission shall perform the task:

(a) In compliance with all requirements and protocols established by the commission in WAC 246-840-910 through 246-840-980;

(b) Only for the specific resident who was the subject of the delegation; and

(c) Only with the resident's consent.

(2) The delegated authority to perform the nursing care task is not transferrable to another nurse assistant.

(3) Facility staff may consent to perform a delegated nursing care task, and shall be responsible for their own actions with regard to the decision to consent to the performance of the delegated task.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-190, filed 5/8/96, effective 6/8/96.]

WAC 388-110-200 Nurse delegation—Penalties. The department shall impose a civil fine on any contractor that knowingly performs or knowingly permits an employee to perform a nursing task except as delegated by a nurse pursuant to chapter 18.79 RCW and chapter 246-840 WAC as follows:

(a) Two hundred fifty dollars for the first time the department finds an unlawful delegation;

(b) Five hundred dollars for the second time the department finds an unlawful delegation; and

(c) One thousand dollars for the third time or more the department finds an unlawful delegation.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-200, filed 5/8/96, effective 6/8/96.]

WAC 388-110-210 Client service eligibility. The contractor shall provide assisted living services only to persons eligible for COPES level of services under WAC 388-15-202 through 388-15-205 and WAC 388-15-600 through 388-15-620 as determined by the department or the department's designee.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-210, filed 5/8/96, effective 6/8/96.]

PART III
ENHANCED ADULT RESIDENTIAL CARE

WAC 388-110-220 Enhanced adult residential care service standards. (1) The contractor shall complete a negotiated service agreement within thirty days of move-in with participation from the resident and the department's case manager, consistent with the general service standards set forth in WAC 388-110-070.

(2) The agreement shall include what services shall be provided, who will provide the services, and when and how the services will be provided.

(3) The service agreement shall support the principles of dignity, privacy, choice in decision making, individuality, and independence.

(4) At a minimum, the contractor shall review and update the negotiated service agreement semi-annually, give a copy of the agreement to the resident and case manager, and keep a copy in the resident's record.

(5) The contractor shall provide personal care services based on the resident's negotiated service agreement.

(6) The contractor shall provide or arrange for limited nursing services to meet the needs of residents who require nursing services, at no additional cost to the resident.

(7) The contractor shall allow a maximum of two residents per room.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-220, filed 5/8/96, effective 6/8/96.]

WAC 388-110-230 Client eligibility. The contractor shall provide enhanced adult residential care services only to persons eligible for COPES level of services under WAC 388-15-202 through 388-15-205 and WAC 388-15-600 through 388-15-620 as determined by the department or the department's designee.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-230, filed 5/8/96, effective 6/8/96.]

PART IV
ADULT RESIDENTIAL CARE

WAC 388-110-240 Adult residential care service standards. (1) The contractor shall complete a negotiated service agreement within thirty days of move-in with participation from the resident and the department's case manager, consistent with the general service standards set forth in WAC 388-110-070.

(2) The agreement shall include what services shall be provided, who will provide the services, and when and how the services will be provided.

(3) The service agreement shall support the principles of dignity, privacy, choice in decision making, individuality, and independence.

(4) At a minimum, the contractor shall review and update the negotiated service agreement semi-annually, give a copy of the agreement to the resident and case manager, and keep a copy in the resident's record.

(5) The contractor shall provide personal care services based on the resident's negotiated service agreement.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-240, filed 5/8/96, effective 6/8/96.]

WAC 388-110-250 Client service eligibility. The contractor shall provide adult residential care services only to persons eligible for community-based services under WAC 388-15-562, 388-15-610, or 388-15-830 as determined by the department or the department's designee.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-250, filed 5/8/96, effective 6/8/96.]

PART V
REMEDIES FOR ASSISTED LIVING, ENHANCED ADULT RESIDENTIAL CARE, AND ADULT RESIDENTIAL CARE

WAC 388-110-260 Remedies. (1) The department may take one or more of the actions listed in subsection (3)(a) of

this section in any case in which the department finds that a contractor of assisted living services, enhanced adult residential care services, or adult residential care services has:

(a) Failed or refused to comply with the applicable requirements of chapter 74.39A RCW, of chapter 70.129 RCW or of this chapter;

(b) Operated without a license or under a revoked license;

(c) Knowingly, or with reason to know, made a false statement of material fact on his or her application for a contract or any data attached thereto, or in any matter under investigation by the department; or

(d) Willfully prevented or interfered with any inspection or investigation by the department.

(2)(a) For failure or refusal to comply with any applicable requirements of chapter 74.39A RCW, of chapter 70.129 RCW or of this chapter, the department may provide consultation and shall allow the contractor a reasonable opportunity to correct before imposing remedies under subsection (3)(a) unless the violations pose a serious risk to residents, are recurring or have been uncorrected.

(b) When violations of this chapter pose a serious risk to a resident, are recurring or have been uncorrected, the department shall impose a remedy or remedies listed under subsection (3)(a). In determining which remedy or remedies to impose, the department shall take into account the severity of the impact of the violations on residents and which remedy or remedies are likely to improve resident outcomes and satisfaction in a timely manner.

(3)(a) Actions and remedies the department may impose include:

(i) Refusal to enter into a contract;

(ii) Imposition of reasonable conditions on a contract, such as correction within a specified time, training, and limits on the type of clients the provider may admit or serve;

(iii) Imposition of civil penalties of not more than one hundred dollars per day per violation;

(iv) Suspension, termination, or refusal to renew a contract; or

(v) Order stop placement of persons under the contract.

(b) When the department orders stop placement, the facility shall not admit any person under the contract until the stop placement order is terminated. The department may approve readmission of a resident to the facility from a hospital or nursing home during the stop placement. The department shall terminate the stop placement when the department determines that:

(i) The violations necessitating the stop placement have been corrected; and

(ii) The provider exhibits the capacity to maintain adequate care and service.

(c) Conditions the department may impose on a contract include, but are not limited to the following:

(i) Correction within a specified time;

(ii) Training related to the violations; and

(iii) Discharge of any resident when the department determines discharge is needed to meet that resident's needs or for the protection of other residents.

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

[Statutory Authority: RCW 74.39A.010, 74.39A.020 and 74.39A.080. 96-21-050, § 388-110-260, 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-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-260, filed 5/8/96, effective 6/8/96.]

WAC 388-110-270 Notice, hearing rights, effective dates relating to imposition of remedies. (1) Chapter 34.05 RCW applies to department actions under this chapter and chapter 74.39A RCW, except that orders of the department imposing contracts suspension, stop placement, or conditions for continuation of a contract are effective immediately upon notice and shall continue pending any hearing.

(2) Civil monetary penalties shall become due twenty eight days after the contractor is served with a notice of the penalty unless the contractor requests a hearing in compliance with chapter 34.05 RCW and RCW 43.20A.215. If a hearing is requested, the penalty becomes due ten days after a final decision in the department's favor is issued. Interest shall accrue beginning thirty days after the department serves the contractor with notice of the penalty at a rate of one percent per month in accordance with RCW 43.20B.695.

(3) A person contesting any decision by the department to impose a remedy shall within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt with the Office of Appeals, PO Box 2465, Olympia, WA 98504; and

(b) Include in or with the application:

(i) The grounds for contesting the department decision; and

(ii) A copy of the contested department decision.

(4) Administrative proceedings shall be governed by chapter 34.05 RCW, RCW 43.20A.215, where applicable, this section, and chapter 388-08 WAC. If any provision in this section conflicts with chapter 388-08 WAC, the provision in this section governs.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-270, filed 5/8/96, effective 6/8/96.]

WAC 388-110-280 Dispute resolution. (1) When a contractor disagrees with the department's finding of a violation under this chapter, the contractor shall have the right to have the violation reviewed under the department's dispute resolution process. Requests for review shall be made to the department within ten days of receipt of the written finding of a violation.

(2) When requested by a contractor, the department shall expedite the dispute resolution process to review violations upon which a department order imposing contract suspension, stop placement, or a contract condition is based.

(3) Orders of the department imposing contracts suspension, stop placement, or conditions for continuation of a contract are effective immediately upon notice and shall continue pending dispute resolution.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-280, filed 5/8/96, effective 6/8/96.]

Chapter 388-150 WAC
MINIMUM LICENSING REQUIREMENTS FOR CHILD DAY CARE CENTERS

WAC

WAC 388-150-005 Authority. The following rules are adopted under chapters 74.12 and 74.15 RCW.

[Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-150-005, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-005, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-005, filed 11/20/90, effective 12/21/90.]

WAC 388-150-010 Definitions. As used and defined under this chapter:

"Capacity" means the maximum number of children the licensee is authorized to have on the premises at a given time.

"Center" means the same as **"child day care center."**

"Child abuse or neglect" means the injury, sexual abuse, sexual exploitation, or negligent treatment or maltreatment of a child by any person under circumstances indicating the child's health, welfare, and safety is harmed thereby.

"Child day care center" means a facility providing regularly scheduled care for a group of children one month of age through twelve years of age for periods less than twenty-four hours; except, a program meeting the definition of a family child care home shall not be licensed as a day care center without meeting the requirements of WAC 388-150-020 (5)(a).

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

"Department of health" means the state department of health.

"Infant" means a child eleven months of age and under.

"License" means a permit issued by the department authorizing by law the licensee to operate a child day care center and certifying the licensee meets minimum requirements under licensure.

"Licensee" means the person, organization, or legal entity responsible for operating the center.

"Premises" means the building where the center is located and the adjoining grounds over which the licensee has control.

"Preschool age child" means a child thirty months of age through five years of age not enrolled in kindergarten or an elementary school.

"School-age child" means a child five years of age through twelve years of age enrolled in kindergarten or an elementary school.

"Staff" means a child care giver or a group of child care givers employed by the licensee to supervise a child served at the center.

"Toddler" means a child twelve months of age through twenty-nine months of age.

"The Washington state training and registry system (STARS)"means the entity approved by the department to determine the classes, courses, and workshops licensees and staff may take to satisfy training requirements.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-150-010, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-010, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-010, filed 11/20/90, effective 12/21/90.]

WAC 388-150-020 Scope of licensing. (1) The person or organization operating a child day care center shall be subject to licensing by authority under chapter 74.15 RCW, unless specifically exempted by RCW 74.15.020(4).

(2) The person or organization operating a child day care center and qualifying for exemption from requirements of this chapter under RCW 74.15.020(4) shall not be subject to

licensure. The person or organization claiming an exemption shall provide the department proof of entitlement to the exemption on the department's request.

(3) RCW 74.15.020 (4)(c) exempts from licensing facilities where parents on a mutually cooperative basis exchange care of one another's children. To qualify for this cooperative exemption:

(a) At least one parent or guardian of each child attending the facility regularly shall be involved in the direct care of children at the facility;

(b) Parents or guardians shall be involved in the direct care of children on a relatively equal basis; and

(c) A person other than a parent or guardian of a child at the facility shall not be involved in the care of children or in the operation of the facility.

(4) The department shall not license the center legally exempt from licensing. However, at the applicant's request, the department shall investigate and may certify the center as meeting licensing and other pertinent requirements. In such cases, the department's requirements and procedures for licensure shall apply equally to certification.

(5) The department may certify a day care center for payment without further investigation if the center is:

(a) Licensed by an Indian tribe;

(b) Certified by the Federal Department of Defense; or

(c) Approved by the superintendent of public instruction's office. The center must be licensed, certified, or approved in accordance with national or state standards or standards approved by the department and be operated on the premises over which the entity operating the center has jurisdiction.

(6) The department shall not license the department employee or the member of the department employee's household when such person is involved directly, or in an administrative or supervisory capacity, in the:

(a) Licensing or certification process;

(b) Placement of a child in a licensed or certified center; or

(c) Authorization of payment for the child in care.

(7)(a) The department may license the center located in a private family residence when the portion of the residence accessible to the child is:

(i) Used exclusively for the child during the center's operating hours or while the child is in care; or

(ii) Separate from the family living quarters.

(b) A child care facility in a separate building on the same premises as a private family residence is a child day care center.

(8) The person or organization desiring to serve state-paid children shall:

(a) Be licensed or certified;

(b) Follow billing policies and procedures in *Child Day Care Subsidies, A Booklet for Providers*, DSHS 22-877(X); and

(c) Bill the department at the person's or organization's customary rate or the DSHS rate, whichever is less.

[Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-150-020, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-020, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 91-15-084 and 91-21-070 (Orders 3205 and 3205A), § 388-150-020, filed 7/23/91 and 10/17/91, effective 8/23/91 and 11/17/91; 90-23-078 (Order 3103), § 388-150-020, filed 11/20/90, effective 12/21/90.]

WAC 388-150-040 Local ordinances and codes. The department shall issue or deny a license on the basis of the applicant's compliance with minimum licensing and procedural requirements. The department shall notify the local planning office of the applicant's intention to operate a child care center within the local jurisdiction. Local officials shall be responsible for enforcing city ordinances and county codes, such as zoning and building regulations.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-040, filed 11/20/90, effective 12/21/90.]

WAC 388-150-050 Waivers. (1) In an individual case, the department, for good cause, may waive a specific requirement and may approve an alternate method for the licensee or applicant to achieve the specific requirement's intent if the:

(a) Licensee or applicant submits to the department a written waiver request fully explaining the circumstances necessitating the waiver; and

(b) Department determines waiver approval will not jeopardize the safety or welfare of the child in care or detract from the quality of licensee-delivered services.

(2) The department may approve a waiver request only for a specific purpose or child and for a specific period of time not exceeding the expiration date of the license.

(3) The department may limit or restrict a license issued to a licensee or an applicant in conjunction with a waiver.

(4) The licensee shall maintain on the premises a copy of the department's written waiver approval.

(5) The department's denial of a licensee's or applicant's waiver request shall not be subject to appeal under chapter 34.05 RCW.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-050, filed 11/20/90, effective 12/21/90.]

WAC 388-150-060 Dual licensure. The department may either:

(1) Issue a child day care center license to the applicant having a license involving full-time care; or

(2) Permit simultaneous care for the child and adolescent or adult on the same premises if the applicant or licensee:

(a) Demonstrates evidence that care of one client category will not interfere with the quality of services provided to another category of clients;

(b) Maintains the most stringent maximum capacity limitation for the client categories concerned;

(c) Requests and obtains a waiver permitting dual licensure; and

(d) Requests and obtains a waiver to subsection (2)(b) of this section, if applicable.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-060, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-060, filed 11/20/90, effective 12/21/90.]

WAC 388-150-070 Application and reapplication for licensing—Investigation. (1) The person or organization applying for a license or relicensure under this chapter and

responsible for operating the center shall comply with application procedures the department prescribes and submit to the department:

(a) A completed department-supplied application for child care agency form, including required attachments, ninety or more days before the:

(i) Expiration of a current license;

(ii) Opening date of a new center;

(iii) Relocation of a center;

(iv) Change of the licensee; or

(v) Change of license category.

(b) A completed criminal history and background inquiry form for each staff person or volunteer having unsupervised or regular access to the child in care; and

(c) The annual licensing fee. The fee is forty-eight dollars for the first twelve children plus four dollars for each additional child.

(2) In addition to the required application materials specified under subsection (1) of this section, the applicant for initial licensure shall submit to the department:

(a) An employment and education resume of the person responsible for the active management of the center and the program supervisor;

(b) Diploma or education transcript copies of the program supervisor; and

(c) Three professional references each for the licensee, director, and program supervisor.

(3) The applicant for a license under this chapter shall be twenty-one years of age or older.

(4) The applicant, licensee, and director shall attend department-provided orientation training.

(5) The department may, at any time, require additional information from the applicant, licensee, staff person, volunteer, member of their households, and other person having access to the child in care as the department deems necessary, including, but not limited to:

(a) Sexual deviancy evaluations;

(b) Substance and alcohol abuse evaluations;

(c) Psychiatric evaluations;

(d) Psychological evaluations; and

(e) Medical evaluations.

(6) The department may perform investigations of the applicant, licensee, staff person, volunteer, member of their households, and other person having access to the child in care as the department deems necessary, including accessing criminal histories and law enforcement files.

(7) The applicant shall conform to rules and regulations approved or adopted by the:

(a) Department of health, promoting the health of the child in care, contained in this chapter; and

(b) State fire marshal's office, establishing standards for fire prevention and protection of life and property from fire, under chapter 212-12 WAC, "fire marshal standards."

(8) The department shall not issue a license to the applicant until the department of health and the state fire marshal's office have certified or inspected and approved the center.

[Statutory Authority: RCW 43.20B.110. 01-02-032, § 388-150-070, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-070, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-070, filed 11/20/90, effective 12/21/90.]

WAC 388-150-080 Licensed capacity. (1) The department shall issue the applicant or licensee a license for a specific number of children dependent on the:

(a) Department's evaluation of the center's premises, equipment, and physical accommodations;

(b) Number and skills of the licensee, staff, and volunteers; and

(c) Ages and characteristics of the children served.

(2) The department:

(a) Shall not issue the applicant or licensee a license to care for more children than permitted under this chapter; and

(b) May issue the applicant or licensee a license to care for fewer children than the center's maximum capacity.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-080, filed 11/20/90, effective 12/21/90.]

WAC 388-150-085 Initial license. (1) The department may issue an initial license to an applicant not currently licensed to provide child day care when the applicant:

(a) Can demonstrate compliance with the rules contained in this chapter pertaining to the health and safety of the child in care; but

(b) Cannot demonstrate compliance with the rules pertaining to:

(i) Staff-child interactions,

(ii) Group size and staff-child ratios,

(iii) Behavior management and discipline,

(iv) Activity programs,

(v) Child records and information, and

(vi) Other rules requiring department observation of the applicant's ability to comply with rules.

(c) Can provide a plan, acceptable to the department, to comply with rules found in subsection (1)(b) of this section.

(2) The department may issue an initial license to an applicant for a period not to exceed six months, renewable for a period not to exceed two years.

(3) The department shall evaluate the applicant's ability to comply with all rules contained in this chapter during the period of initial licensure prior to issuing a full license.

(4) The department may issue a full license to the applicant demonstrating compliance with all rules contained in this chapter at any time during the period of initial licensure.

(5) The department shall not issue a full license to the applicant who does not demonstrate the ability to comply with all rules contained in this chapter during the period of initial licensure.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-085, filed 10/1/96, effective 11/1/96.]

WAC 388-150-090 License denial, suspension, or revocation. (1) Before granting a license and as a condition for continuance of a license, the department shall consider the ability of the applicant and licensee to meet the requirements of this chapter. If more than one person is the applicant or licensee, the department:

(a) Shall consider the persons' qualifications separately and jointly; and

(b) May deny, suspend, revoke, or not renew the license based on the failure of one of the persons to meet the requirements.

(2) The department shall deny, suspend, revoke, or not renew the license of a person who:

(a) Has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130, is ineligible to provide care because of a criminal history under chapter 388-330 WAC, or allows such a person on the premises;

(b) Commits or was convicted of a felony reasonably related to the competency of the person to meet the requirements of this chapter;

(c) Engages in illegal use of a drug or excessive use of alcohol;

(d) Commits, permits, aids, or abets the commission of an illegal act on the premises;

(e) Commits, permits, aids, or abets the abuse, neglect, exploitation, or cruel or indifferent care to a child in care;

(f) Refuses to permit an authorized representative of the department, state fire marshal, state auditor's office, or department of health to inspect the premises; or

(g) Refuses to permit an authorized representative of the department, the department of health, or state auditor's office access to records related to operation of the center or to interview staff or a child in care.

(3) The department may deny, suspend, revoke, or not renew a license of a person who:

(a) Seeks to obtain or retain a license by fraudulent means or misrepresentation, including, but not limited to:

(i) Making a materially false statement on the application; or

(ii) Omitting material information on the application.

(b) Provides insufficient staff in relation to the number, ages, or characteristics of children in care;

(c) Allows a person unqualified by training, experience, or temperament to care for or be in contact with a child in care;

(d) Violates any condition or limitation on licensure including, but not limited to:

(i) Permitting more children on the premises than the number for which the center is licensed; or

(ii) Permitting on the premises a child of an age different from the ages for which the center is licensed.

(e) Fails to provide adequate supervision to a child in care;

(f) Demonstrates an inability to exercise fiscal responsibility and accountability with respect to operation of the center;

(g) Misappropriates property of a child in care;

(h) Knowingly permits on the premises an employee or volunteer who has made a material misrepresentation on an application for employment or volunteer service;

(i) Refuses or fails to supply necessary, additional department-requested information; or

(j) Fails to comply with any provision of chapter 74.15 RCW or this chapter.

(4) The department shall not issue a license to a person who has had denied, suspended, revoked, or not renewed a license to operate a facility for the care of children or adults, in this state or elsewhere, unless the person demonstrates by clear, cogent, and convincing evidence the person has undertaken sufficient corrective action or rehabilitation to warrant public trust and to operate the center in accordance with the rules of this chapter.

(5) The department's notice of a denial, revocation, suspension, or modification of a license and the applicant's or licensee's right to a hearing is governed under RCW 43.20A.205.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-150-090, filed 4/26/96, effective 5/27/96. Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-150-090, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-090, filed 11/20/90, effective 12/21/90.]

WAC 388-150-092 Civil penalties. (1) Before imposing a civil penalty, the department shall provide written notification by personal service, including by the licensor, or certified mail which shall include:

(a) A description of the violation and citation of the applicable requirement or law;

(b) A statement of what is required to achieve compliance;

(c) The date by which the department requires compliance;

(d) The maximum allowable penalty if timely compliance is not achieved;

(e) The means to contact any technical assistance services provided by the department or others; and

(f) Notice of when, where, and to whom a request to extend the time to achieve compliance for good cause may be filed with the department.

(2) The length of time in which to comply shall depend on:

(a) The seriousness of the violation;

(c) The potential threat to the health, safety and welfare of children in care; or

(c) Previous opportunities to correct the deficiency.

(3) The department may impose a civil penalty based on but not limited to these reasons:

(a) The child care center has previously been subject to an enforcement action for the same or similar type of violation of the same statute or rule; or

(b) The child care center has previously been given notice of the same or similar type of violation of the same statute or rule; or

(c) The violation represents a potential threat to the health, safety, and/or welfare of children in care.

(4) The department may impose a civil penalty in addition to or in conjunction with other disciplinary actions against a child care license including probation, suspension, or other action.

(5) The civil fine shall be payable twenty-eight days after receipt of the notice or later as specified by the department.

(6) The fine may be forgiven if the agency comes into compliance during the notification period.

(7) The center or person against whom the department assesses a civil fine has a right to an adjudicative proceeding as governed by RCW 43.20A.215.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-092, filed 10/1/96, effective 11/1/96.]

WAC 388-150-093 Civil penalties—Amount of penalty. Whenever the department imposes a civil monetary penalty per WAC 388-150-092(3), the department shall impose a penalty of two hundred and fifty dollars per violation per day. The department may assess and collect the penalty with interest for each day of noncompliance.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-093, filed 10/1/96, effective 11/1/96.]

WAC 388-150-094 Civil penalties—Posting of notice of penalty. (1) The licensee shall post the final notice of a civil penalty in a conspicuous place in the facility.

(2) The notice shall remain posted until payment is received by the department.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-094, filed 10/1/96, effective 11/1/96.]

WAC 388-150-095 Civil penalties—Unlicensed programs. Where the department has determined that an agency is operating without a license, the department shall send written notification by certified mail or other means showing proof of service. This notification shall contain the following:

(1) Advising the agency of the basis of determination of providing child care without a license and the need to be licensed by the department;

(2) The citation of the applicable law;

(3) The assessment of seventy-five dollars per day penalty of each day unlicensed care is provided. The fine would be effective and payable within thirty days of receipt of the notification;

(4) How to contact the office of child care policy;

(5) The need to submit an application to the office of child care policy within thirty days of receipt of the notification;

(6) That the penalty may be forgiven if the agency submits an application within thirty days of the notification; and

(7) The right of an adjudicative proceeding as a result of the assessment of a monetary penalty and the appropriate procedure for requesting an adjudicative proceeding.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-095, filed 10/1/96, effective 11/1/96.]

WAC 388-150-096 Civil penalties—Separate violations. Each violation of a law or rule constitutes a separate violation and may be penalized as such. A penalty may be imposed as a flat amount of the maximum allowable, or may be imposed for each day the violation continues.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-096, filed 10/1/96, effective 11/1/96.]

WAC 388-150-097 Civil penalties—Penalty for nonpayment. Penalty for nonpayment. The department may suspend, revoke or not renew a license for failure to pay a civil monetary penalty it has assessed within ten days after such assessment becomes final.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-097, filed 10/1/96, effective 11/1/96.]

WAC 388-150-098 Probationary license. (1) The department shall base the decision as to whether a probationary license will be issued upon the following factors:

(a) Willful or negligent noncompliance by the licensee,

(b) History of noncompliance,

(c) Extent of deviation from the requirements,

(d) Evidence of a good faith effort to comply,

(e) Any other factors relevant to the unique situation.

(2) Where the negligent or willful violation of the licensing requirements does not present an immediate threat to the health and well-being of the children but would be likely to do so if allowed to continue, a probationary license may be issued as well as civil penalties or other sanctions. Such situations may include:

(a) Substantiation that a child (or children) was abused or neglected while in the care of the center,

(b) Disapproved fire safety or sanitation report,

(c) Use of unauthorized space for child care,

(d) Inadequate supervision of children,

(e) Understaffing for the number of children in care,

(f) Noncompliance with requirements addressing:

(i) Children's health,

(ii) Proper nutrition,

(iii) Discipline,

(iv) Emergency medical plan,

(v) Sanitation and personal hygiene practices.

(3) Licensee required to notify parents when a probationary licensed is issued:

(a) The licensee shall notify the parents or guardians of all children in care that it is in probationary status within five working days of receiving notification he or she has been issued a probationary license;

(b) The notification shall be in writing and shall be approved by the department prior to being sent;

(c) The licensee shall provide documentation to the department that parents or guardians of all children in care have been notified within ten working days of receiving notification that he or she has been issued a probationary license;

(d) The department may issue a probationary license for up to six months, and at the discretion of the department it may be extended for an additional six months.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-098, filed 10/1/96, effective 11/1/96.]

WAC 388-150-100 Activity program. (1) The licensee shall implement an activity program designed to meet the developmental, cultural, and individual needs of the child served. The licensee shall ensure the program contains a range of learning experiences for the child to:

(a) Gain self-esteem, self-awareness, self-control, and decision making abilities;

(b) Develop socially, emotionally, intellectually, and physically;

(c) Learn about nutrition, health, and personal safety; and

(d) Experiment, create, and explore.

(2) The licensee shall ensure the center's program offers variety and options, including a balance between:

(a) Child-initiated and staff-initiated activities;

(b) Free play and organized events;

(c) Individual and group activities; and

(d) Quiet and active experiences.

(3) The licensee shall ensure the center's program affords the child daily opportunities for small and large muscle activities and outdoor play.

(4) The licensee shall operate the center's program under a regular schedule of activities with allowances for a variety of special events. The licensee shall implement a planned program of activities as evidenced by a current, written activity schedule, and afford staff classroom planning time.

(5) The licensee shall manage child and staff movements from one planned activity or care area to another to achieve smooth, unregimented transitions by:

(a) Establishing familiar routines;

(b) Contributing to learning experiences; and

(c) Maintaining staff-to-child ratio and group size guidelines.

(6) The child may remain in care only ten hours or less per day except as necessitated by the parent's working hours and travel time from and to the center.

[Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-100, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-100, filed 11/20/90, effective 12/21/90.]

WAC 388-150-110 Learning and play materials. The licensee shall provide the child a variety of easily accessible, developmentally appropriate learning and play materials of sufficient quantity to implement the center's program. The licensee shall ensure material is culturally relevant and promotes:

(1) Social development;

(2) Intellectual ability;

(3) Language development and communication;

(4) Self-help skills;

(5) Sensory stimulation;

(6) Large and small muscle development; and

(7) Creative expression.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-110, filed 11/20/90, effective 12/21/90.]

WAC 388-150-120 Staff-child interactions. (1) The licensee shall furnish the child a nurturing, respectful, supportive, and responsive environment through frequent interactions between the child and staff:

(a) Supporting the child in developing an understanding of self and others by assisting the child to share ideas, experiences, and feelings;

(b) Providing age-appropriate opportunities for intellectual growth and development of the child's social and language skills, including encouraging the child to ask questions;

(c) Helping the child solve problems;

(d) Fostering creativity and independence in routine activities, including showing tolerance for mistakes; and

(e) Treating equally all children in care regardless of race, religion, culture, sex, and handicapping condition.

(2) The licensee shall furnish the child a pleasant and educational environment at meal and snack times. Staff shall provide good models for nutrition habits and social behavior by:

(a) Sitting and eating with children, when possible; and

(b) Encouraging conversation among children.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-120, filed 11/20/90, effective 12/21/90.]

WAC 388-150-130 Behavior management and discipline. (1) The licensee shall guide the child's behavior based on an understanding of the individual child's needs and stage of development. The licensee shall promote the child's developmentally appropriate social behavior, self-control, and respect for the rights of others.

(2) The licensee shall ensure behavior management and discipline practices are fair, reasonable, consistent, and related to the child's behavior. Staff shall not administer cruel, unusual, hazardous, frightening, or humiliating discipline.

(3) The licensee shall be responsible for implementing the behavior management and discipline practices of the center. The child in care shall not determine or administer behavior management or discipline.

(4) The licensee shall prohibit and prevent:

(a) Corporal punishment by any person on the premises, including biting, jerking, shaking, spanking, slapping, hitting, striking, or kicking the child, or other means of inflicting physical pain or causing bodily harm;

(b) The use of a physical restraint method injurious to the child;

(c) The use of a mechanical restraint for disciplinary purposes, locked time-out room, or closet; or

(d) The withholding of food as a punishment.

(5) In emergency situations, the staff person competent to use restraint methods may use limited physical restraint when:

(a) Protecting a person on the premises from physical injury;

(b) Obtaining possession of a weapon or other dangerous object; or

(c) Protecting property from serious damage.

(6) The licensee shall document any incident involving the use of physical restraint.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-130, filed 11/20/90, effective 12/21/90.]

WAC 388-150-140 Rest periods. (1) The licensee shall offer a supervised rest period to the child:

(a) Five years of age and under remaining in care more than six hours; or

(b) Showing a need for rest.

(2) The licensee shall plan quiet activities for the child not needing rest.

(3) The licensee shall allow the child twenty-nine months of age or younger to follow an individual sleep schedule.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-140, filed 11/20/90, effective 12/21/90.]

WAC 388-150-150 Evening and nighttime care. (1) For the center offering child care during evening and nighttime hours, the licensee shall adapt the program, equipment,

and staffing pattern to meet the physical and emotional needs of the child away from home at night.

(2) The licensee shall maintain the same staff-to-child ratio in effect during daytime care. At all times, including sleeping hours, staff shall keep the child within continuous visual or auditory range.

(3) The licensee shall arrange child grouping so the sleeping child remains asleep during the arrival or departure of another child.

(4) The licensee shall ensure that staff in charge during evening and nighttime hours meet at least the requirements of a lead worker.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-150, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-150, filed 11/20/90, effective 12/21/90.]

WAC 388-150-160 Off-site trips. (1) The licensee may transport or permit the off-site travel of the child to attend school, participate in supervised field trips, or engage in other supervised off-site activities only with written parent consent.

(2) The parent's consent may be:

(a) For a specific date and trip; or

(b) A blanket authorization describing the full range of trips the child may take. In such case, the licensee shall notify the parent in advance about the trip.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-160, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-160, filed 11/20/90, effective 12/21/90.]

WAC 388-150-165 Transportation. When the licensee provides transportation for the child in care:

(1) The licensee shall ensure that the motor vehicle operated by the facility is maintained in a safe operating condition;

(2) The licensee shall ensure the motor vehicle in which the child rides during hours of care is equipped with appropriate safety devices and individual seat belts or safety seats for each child to use when the vehicle is in motion. The licensee shall assure that children less than two years of age are restrained in a restraint system that complies with standards of the United States department of transportation. Seat belts are not required for buses approved by the state patrol;

(3) The licensee shall ensure the number of passengers does not exceed the seating capacity of the motor vehicle;

(4) The licensee or driver shall carry liability and medical insurance. The driver shall have a current Washington driver's license, valid for the classification of motor vehicle operated;

(5) The driver or staff supervising the child in the motor vehicle shall have current first aid and cardiopulmonary resuscitation training, except that when the center uses more than one vehicle for a field trip, only one person in the group is required to have this training;

(6) The licensee shall ensure a minimum of one staff person, other than the driver, is present in the motor vehicle when:

(a) Seven or more preschool age and younger children are present; or

(b) Staff-to-child ratio guidelines require additional staff.

(7) Staff or driver shall not leave the child unattended in the motor vehicle.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-165, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-165, filed 11/20/90, effective 12/21/90.]

WAC 388-150-170 Parent communication. (1) The licensee shall orally:

(a) Explain to the parent the center's policies and procedures;

(b) Orient the parent to the center's philosophy, program, and facilities;

(c) Advise the parent of the child's progress and issues relating to the child's care and individual practices concerning the child's special needs; and

(d) Encourage parent participation in center activities.

(2) The licensee shall give the parent the following written policy and procedure information:

(a) Enrollment and admission requirements;

(b) The fee and payment plan;

(c) A typical activity schedule, including hours of operation;

(d) Meals and snacks served, including guidelines on food brought from the child's home;

(e) Permission for free access by the child's parent to all center areas used by the child;

(f) Signing in and signing out requirements;

(g) Child abuse reporting law requirements;

(h) Behavior management and discipline;

(i) Nondiscrimination statement;

(j) Religious activities, if any;

(k) Transportation and field trip arrangements;

(l) Practices concerning an ill child;

(m) Medication management;

(n) Medical emergencies; and

(o) If licensed for the care of an infant or toddler:

(i) Diapering;

(ii) Toilet training; and

(iii) Feeding.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-170, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-170, filed 11/20/90, effective 12/21/90.]

WAC 388-150-180 Staff pattern and qualifications. (1) General qualifications. The licensee, staff, volunteer, and other person associated with the operation of the center who has access to the child in care shall:

(a) Be of good character;

(b) Demonstrate the understanding, ability, personality, emotional stability, and physical health suited to meet the cultural, emotional, mental, physical, and social needs of the child in care; and

(c) Not have committed or been convicted of child abuse or any crime involving harm to another person.

(2) Center management. The licensee shall serve as or employ a director, responsible for the overall management of the center's facility and operation. The director shall:

(a) Be twenty-one years of age or older;

(b) Serve as administrator of the center, ensuring compliance with minimum licensing requirements;

(c) Have knowledge of child development as evidenced by professional references, education, experience, and on-the-job performance;

(d) Have the management and supervisory skills necessary for the proper administration of the center, including:

(i) Record maintenance;

(ii) Financial management; and

(iii) Maintenance of positive relationships with staff, children, parents, and the community;

(e) Have completed the following number of college quarter credits or department-approved clock hours in early childhood education/child development, or possess an equivalent educational background, or be a certified child development associate:

(i) In centers licensed for twenty-five or more children, the director shall have completed forty-five or more credits;

(ii) In centers licensed for thirteen through twenty-four children, the director shall have completed twenty-five or more credits;

(iii) In centers licensed for twelve or fewer children, the director shall have completed ten or more credits; and

(iv) In (i), (ii) and (iii) above, one-third of the credits may be clock hours.

(f) Have two or more years successful experience working with children of the same age level as those served by the center as evidenced by professional references and on-the-job performance;

(g) Have planning, coordination, and supervisory skills to implement a high quality, developmentally appropriate program;

(h) Have knowledge of children and how to meet children's needs; and

(i) Have completed one of the following prior to or within the first six months of employment or initial licensure, except as provided in subsection (2)(j) of this section:

(i) Twenty clock hours or two college quarter credits of basic training approved by the Washington state training registry system (STARS); or

(ii) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education or child development; or

(iii) Associate of arts or AAS or higher college degree in early childhood education or child development.

(j) Directors who are already employed or licensed on the effective date of this rule must complete the training required in WAC 388-150-180 (2)(i) prior to or within twelve months after the effective date of this rule.

(3) When the director does not meet the qualifications specified in subsections (2)(e), (f), (g), and (h) of this section, the director or licensee shall employ a program supervisor responsible for planning and supervising the center's learning and activity program. In such a case, the director shall have had at least one three credit college class in early childhood development. The program supervisor shall:

(a) Be twenty-one years of age or older;

(b) Meet the education, experience, and competency qualifications specified under subsection (2)(e), (f), (g), (h), (i), and (j) of this section; and

(c) Discharge on-site program supervisory duties twenty hours or more a week.

(4) For the center serving the school age child only, the program supervisor may substitute equivalent courses in education, recreation, or physical education for required education.

(5) The director and program supervisor may be one and the same person when qualified for both positions. The director or program supervisor shall normally be on the premises while the child is in care. If temporarily absent from the center, the director and program supervisor shall leave a competent, designated staff person in charge who meets the qualifications of a lead staff person.

(6) The director and program supervisor may also serve as child care staff when such role does not interfere with the director's or program supervisor's management and supervisory responsibilities.

(7) Center staffing. The licensee shall ensure the lead child care staff person in charge of a child or a group of children implementing the activity program:

(a) Is eighteen years of age or older; and

(b) Possesses a high school education or equivalent; or

(c) Has child development knowledge and experience;

(d) Has completed one of the following prior to or within the first six months of licensure or employment except as provided in subsection (7)(e) of this section:

(i) Twenty clock hours or two college quarter credits of basic training. Training shall be approved by the Washington state training and registry system (Washington STARS); or

(ii) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education or child development; or

(iii) Associate of arts (AA) or associate of applied science (AAS) or higher college degree in early childhood education or child development.

(e) Lead child care staff persons who are already employed on the effective date of this rule must complete the training required in WAC 388-150-180 (7)(d) prior to or within twelve months after the effective date of this rule.

(8) The licensee may assign a child care assistant or aide to support lead child care staff. The child care assistant or aide shall be sixteen years of age or older. The child care assistant or aide shall care for the child under the direct supervision of the lead child care staff person. The licensee shall ensure no person under eighteen years of age is assigned sole responsibility for a group of children. The assistant or aide, eighteen years of age or older, may care for a child or group of children without direct supervision by a superior for a brief period time.

(9) The licensee may arrange for a volunteer to support lead child care staff. The volunteer shall be sixteen years of age or older. The volunteer shall care for the child under the direct supervision of the lead child care staff person. The licensee may count the volunteer in the staff-to-child ratio when the volunteer meets staff qualification requirements.

(10) Support service personnel. The licensee shall provide or arrange for fulfillment of administrative, clerical,

accounting, maintenance, transportation, and food service responsibilities so the child care staff is free to concentrate on program implementation.

(11) The licensee shall ensure completion of support service duties occurs in a manner allowing the center to maintain required staff-to-child ratios.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-150-180, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-180, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-180, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-180, filed 11/20/90, effective 12/21/90.]

WAC 388-150-190 Group size and staff-child ratios. (1) In centers licensed for thirteen or more children, the licensee shall conduct group activities within the following group size and staff-to-child ratio requirements, according to the age of the children:

AGE OF CHILDREN	STAFF-CHILD RATIO	MAXIMUM GROUP SIZE
1 mo. through 11 mos. (infant)	1:4	8
12 mos. through 29 mos. (toddler)	1:7	14
30 mos. through 5 years (preschooler)	1:10	20
5 years and older (school-age child)	1:15	30

(2) In centers licensed for twelve or fewer children, the licensee may combine children of different age groups, provided the licensee:

(a) Maintains the staff-to-child ratio designated for the youngest child in the mixed group; and

(b) Provides a separate care area when four or more infants are in care. In such case the maximum group size shall be eight children.

(3) The licensee shall conduct activities for each group in a specific room or other defined space within a larger area.

(4) The licensee shall ensure each group is under the direct supervision of a qualified staff person or team of staff involved in directing the child's activities.

(5) The department may approve reasonable variations to group size limitations if the licensee maintains required staff-to-child ratios, dependent on:

(a) Staff qualifications;

(b) Program structure; and

(c) Usable square footage.

(6) After consulting with the child's parent, the licensee may place the individual child in a different age group and serve the child within the different age group's required staff-to-child ratio based on the child's:

(a) Developmental level; and

(b) Individual needs.

(7) The licensee may briefly combine children of different age groups provided the licensee maintains the staff-to-child ratio and group size designated for the youngest child in the mixed group.

(8) In centers licensed for thirteen or more children, the licensee may group ambulatory children between one year, and two and one-half years of age with older children, provided:

(a) The total number of children in the group does not exceed twelve; and

(b) Two staff are assigned to the group.

(9) The licensee shall ensure the staff person providing direct care and supervision of the child is free of other duties at the time of care.

(10) The licensee shall maintain required staff-to-child ratios indoors, outdoors, on field trips, and during rest periods. During rest periods, staff may be involved in other activities if staff remain on the premises and each child is within continuous visual and auditory range of a staff person.

(11) The licensee shall ensure staff:

(a) Attend the child or group of children at all times; and

(b) Keep each child within continuous visual and auditory range, except when a toilet-trained child uses the toilet.

(12) When only one staff person is present, the licensee shall ensure a second staff person is readily available in case of an emergency.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-190, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-190, filed 11/20/90, effective 12/21/90.]

WAC 388-150-200 Staff development and training. (1) The licensee shall have an orientation system making the employee and volunteer aware of program policies and practices. The licensee shall provide staff an orientation including, but not limited to:

(a) Minimum licensing rules required under this chapter;

(b) Goals and philosophy of the center;

(c) Planned daily activities and routines;

(d) Child guidance and behavior management methods;

(e) Child abuse and neglect prevention, detection, and reporting policies and procedures;

(f) Special health and developmental needs of the individual child;

(g) The health care plan;

(h) Fire prevention and safety procedures;

(i) Personnel policies, when applicable;

(j) Limited restraint techniques;

(k) Cultural relevancy; and

(l) Developmentally appropriate practices.

(2) The licensee shall provide or arrange for regular training opportunities for the child care staff to promote ongoing employee education and enhance practice skills.

(3) The licensee shall conduct periodic staff meetings for planning and coordination purposes.

(4) The licensee shall ensure:

(a) A staff person with basic, standard, current first aid and cardiopulmonary resuscitation (CPR) training, or department of health approved training, is present at all times and in all areas the child is in care; and

(b) Staff's CPR training includes methods appropriate for child age groups in care.

(5) The licensee shall provide or arrange appropriate education and training for child care staff on the prevention and transmission of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

(6) The licensee shall ensure the staff person preparing full meals has a valid food handler permit.

(7) The licensee shall ensure that the director, program supervisor and lead staff annually, beginning one year after licensure or employment, complete ten clock hours or one

college quarter credit of training approved by the Washington state training and registry system (STARS). For those already employed or licensed on the effective date of this rule, this requirement for annual training shall begin one year after the effective date of this rule.

For the director and the program supervisor, five of the ten hours of training shall be in program management and administration.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-150-200, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-200, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-200, filed 11/20/90, effective 12/21/90.]

WAC 388-150-210 Health care plan. (1) The licensee shall maintain current written health policies and procedures for staff orientation and use, and for the parent. The health care plan shall include, but not be limited to, information about the center's procedures concerning:

(a) Communicable disease prevention, reporting, and management;

(b) Action taken for medical emergencies;

(c) First aid;

(d) Care of minor illnesses;

(e) Medication management;

(f) General hygiene practices;

(g) Handwashing practices;

(h) Food and food services; and

(i) Infant care procedures and nursing consultation, where applicable.

(2) In centers licensed for thirteen or more children, the licensee shall use the services of an advisory physician, physician's assistant, or registered nurse to assist in the development, approval, and periodic review of the center's health care plan. This medical practitioner shall sign and date the health plan.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-210, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-210, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-210, filed 11/20/90, effective 12/21/90.]

WAC 388-150-220 Health supervision and infectious disease prevention. (1) Child. The licensee shall encourage the parent to arrange a physical examination for the child who has not had regular health care or a physical examination within one year before enrollment.

(2) The licensee shall encourage the parent to obtain health care for the child when necessary. The licensee shall not be responsible for providing or paying for the child's health care.

(3) Before or on the child's first day of attendance, the licensee shall have on file a certificate of immunization status form prescribed by the department of health proving the child's full immunization for:

(a) Diphtheria;

(b) Tetanus;

(c) Pertussis (whooping cough);

(d) Poliomyelitis;

(e) Measles (rubeola);

(f) Rubella (German measles);

(g) Mumps; and

(h) Other diseases prescribed by the department of health.

(4) The licensee may accept the child without all required immunizations on a conditional basis if immunizations are:

(a) Initiated before or on enrollment; and

(b) Completed as rapidly as medically possible.

(5) The licensee may exempt the immunization requirement for the child if the parent or guardian:

(a) Signs a statement expressing a religious, philosophical, or personal objection; or

(b) Furnishes a physician's statement of a valid medical reason for the exemption.

(6) Program. Staff shall daily observe and screen the child for signs of illness. The licensee shall care for or discharge home the ill child based on the center's policies concerning the ill child.

(a) When the child has a severe illness or is injured, tired, or upset, staff shall separate the child from other children and attend the child continuously until:

(i) The child is able to rejoin the group;

(ii) Staff return the child to the parent; or

(iii) Staff secure appropriate health care for the child.

(b) The licensee shall provide a quiet, separate care room or area allowing the child requiring separate care an opportunity to rest.

(c) Staff shall sanitize equipment used by the child if staff suspects the child has a communicable disease.

(d) The licensee may use the separate care room or area for other purposes when not needed for separation of the child.

(7) Staff shall wash, or assist the child to wash hands:

(a) After the child's toileting or diapering;

(b) Before the child eats; and

(c) Before the child participates in food activities.

(8) Staff shall clean and disinfect toys, equipment, furnishings, and facilities according to the center's cleaning and disinfecting policies, as needed.

(9) The licensee shall have appropriate extra clothing available for the child who wets or soils clothes.

(10) Staff shall ensure the child does not share personal hygiene or grooming items.

(11) Staff. Each center employee, volunteer, and other person having regular contact with the child in care shall have a tuberculin (TB) skin test, by the Mantoux method, upon employment or licensure, unless against medical advice.

(a) The person whose TB skin test is positive (ten millimeters or more induration) shall have a chest x-ray within thirty days following the skin test.

(b) The licensee shall not require the person to obtain routine periodic TB retesting or x-ray (biennial or otherwise) after entry testing unless directed to obtain retesting by the person's health care provider or the local health department.

(12) The licensee shall not permit the person with a reportable communicable disease to be on duty in the center or have contact with the child in care unless approved in writing by a health care provider.

(13) Staff shall wash hands:

(a) After toileting and diapering the child;

(b) After personal toileting;

(c) After attending to an ill child; and

(d) Before serving or preparing food.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-220, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-220, filed 11/20/90, effective 12/21/90.]

WAC 388-150-230 Medication management. The center may have a policy of not giving medication to the child in care. If the center's health care plan includes giving medication to the child in care, the licensee:

(1) Shall give medications, prescription and nonprescription, only on the written approval of a parent, person, or agency having authority by court order to approve medical care;

(2) Shall give prescription medications:

(a) Only as specified on the prescription label; or

(b) As authorized, in writing, by a physician or other person legally authorized to prescribe medication.

(3) Shall give the following classifications of nonprescription medications, with written parent authorization, only at the dose, duration, and method of administration specified on the manufacturer's label for the age or weight of the child needing the medication:

(a) Antihistamines;

(b) Nonaspirin fever reducers/pain relievers;

(c) Nonnarcotic cough suppressants;

(d) Decongestants;

(e) Anti-itching ointments or lotions, intended specifically to relieve itching;

(f) Diaper ointments and powders, intended specifically for use in the diaper area of the child; and

(g) Sun screen.

(4) Shall give other nonprescription medication:

(a) Not included in the categories listed in subsection (3) of this section; or

(b) Taken differently than indicated on the manufacturer's label; or

(c) Lacking labeled instructions, only when disbursement of the nonprescription medication is as required under subsection (4)(a), (b), and (c):

(i) Authorized, in writing, by a physician; or

(ii) Based on established medical policy approved, in writing, by a physician or other person legally authorized to prescribe medication.

(5) Shall accept from the child's parent, guardian, or responsible relative only medicine in the original container, labeled with:

(a) The child's first and last names;

(b) The date the prescription was filled; or

(c) The medication's expiration date; and

(d) Legible instructions for administration, such as manufacturer's instructions or prescription label.

(6) Shall keep medication, refrigerated or nonrefrigerated, in an orderly fashion, inaccessible to the child;

(7) Shall store external medication in a compartment separate from internal medication;

(8) Shall keep a record of medication disbursed;

(9) Shall return to the parent or other responsible party, or shall dispose of medications no longer being taken; and

(10) May, at the licensee's option, permit self-administration of medication by a child in care if the:

(a) Child is physically and mentally capable of properly taking medication without assistance;

(b) Licensee includes in the child's file a parental or physician's written statement of the child's capacity to take medication without assistance; and

(c) Licensee ensures the child's medications and other medical supplies are stored so the medications and medical supplies are inaccessible to another child in care.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-230, filed 11/20/90, effective 12/21/90.]

WAC 388-150-240 Nutrition. (1) The licensee shall provide food meeting the nutritional needs of the child in care, taking into consideration the:

(a) Number of children in care;

(b) Child's age and developmental level;

(c) Child's cultural background;

(d) Child's handicapping condition; and

(e) Hours of care on the premises.

(2) The licensee shall provide only pasteurized milk or a pasteurized milk product.

(3) The licensee shall provide only whole milk to the child twenty-three months of age or younger except with written permission of the child's parent.

(4) The licensee may serve the child twenty-four months of age or older powdered Grade A milk mixed in the center provided the licensee completes the dry milk mixture, service, and storage in a safe and sanitary manner.

(5) The licensee may provide the child nutrient concentrates, nutrient supplements, a modified diet, or an allergy diet only with written permission of the child's health care provider. The licensee shall obtain from the parent or child's health care provider a written list of foods the child cannot consume.

(6) The licensee shall:

(a) Record food and portion sizes planned and served;

(b) Prepare and date menus one week or more in advance, containing meals and snacks to be served, including parent-provided snacks; and

(c) Specify on the menu a variety of foods enabling the child to consume adequate nutrients.

(7) The licensee shall provide two weeks or more of meal and snack menu variety before repeating the menu.

(8) The licensee shall only make nutrition substitutions of comparable nutrient value and record changes on the menu.

(9) The licensee shall use the following meal pattern to provide food to the child in care in age-appropriate servings:

(a) Providing the child in care for nine or less hours:

(i) Two or more snacks and one meal; or

(ii) Two meals and one snack.

(b) Providing the child in care for nine or more hours:

(i) Two or more meals and two snacks; or

(ii) One meal and three snacks.

(c) Providing the child arriving after school a snack;

(d) Providing the child food at intervals not less than two hours and not more than three and one-half hours apart; and

(e) Allowing the occasional serving of party foods not meeting nutritional requirements.

(10) When serving food, the licensee shall provide the child the following:

(a) At a minimum, the child's breakfast must contain:

(i) A dairy product, including fluid milk, cheese, yogurt, or cottage cheese;

(ii) Cereal or bread, whole grain or enriched; and

(iii) Fruit or vegetable or juice containing a minimum of fifty percent real juice.

(b) At a minimum, the child's lunch or dinner must contain:

(i) A dairy product;

(ii) A protein food including lean meat, fish, poultry, egg, legumes, nut butters, or cheese;

(iii) Bread or bread alternate, whole grain or enriched; and

(iv) Fruit or vegetable, two total servings.

(c) In centers not serving full meals, the child's snacks must include one or more dairy or protein source provided daily, and contain a minimum of two of the following four components at each snack:

(i) A dairy product;

(ii) A protein food;

(iii) Bread or bread alternate; or

(iv) Fruit or vegetable or juice containing a minimum of fifty percent real juice.

(d) The child's food must contain:

(i) A minimum of one serving of Vitamin C fruit, vegetable, or juice, provided daily; and

(ii) Servings of food high in Vitamin A, provided three or more times weekly.

(11) The licensee shall provide:

(a) Dinner to the child in evening care when the child did not receive dinner at home before arriving at the center;

(b) A bedtime snack to the child in nighttime care; and

(c) Breakfast to the child in nighttime care if the child remains at the center after the child's usual breakfast time.

(12) The licensee shall monitor sack lunches, snacks, and other foods brought from the child's home for consumption by the child, all children, or a group of children in care, ensuring safe preparation, storage, and serving and nutritional adequacy.

(13) For the center permitting sack lunches, the licensee shall have available food supplies to supplement food deficient in meeting nutrition requirements brought from the child's home and to nourish the child arriving without home-supplied food.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-240, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-240, filed 11/20/90, effective 12/21/90.]

WAC 388-150-250 Kitchen and food service. (1) The licensee shall provide equipment for the proper storage, preparation, and service of food to meet program needs.

(2) The licensee shall meet food service standards by requiring:

(a) The staff person preparing full meals have a valid food handler permit;

(b) The staff person preparing and serving meals wash hands before handling food;

(c) Handwashing facilities be located in or adjacent to food preparation areas;

(d) Food be stored in a sanitary manner, especially milk, shellfish, meat, poultry, eggs, and other protein food sources;

(e) Food requiring refrigeration be stored at a temperature no warmer than forty-five degrees Fahrenheit;

(f) Frozen food be stored at a maximum temperature of zero degrees Fahrenheit;

(g) Refrigerators and freezers be equipped with thermometers and be regularly cleaned and defrosted;

(h) Food be cooked to correct temperatures;

(i) Raw food be washed thoroughly with clean running water;

(j) Cooked food to be stored be rapidly cooled and refrigerated after preparation;

(k) Food be kept in original containers or in clean, labeled containers and stored off the floor;

(l) Packaged, canned, and bottled food with a past expiration date be discarded;

(m) Food in dented cans or torn packages be discarded; and

(n) When food containing sulfiting agents is served, parents be notified.

(3) The child may participate in food preparation as an education activity. The licensee shall supervise the child when the child is in the kitchen or food preparation area.

(4) The licensee shall make kitchen equipment inaccessible to the child, except during planned and supervised kitchen activities. Staff shall supervise food preparation activities. The licensee shall make potentially hazardous appliances and sharp or pointed utensils inaccessible to the child when the child is not under direct supervision.

(5) The licensee shall install and maintain kitchen equipment and clean re-usable utensils in a safe and sanitary manner.

(6) The licensee shall sanitize reusable utensils in a dishwasher or through use of a three-compartment dishwashing procedure.

(7) The licensee shall use only single-use or clean cloths, used solely for wiping food service, preparation, and eating surfaces.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-250, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-250, filed 11/20/90, effective 12/21/90.]

WAC 388-150-260 Drinking and eating equipment. (1) The licensee shall provide the child disposable single-use cups, individual drinking cups or glasses, or inclined jet-type drinking fountains.

(2) The department shall prohibit the center from using bubbler-type drinking fountains and common drinking cups or glasses.

(3) The licensee shall provide the child durable eating utensils appropriate in size and shape for the child in care.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-260, filed 11/20/90, effective 12/21/90.]

WAC 388-150-270 Care of young children. (1) The licensee shall not accept for care a child under one month of age.

(2) Facility. The licensee shall:

(a) Provide a separate, safe play area for the child under one year of age, or the child not walking;

(b) In centers licensed for thirteen or more children, care for the child under one year of age in rooms or areas separate from older children, with:

(i) Not more than eight children under one year of age to a room or area; and

(ii) Handwashing facilities in or adjacent to each such room or area.

(3) Diapering and toileting. The licensee shall ensure:

(a) The diaper changing area is:

(i) Separate from food preparation areas;

(ii) Adjacent to a handwashing sink; and

(iii) Sanitized between use for different children; or

(iv) Protected by a disposable covering discarded after each use.

(b) The designated change area is impervious to moisture and washable;

(c) Diaper changing procedures are posted at the changing area;

(d) Disposable towels or clean, reusable towels, laundered between usage for different children, are used for cleaning the child;

(e) Staff wash hands after diapering the child or helping the child with toileting;

(f) Disposable diapers, a commercial diaper service, or reusable diapers supplied by the child's family are used;

(g) Soiled diapers are placed without rinsing into a separate, cleanable, covered container provided with a waterproof liner before transporting to the laundry, parent, or acceptable disposal;

(h) Soiled diapers are removed from the facility daily or more often unless the licensee uses a commercial diaper service;

(i) Toilet training is initiated when the child indicates readiness and in consultation with the child's parent;

(j) Potty chairs, when in use, are located on washable, impervious surfaces; and

(k) Toilet training equipment is sanitized after each use.

(4) Feeding. The licensee and the infant's parent shall agree on a schedule for the infant's feedings.

(a) Bottle feedings.

(i) The licensee or parent may provide the child's bottle feeding in the following manner:

(A) A filled bottle brought from home;

(B) Whole milk or formula in ready-to-feed strength; or

(C) Formula requiring no preparation other than dilution with water, mixed on the premises.

(ii) The licensee shall prepare the child's bottle and nipple in a sanitary manner in an area separate from diapering areas.

(iii) The licensee shall sanitize the child's bottle and nipple between uses.

(iv) The licensee shall label the child's bottle with the child's name and date prepared.

(v) The licensee shall refrigerate a filled bottle if the child does not consume the content immediately and shall discard the bottle's content if the child does not consume the content within twelve hours.

(b) To ensure safety and promote nurturing, the licensee shall ensure staff:

(i) Hold in a semi-sitting position for feedings the infant unable to sit in a high chair, unless such is against medical advice;

(ii) Interact with the child;

(iii) Do not prop a bottle;

(iv) Do not give a bottle to the reclining child, unless the bottle contains water only;

(v) Take the bottle from the child when the child finishes feeding; and

(vi) Keep the child in continuous visual and auditory range.

(c) The licensee shall provide semi-solid food for the infant, upon consultation with the parent, not before the child is four months of age and not later than ten months of age, unless such is not recommended by the child's health care provider.

(5) Sleeping equipment. The licensee shall furnish the infant a single-level crib, infant bed, bassinet, or play pen for napping until such time the licensee and parent concur the infant can safely use a mat, cot, or other approved sleeping equipment.

(6) When the licensee furnishes the infant or child a crib, the licensee shall ensure the crib is:

(a) Sturdy and made of wood, metal, or plastic with secure latching devices; and

(b) Constructed with two and three-eighths inches or less space between vertical slats when the crib is used for an infant six months of age or younger. The licensee may allow an infant to use a crib not meeting the spacing requirement provided the licensee uses crib bumpers or another effective method preventing the infant's body from slipping between the slats.

(7) The licensee shall not allow the infant or child to use a stacked crib.

(8) The licensee shall ensure the infant's or child's crib mattress is:

(a) Snug fitting, preventing the infant from being caught between the mattress and crib side rails; and

(b) Waterproof and easily sanitized.

(9) Program and equipment. The licensee shall provide the infant a daily opportunity for:

(a) Large and small muscle development;

(b) Crawling and exploring;

(c) Sensory stimulation;

(d) Social interaction;

(e) Development of communication; and

(f) Learning self-help skills.

(10) The licensee shall provide the infant safe, noningestible, and suitable toys and equipment for the infant's mental and physical development.

(11) Nursing consultation. The licensee licensed for the care of four or more infants shall arrange for regular nursing

consultation to include one or more monthly on-site visits by a registered nurse trained or experienced in the care of young children.

(12) In collaboration with the licensee, the nurse shall advise the center on the:

(a) Operation of the infant care program; and

(b) Implementation of the child health program.

(13) The licensee shall obtain a written agreement with the nurse for consultation services.

(14) The licensee shall document the nurse's on-site consultations.

(15) The licensee shall ensure the nurse consultant's name and telephone number is posted or otherwise available on the premises.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-270, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-270, filed 11/20/90, effective 12/21/90.]

WAC 388-150-280 General safety, maintenance, and site. (1) The licensee shall operate the center:

(a) On an environmentally safe site;

(b) In a neighborhood free from a condition detrimental to the child's welfare; and

(c) In a location accessible to other services to carry out the program.

(2) The licensee shall maintain the indoor and outdoor premises in a safe and sanitary condition, free of hazards, and in good repair. The licensee shall ensure furniture and equipment are safe, stable, durable, child-sized, and free of sharp, loose, or pointed parts.

(3) The licensee shall:

(a) Install handrails or safety devices at child height adjacent to steps, stairways, and ramps;

(b) Maintain a flashlight or other emergency lighting device in working condition;

(c) Ensure there is no flaking or deteriorating lead-based paint on interior and exterior surfaces, equipment, and toys accessible to the preschool age and younger child;

(d) Finish or cover rough or untreated wood surfaces; and

(e) Maintain one or more telephones on the premises in working order, accessible to staff.

(4) The licensee shall supply bathrooms and other rooms subject to moisture with washable, moisture-impervious flooring.

(5) The licensee caring for the preschool age and younger child shall equip child-accessible electrical outlets with nonremovable safety devices or covers preventing electrical injury.

(6) The licensee shall ensure staff can gain rapid access in an emergency to a bathroom or other room occupied by the child.

(7) The licensee shall shield light bulbs and tubes in child-accessible areas.

(8) The licensee shall keep the premises free from rodents, fleas, cockroaches, and other insects and pests.

(9) The licensee shall use a housekeeping sink or another appropriate method for drawing clean mop water and disposing waste water.

(10) The licensee shall ensure the mop storage area is ventilated.

(11) The licensee shall ensure no firearm or another weapon is on the premises.

(12) The licensee shall comply with fire safety regulations adopted by the state fire marshal's office.

(13) The licensee shall ensure that rooms or closets to be made inaccessible to children shall be equipped with a lock or approved safety latch.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-280, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-280, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-280, filed 11/20/90, effective 12/21/90.]

WAC 388-150-290 Water safety. (1) The licensee shall maintain the following water safety precautions when the child uses an on-premises swimming pool, wading pool, or natural body of water, or enters the water on a field trip by ensuring:

(a) The on-premises pool or natural body of water is inaccessible to the child when not in use;

(b) During the child's use of a wading pool, an adult with current CPR training supervises the child at all times; and

(c) During the child's use of a swimming pool or open body of water, a certified lifeguard is present at all times, in addition to required staff.

(2) The licensee shall daily empty and clean portable wading pools when in use.

(3) The licensee shall not permit the child to use or access a hot tub, spa, whirlpool, tank, or similar equipment.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-290, filed 11/20/90, effective 12/21/90.]

WAC 388-150-295 Water supply, sewage, and liquid wastes. (1) The licensee shall obtain approval of a private water supply by the local health authority or department.

(2) The licensee shall ensure sewage and liquid wastes are discharged into:

(a) A public sewer system; or

(b) An independent sewage system approved by the local health authority or department.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-295, filed 8/18/93, effective 9/18/93.]

WAC 388-150-310 First-aid supplies. The licensee shall maintain on the premises adequate first-aid supplies, conforming with the center's first-aid policies and procedures. The licensee's first-aid supplies shall include unexpired syrup of ipecac which may be administered only on the advice of a physician or poison control center.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-310, filed 11/20/90, effective 12/21/90.]

WAC 388-150-320 Outdoor play area. (1) The licensee shall provide a safe and securely-fenced or department-approved, enclosed outdoor play area:

(a) Adjoining directly the indoor premises; or

(b) Reachable by a safe route and method; and

(c) Promoting the child's active play, physical development, and coordination; and

(d) Protecting the play area from unsupervised exit or entry by the child; and

(e) Preventing child access to roadways and other dangers.

(2) The licensee shall ensure the play area contains a minimum of seventy-five usable square feet per child. If the center uses a rotational schedule of outdoor play periods so only a portion of the child population uses the play area at one time, the licensee may reduce correspondingly the child's play area size. The licensee shall ensure appropriate child grouping by developmental or age levels, staff-to-child ratio adherence, and group size maintenance.

(3) At its discretion, the department may approve the licensee providing drop-in care only or operating in a densely developed area to use equivalent, separate, indoor space for the child's large muscle play.

(4) The licensee providing full-time care shall ensure the center's activity schedule affords the child sufficient daily time to participate actively in outdoor play.

(5) The licensee shall provide a variety of age appropriate play equipment for climbing, pulling, pushing, riding, and balancing activities. The licensee shall arrange, design, construct, and maintain equipment and ground cover to prevent child injury. The licensee's quantity of outdoor play equipment shall offer the child a range of outdoor play options.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-320, filed 11/20/90, effective 12/21/90.]

WAC 388-150-330 Indoor play area. (1) The center's indoor premises shall contain adequate area for child play and sufficient space to house a developmentally appropriate program for the number and age range of children served. The licensee shall provide a minimum of thirty-five square feet of usable floor space per child, exclusive of a bathroom, hallway, and closet. If the staff removes mats and cots when not in use, the licensee may use and consider the napping area as child care space.

(2)(a) The licensee may consider the kitchen usable space if:

(i) Appliances and utensils do not create a safety hazard;

(ii) Toxic or harmful substances are not accessible to the child;

(iii) Food preparation and storage sanitation is maintained; and

(iv) The space is located safely and appropriately for use as a child care activity area.

(b) The department may allow the licensee the use of a kitchen for occasional activities, but not include the kitchen in calculating the center's capacity.

(c) The department may allow the licensee to count the kitchen in calculating the center's capacity if the kitchen is:

(i) Adjacent to the care area;

(ii) Available for more than an occasional activity; and

(iii) Large enough for group activities.

(3) The licensee shall provide a minimum of fifty square feet of usable floor space per child for the play and napping of the infant and other child requiring a crib.

(4) The licensee may use a room for multiple purposes such as playing, dining, napping, and learning activities, provided the:

(a) Room is of sufficient size; and

(b) Room's usage for one purpose does not interfere with usage of the room for another purpose.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-330, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-330, filed 11/20/90, effective 12/21/90.]

WAC 388-150-340 Toilets, handwashing sinks, and bathing facilities. (1) The licensee shall provide a minimum of one indoor flush-type toilet and one adjacent handwash sink for every fifteen children normally on site, except:

(a) The child eighteen months of age or younger and other children using toilet training equipment need not be included when determining the number of required flush-type toilets;

(b) If urinals are provided, the number of urinals shall not replace more than one-third of the total required toilets; and

(c) For the center serving the school age child only, the number of sinks and toilets for the child shall equal or exceed the number required by the local school district.

(2) The licensee shall supply the child warm running water for handwashing at a temperature range not less than eighty-five degrees Fahrenheit and not more than one hundred and twenty degrees Fahrenheit.

(3) The licensee shall locate the child's handwashing facilities in or adjacent to rooms used for toileting.

(4) The licensee shall provide toileting privacy for the child of opposite sex six years of age and older and for other children demonstrating a need for privacy.

(5) The licensee shall provide toilets, urinals, and handwashing sinks of appropriate height and size for the child in care or furnish safe, easily cleanable platforms impervious to moisture.

(6) The licensee shall provide a mounted toilet paper dispenser for each toilet.

(7) The licensee shall ensure rooms used for toileting are ventilated to the outdoors.

(8) When the center serves the child not toilet trained, the licensee shall provide developmentally appropriate equipment for the toileting and toilet training of the young child. The licensee shall sanitize the equipment after each child's use.

(9) The licensee shall provide the child with soap and individual towels or other appropriate devices for washing and drying the child's hands and face.

(10) If the center is equipped with a bathing facility, the licensee shall:

(a) Make the bathing facility inaccessible to the child; or

(b) Ensure the preschool age and younger child is supervised while using the bathing facility; and

(c) Equip the bathing facility with a conveniently located grab bar or other safety device such as a nonskid pad.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-340, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-340, filed 11/20/90, effective 12/21/90.]

WAC 388-150-350 Laundry. (1) The licensee shall maintain access to laundry washing and drying facilities, which may include using on-premises or off-site equipment.

(2) The licensee shall use an effective method through temperature or chemical measures for adequately sanitizing the child's laundry contaminated with urine, feces, lice, scabies, or other infectious material.

(3) When washing or drying occurs on-site, the licensee shall locate equipment in an area separate from the kitchen and inaccessible to the child.

(4) The licensee shall store the child's soiled laundry separately from clean laundry.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-350, filed 11/20/90, effective 12/21/90.]

WAC 388-150-360 Nap and sleep equipment. (1) The licensee shall provide a clean, separate, firm mat, cot, bed, mattress, play pen, or crib for each child five years of age and under remaining in care for six or more hours and for another child requiring a nap or rest period.

(2) The licensee shall ensure the child's mat is of sufficient length, width, and thickness to provide adequate comfort for the child to nap. The licensee may use a washable sleeping bag meeting the mat requirements for the toilet-trained child.

(3) The licensee shall ensure the child's cot is of sufficient length and width and constructed to provide adequate comfort for the child to nap. The licensee shall ensure the cot surface is of a material which can be cleaned with a detergent solution, disinfected, and allowed to air dry.

(4) The licensee shall clean the child's nap equipment as needed and between use by another child.

(5) The licensee shall separate the child's nap equipment when in use to facilitate sanitation, child comfort, and staff access.

(6) The licensee shall ensure the child's bedding:

(a) Consists of a clean sheet or blanket to cover the sleeping surface and a clean, suitable cover for the child;

(b) Is laundered weekly or more often and between use by different children; and

(c) Is stored separately from bedding used by another child.

(7) The licensee shall not use the upper bunk of a double deck bed for a preschool age or younger child.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-360, filed 11/20/90, effective 12/21/90.]

WAC 388-150-370 Storage. (1) The licensee shall provide accessible individual space for the child to store clothes and personal possessions.

(2) The licensee shall provide space separate from child care area to store play and teaching equipment and supplies, records and files, cots, mats, and bedding.

(3) The licensee shall store and make inaccessible to the child cleaning supplies, toxic substances, paint, poisons, aerosol containers, and items bearing warning labels.

(4) The licensee shall label a container filled from a stock supply to identify contents.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-370, filed 11/20/90, effective 12/21/90.]

WAC 388-150-380 Program atmosphere. (1) The licensee shall provide a cheerful learning environment for the child by:

(a) Covering walls and ceilings with light or bright colors; and

(b) Placing visually stimulating decorations, pictures, or other attractive materials at appropriate heights for the child.

(2) The licensee shall maintain a safe and developmentally appropriate noise level, without inhibiting normal ranges of expression by the child, so staff and child can be clearly heard and understood in normal conversation.

(3) The licensee shall locate light fixtures and provide lighting intensities promoting good visibility and comfort for the child care.

(4) The licensee shall maintain the temperature within the center at:

(a) Sixty-eight degrees Fahrenheit or more during the child's waking hours; and

(b) Sixty degrees Fahrenheit or more during the child's napping or sleeping hours.

(5) The licensee shall regulate the temperature and ventilate the center for the health and comfort of the child in care.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-380, filed 11/20/90, effective 12/21/90.]

WAC 388-150-390 Discrimination prohibited. (1) Child day care centers are defined by state and federal law as places of public accommodation and shall not discriminate in employment practices and client services on the basis of race, creed, color, national origin, sex, age, or disability.

(2) Day care centers shall:

(a) Post a nondiscrimination poster;

(b) Have a nondiscrimination plan;

(c) Have a nondiscrimination policy; and

(d) Comply with the requirements of the Americans with Disabilities Act in respect to accessibility.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-390, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-390, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-390, filed 11/20/90, effective 12/21/90.]

WAC 388-150-400 Religious activities. (1) Consistent with state and federal laws, the licensee shall respect and facilitate the rights of the child in care to observe the tenets of the child's faith.

(2) The licensee shall not punish or discourage the child for exercising these rights.

(3) If the center conducts a religious activity program, the licensee shall maintain a written description of the center's religious policies and practices affecting the child in care.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-400, filed 11/20/90, effective 12/21/90.]

WAC 388-150-410 Special requirements regarding American Indian children. When five percent or more of the center's child enrollment consists of Indian children, the licensee shall develop social service resources and staff training programs designed to meet the special needs of such chil-

dren through coordination with tribal, Indian health service, and Bureau of Indian Affairs social service staff, and appropriate urban Indian and Alaskan native consultants.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-410, filed 11/20/90, effective 12/21/90.]

WAC 388-150-420 Child abuse, neglect, and exploitation. The licensee and staff shall protect the child in care from child abuse, neglect, or exploitation, as required under chapter 26.44 RCW.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-420, filed 11/20/90, effective 12/21/90.]

WAC 388-150-430 Prohibited substances. (1) During operating hours or when the child is in care, the licensee, staff, and volunteers on center premises or caring for the child off-site shall not be under the influence of, consume, or possess an:

(a) Alcoholic beverage; or

(b) Illegal drug.

(2) The licensee shall prohibit smoking in the center when the child is present and in a motor vehicle when the licensee transports the child. The licensee may permit on premises smoking out doors, away from the building, where the child is not present.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-430, filed 11/20/90, effective 12/21/90.]

WAC 388-150-440 Limitations to persons on premises. (1) During center operating hours or while the child is in care, only the licensee, employee, or volunteer, or an authorized representative of a governmental agency, or parent shall have unsupervised or regular access to the child in care.

(2) The licensee shall allow the parent of the child in care unsupervised access only to the parent's child.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-440, filed 11/20/90, effective 12/21/90.]

WAC 388-150-450 Child records and information. The licensee shall maintain on the premises organized confidential records and information concerning the child in care. The licensee shall ensure the child's record contains, at a minimum:

(1) Registration data:

(a) Name, birthdate, dates of enrollment and termination, and other identifying information;

(b) Name, address, and home and business telephone number of the parent and other person to be contacted in case of emergency; and

(c) Completed enrollment application signed by the parent, guardian, or responsible relative.

(2) Authorizations:

(a) Name, address, and telephone number of the person authorized to remove from the center the child under care;

(b) Written parental consent for transportation provided by the center, including field trips and swimming, when the child participates in these activities. A parent-signed blanket consent form may authorize the child's off-site travel; and

(c) Written parental consent, or court order, for providing medical care and emergency surgery, except for such care authorized by law.

(3) Medical and health data:

(a) Date and kind of illness and injury occurring on the premises, including the treatment given by staff;

(b) Medication given indicating dosage, date, time, and name of dispensing staff person; and

(c) A health history, obtained when the licensee or staff enrolls the child for care. The history includes:

(i) The date of the child's last physical examination;

(ii) Allergies;

(iii) Special health or developmental problems and other pertinent health information;

(iv) Immunization history as required under WAC 388-150-220; and

(v) Name, address, and telephone number of the child's health care provider or facility.

[Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-450, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-450, filed 11/20/90, effective 12/21/90.]

WAC 388-150-460 Program records. The licensee shall maintain the following documentation on the premises:

(1) The daily attendance record:

(a) The parent, or other person authorized by the parent to take the child to or from the center, shall sign in the child on arrival and shall sign out the child at departure, using a full, legal signature; and

(b) When the child leaves the center to attend school or participate in off-site activities as authorized by the parent, the staff person shall sign out the child, and sign in the child on return to the center.

(2) A copy of the report sent to the licensor about the illness or injury to the child in care requiring medical treatment or hospitalization;

(3) Copies of meal and snack menus for a minimum of six months;

(4) The twelve-month record indicating the date and time the licensee conducted the required monthly fire evacuation drills;

(5) A written plan for staff development specifying the content, frequency, and manner of planned training;

(6) Activity program plan records;

(7) Nursing consultation records, if applicable, including:

(a) A copy of the written agreement with the nurse; and

(b) A summary of the nurse's on-site consultation activities.

(8) A record of:

(a) Accidents;

(b) Injuries; and

(c) Incidents requiring restraint.

(9) Attendance records and invoices for state-paid children for at least five years.

[Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-150-460, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-460, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-460, filed 11/20/90, effective 12/21/90.]

WAC 388-150-470 Personnel policies and records. (1) Each employee and volunteer having unsupervised or regular access to the child in care shall complete and submit to the licensee or director by the date of hire:

(a) An application for employment on a department-prescribed form, or its equivalent; and

(b) A criminal history and background inquiry form.

(i) The licensee shall submit this form to the department for the employee and volunteer, within seven calendar days of the employee's first day of employment, permitting a criminal and background history check.

(ii) The department shall discuss the inquiry information with the licensee or director, when applicable.

(2) Each employee serving as a director, program supervisor, or lead child care staff person shall complete and submit to the licensee or director by the date of hire a Washington state training and registry system (STARS) profile form. The licensee shall submit this form to the Washington state training and registry system within seven calendar days of the employee's first day of employment, to permit the department to track the employee's compliance with training requirements.

(3) The licensee employing five or more persons shall have written personnel policies describing staff benefits, if any, duties, and qualifications.

(4) The licensee shall maintain a personnel recordkeeping system, having on file, on the premises, for the licensee, staff person, and volunteer:

(a) An employment application, including work and education history;

(b) Documentation of criminal history and background inquiry form submission;

(c) A record of tuberculin skin test results, x-ray, or an exemption to the skin test or x-ray;

(d) Documentation of HIV/AIDS education and training;

(e) A record of participation in staff development training;

(f) Documentation of orientation program completion;

(g) Documentation of a valid food handler permit, when applicable;

(h) Documentation of current first aid and CPR training, when applicable; and

(i) Documentation of basic and annual training required under WAC 388-150-180 (2)(i) or (7)(b) and 388-150-200(7), when applicable.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-150-470, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-470, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-470, filed 11/20/90, effective 12/21/90.]

WAC 388-150-480 Reporting of death, injury, illness, epidemic, or child abuse. The licensee or staff shall report immediately:

(1) A death, serious injury requiring medical treatment, or illness requiring hospitalization of a child in care, by telephone and in writing, to the parent, licensor, and child's social worker, if any;

(2) An instance when the licensee or staff has reason to suspect the occurrence of physical, sexual, or emotional child abuse, child neglect, or child exploitation as required under chapter 26.44 RCW, by telephone, to child protective services or local law enforcement; or

(3) An occurrence of food poisoning or communicable disease, as required by the state board of health, by telephone, to the local public health department.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-480, filed 11/20/90, effective 12/21/90.]

WAC 388-150-490 Reporting of circumstantial changes. A child day care center license is valid only for the address, person, and organization named on the license. The licensee shall promptly report to the licensor any major changes in administrative staff, program, or premises affecting the center's classification, delivery of safe, developmentally appropriate services, or continued eligibility for licensure. A major change includes the:

(1) Center's address, location, space, or phone number;

(2) Maximum number and age ranges of children the licensee wishes to serve as compared to current license specifications;

(3) Number and qualifications of the center's staffing pattern that may affect staff competencies to implement the specified program, including:

(a) Change of ownership, chief executive, director, or program supervisor; and

(b) The death, retirement, or incapacity of the licensee.

(4) Name of the licensed corporation, or name by which the center is commonly known, or changes in the center's articles of incorporation and bylaws;

(5) Occurrence of a fire, major structural change, or damage to the premises; and

(6) Plans for major remodeling of the center, including planned use of space not previously department approved.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-490, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-490, filed 11/20/90, effective 12/21/90.]

WAC 388-150-500 Posting requirements. (1) The licensee shall post the following items, clearly visible to the parent and staff:

(a) The center's child care license issued under this chapter;

(b) A schedule of regular duty hours with the names of staff;

(c) A typical activity schedule, including operating hours and scheduled mealtimes;

(d) Meal and snack menus;

(e) Evacuation plans and procedures, including a diagram of exiting routes;

(f) Emergency telephone numbers near the telephone; and

(g) Nondiscrimination poster.

(2) For the staff, the licensee shall post:

(a) Dietary restrictions and nutrition requirements for particular children;

(b) Handwashing practices; and

(c) Diaper changing procedures, if applicable.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-500, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-500, filed 11/20/90, effective 12/21/90.]

WAC 388-150-990 Purpose and authority. Chapter 440-44 WAC establishes fees for all license activities of the department of social and health services. Chapter 440-44 WAC is adopted under authority of RCW 43.20A.___ [43.20A.055] (section 2, chapter 201, Laws of 1982).

Pursuant to this authority, the secretary is required to establish fees for obtaining a license. The term "license" is defined as the "exercise of regulatory authority by the secretary to grant permission, authority, or liberty to do or to forebear certain activities."

Pursuant to this authority, fees may be waived when, in the discretion of the secretary, the fees would not be in the best interest of public health and safety, or when the fees would be to the financial disadvantage of the state. No fees may be charged to municipal corporations for licensing of emergency medical care and transportation services under chapter 18.73 RCW.

[00-23-088, recodified as § 388-150-990, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-001, filed 6/4/82.]

WAC 388-150-991 Waiver of fees. Any person or agency subject to license fees under chapter 440-44 WAC, and organizations in the person's or agency's behalf, may submit a sworn, notarized petition seeking waiver of fees for a licensee or distinguishable class of licensee.

The petition shall be mailed or delivered to the office of the secretary. Following receipt of the petition, the secretary may require submission of additional information considered relevant.

[00-23-088, recodified as § 388-150-991, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-002, filed 6/4/82.]

WAC 388-150-992 Fee payment and refunds. (1) Fees are due with applications for initial license or renewal. The department will not proceed on applications until required fees are paid.

Except as otherwise provided in these rules, fees shall be paid for a minimum of one year.

(2) Fees for licenses issued for other than yearly periods shall be prorated based on the stated annual fee.

(3) When the department issues a license for more than one year:

(a) Fees may be paid for the entire licensing period by paying at the rate established at the time the application was submitted, or

(b) If the licensee does not pay the fee for the entire license period, annual fees shall be due thirty days prior to each annual anniversary date of the license, at the annual fee rate established by these rules at the time such fee is paid.

(4) Except as otherwise provided in these rules, if an application is withdrawn prior to issuance or denial, one-half of the fee shall be refunded.

(5) If there is a change of or by the licensee requiring a new license, the fee paid for a period beyond the next license anniversary date shall be refunded. Changes requiring a new license shall require a new application and payment of fee as provided herein.

(6) If there is a change by the applicant or licensee that requires an amendment placing the licensee in a higher fee category, the additional fee shall be prorated for the remainder of the license period.

(7) Fees becoming due on or after the effective date of this chapter shall be at the rates provided herein.

(8) To the extent fees are reduced through regular rule adoption of this chapter on or before December 31, 1982, fees shall be refunded.

(9) Fee payments shall be by mail. Payment shall be by check, draft, or money order made payable to the department of social and health services.

[00-23-088, recodified as § 388-150-992, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-010, filed 6/4/82.]

WAC 388-150-993 Denial, revocation, suspension, and reinstatement. (1) If a license is denied, revoked, or suspended, fees shall not be refunded.

(2) Application for license after denial or revocation must include fees as provided for in these rules.

(3) Failure to pay fees when due will result in suspension or denial of license.

[00-23-088, recodified as § 388-150-993, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-015, filed 6/4/82.]

Chapter 388-151 WAC

SCHOOL-AGE CHILD CARE CENTER MINIMUM LICENSING REQUIREMENTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-151-050 Waivers. [Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-050, filed 12/30/92, effective 1/30/93.] Repealed by 01-02-031, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.020.

WAC 388-151-010 What definitions are important for the school-age child care center program? The following definitions are important under this chapter:

"Capacity" means the maximum number of children the licensee is authorized to have on the premises at a given time.

"Child abuse or neglect" means the injury, sexual abuse, sexual exploitation, or negligent treatment or maltreatment of a child as defined in RCW 26.44.020 and chapter 388-15 WAC.

"Department" means the state department of social and health services (DSHS), the state agency with the legal authority to regulate and certify school-age child care centers.

"Department of health" means the state department of health.

"I," "you," and **"your"** refer to and mean the licensee or applicant for child care license.

"License" means a permit issued by the department to a person or organization to operate a school-age child care center and affirming the licensee meets requirements under licensure.

"Licensee" means the person, organization, or legal entity named on the facility license and responsible for operating the center.

"Licensor" means the person employed by the department to regulate and license a school-age child care center.

"Premises" means the building where the center is located and the adjoining grounds over which the licensee has control.

"School-age child" means a child five years of age through twelve years of age enrolled in a public or private school.

"School-age child care center" means a program operating in a facility other than a private residence, accountable for school-age children when school is not in session. The program must meet department licensing requirements, provide adult-supervised care, and a variety of developmentally appropriate activities.

"Staff" means a person or persons employed by the licensee to provide child care and to supervise children served at the center.

"The Washington state training and registry system (STARS)" means the entity approved by the department to determine the classes, courses, and workshops licensees and staff may take to satisfy the department's training requirements.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-010, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 98-24-052, § 388-151-010, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-010, filed 12/30/92, effective 1/30/93.]

WAC 388-151-020 Who needs to be licensed? (1) The person or organization operating a school-age child care center must receive a license from the department to provide school-age child care, in accordance with chapter 74.15 RCW.

(2) The department does not need to license the person or organization operating a school-age child care center [if chapter 74.15 RCW exempts the person or organization from the licensing requirements]. The person or organization claiming an exemption from the licensing requirements must provide the department proof of entitlement to the exemption at the licensor's request.

(3) You may use the following matrix to determine whether or not you are exempt from licensing:

Child care	Recreational
The child care facility assumes responsibility for the child and his welfare.	Children are free to come and go as they choose.
Children are signed in and can only be released to an authorized adult.	No responsibility is assumed in lieu of parent.

A specific registration procedure and required forms must be completed.	No registration form or procedure.
Must adhere to DSHS standards; has specific requirements regarding staff-child ratio and group size.	No required staff-child ratio or group size requirements.
Specific DSHS requirements regarding policies and procedures are in a parent handbook.	No specific detailed policies and procedures. General "house rules" apply at each site.
There are specific program goals and activities; calendars of activities are posted and available.	Activities occur on a daily basis; no long-term goals or activities exist.

(4) The person or organization that serves state-paid children must:

(a) Be licensed or certified;

(b) Follow billing policies and procedures in Child Care Subsidies, a brochure for providers, DSHS 22-877(X), and;

(c) Bill the department at the person's or organization's customary rate or the DSHS rate, whichever is less.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-020, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-020, filed 12/30/92, effective 1/30/93.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-151-040 What local ordinances and codes apply? The licensee or applicant for license must comply with city ordinances and county codes, including zoning and building regulations.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-040, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-040, filed 12/30/92, effective 1/30/93.]

WAC 388-151-045 What is the basis for the department's issuance or denial of a license? The department must issue or deny a license on the basis of the applicant's compliance with school-age child care licensing requirements.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-045, filed 12/22/00, effective 1/22/01.]

WAC 388-151-070 How do I apply or reapply for a license? (1) You must comply with the department's application procedures and submit to the department:

(a) A completed department-supplied application for school-age child care center license, including attachments, ninety or more days before the:

(i) Expiration of your current license;

(ii) Opening date of your center;

(iii) Relocation of your center; or

(iv) Change of the licensee.

(b) A completed criminal history and background inquiry form for each staff person or volunteer having unsupervised or regular access to the child in care; and

(c) The annual licensing fee. The fee is forty-eight dollars per year for the first twelve children plus four dollars for each additional child over the licensed capacity of twelve children.

(2) In addition to the required application materials specified under subsection (1) of this section, you must submit to the department:

(a) An employment and education resume of the person responsible for the active management of the center and of the site coordinator;

(b) Copies of diplomas or education transcripts of the director and site coordinator; and

(c) Three professional references each for you, the director, and the site coordinator.

(3) You, as the applicant for a license under this chapter must be twenty-one years of age or older.

(4) The department may, at any time, require additional information from you, any staff person, any volunteer, members of the household of any of these individuals, and other persons having access to the children in care. The additional information includes, but is not limited to:

(a) Sexual deviancy evaluations;

(b) Substance and alcohol abuse evaluations;

(c) Psychiatric evaluations;

(d) Psychological evaluations; and

(e) Medical evaluations.

(5) The department may perform investigations of you, staff persons, volunteers, members of the households of these individuals, and other persons having access to the child in care as the department deems necessary, including accessing criminal histories and law enforcement files.

(6) You must conform to rules and regulations approved or adopted by the:

(a) State department of health and relating to the health care of children at school-age child care centers;

(b) State fire marshal's office, establishing standards for fire prevention and protection of life and property from fire, under chapter 212-56A WAC.

(7) The department must not issue a license to you until the department of health and the state fire marshal's office have certified or inspected and approved the center.

(8) The department may exempt a school site possessing a fire safety certification signed by the local fire official within six months prior to licensure from the requirement to receive an additional fire safety inspection by the state fire marshal's office.

(9) You must submit a completed plan of deficiency correction, when required, to the department of health and the department licensor before the department will issue you a license.

(10) You, your director and site coordinator must attend department-provided orientation training.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-070, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-070, filed 12/30/92, effective 1/30/93.]

WAC 388-151-075 How do I get a waiver of the licensing requirements contained in this chapter? (1) In an individual case, the department, for good cause, may waive a

specific requirement and approve an alternate method for you to achieve the specific requirement's intent if:

(a) You submit to the department a written waiver request fully explaining the circumstances necessitating the waiver; and

(b) The department decides the department's approval of the waiver approval will not jeopardize the safety or welfare of the child in care or detract from the quality of licensee-delivered services.

(2) The department may approve a waiver request only for a specific purpose or child and for a specific period of time not exceeding the expiration date of your license.

(3) The department may limit or restrict a license the department issues to you in conjunction with a waiver.

(4) You must maintain a copy of the department's written waiver approval on the premises.

(5) You may not appeal the department's denial of your request for waiver under chapter 34.05 RCW.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-075, filed 12/22/00, effective 1/22/01.]

WAC 388-151-080 How does the department determine my licensed capacity? (1) The department issues the applicant or licensee a license for a specific number of children depending on:

(a) The department's evaluation of your center's premises, equipment, and physical accommodations;

(b) The number and skills of you, your, staff, and your volunteers; and

(c) The ages and characteristics of the children you serve.

(2) The department:

(a) Must not issue you a license to care for more children than this chapter permits; and

(b) May issue you a license to care for fewer children than your center's maximum capacity.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-080, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-080, filed 12/30/92, effective 1/30/93.]

WAC 388-151-085 How do I get an initial license? (1) The department may issue an initial license to you if you are not currently licensed to provide child care when you:

(a) Can demonstrate compliance with the rules contained in this chapter pertaining to the health and safety of the child in care; but

(b) Cannot demonstrate compliance with the rules pertaining to:

(i) Staff-child interactions,

(ii) Group size and staff-child ratios,

(iii) Behavior management and discipline,

(iv) Activity programs,

(v) Child records and information, and

(vi) Other rules requiring department observation of the applicant's ability to comply with rules.

(c) Can provide a plan, acceptable to the department, to comply with rules found in subsection (1)(b) of this section.

(2) The department may issue an initial license to you for a period not to exceed six months, renewable for a period not to exceed two years.

(3) The department must evaluate your ability to comply with all rules contained in this chapter during the period of initial licensure prior to issuing a full license.

(4) The department may issue a full license to you if you demonstrate your compliance with all rules contained in this chapter at any time during the period of initial licensure.

(5) The department must not issue a full license to you if you do not demonstrate the ability to comply with all rules contained in this chapter during the period of initial licensure.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-085, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-085, filed 10/1/96, effective 11/1/96.]

WAC 388-151-090 How may the department deny, suspend, or revoke my license? (1) Before granting a license and as a condition for continuance of a license, the department must consider your ability to meet the requirements of this chapter. If more than one person is the applicant or licensee, the department:

(a) Must consider the applicants' or the licensees' qualifications separately and jointly; and

(b) May deny, suspend, revoke, or not renew the license based on the failure of one of the persons to meet the requirements of chapter 74.15 RCW and this chapter.

(2) The department must deny, suspend, revoke, or not renew the license of a person who:

(a) Has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and chapter 388-15 WAC;

(b) Is ineligible to provide care because the person has a criminal history as described in chapter 388-330 WAC;

(c) Allows a person meeting the conditions of (a) or (b) of this subsection on the premises;

(d) Commits or was convicted of a felony reasonably related to the competency of the person to meet the requirements of this chapter;

(e) Engages in illegal use of a drug or excessive use of alcohol;

(f) Commits, permits, aids, or abets the commission of an illegal act on the premises;

(g) Commits, permits, aids, or abets the abuse, neglect, exploitation, or cruel or indifferent care of a child in care;

(h) Refuses to permit an authorized representative of the department, state fire marshal's office, or department of health to inspect the premises; or

(i) Refuses to permit an authorized representative of the department or the department of health access to records related to operation of the center or to interview staff or a child in care.

(3) The department may deny, suspend, revoke, or not renew a license of a person who:

(a) Seeks to obtain or retain a license by fraudulent means or misrepresentation including, but not limited to:

(i) Making a materially false statement on the application; or

(ii) Omitting material information on the application.

(b) Provides insufficient staff in relation to the number, ages, or characteristics of children in care;

(c) Allows a person unqualified by training, experience, or temperament to care for or be in contact with a child in care;

(d) Violates any condition or limitation on licensure including, but not limited to:

(i) Permitting more children on the premises than the number for which the department licensed the center; or

(ii) Permitting a child of a different age from the ages for which the department licensed the center to be on the premises.

(e) Fails to provide adequate supervision to a child in care;

(f) Demonstrates an inability to exercise fiscal responsibility and accountability with respect to operation of the center;

(g) Misappropriates property of a child in care;

(h) Knowingly permits an employee or volunteer who has made a material misrepresentation on an application for employment or volunteer service to be on the premises;

(i) Refuses or fails to supply necessary, additional department requested information; or

(j) Fails to comply with any provision of chapter 74.15 RCW or this chapter.

(4) The department must not issue a license to a person who has been denied a license, or has had a license to operate a facility for the care of children or adults suspended, revoked, or not renewed, either in this state or another state. Exception: If the person demonstrates by clear, cogent, and convincing evidence that the person has undertaken sufficient corrective action or rehabilitation to warrant public trust and to operate the center in accordance with the rules of this chapter, the department may issue a license to that person.

(5) RCW 43.20.205 governs the department's notice of a denial, revocation, suspension, or modification of a license and your right to a hearing.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-090, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-151-090, filed 4/26/96, effective 5/27/96. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-090, filed 12/30/92, effective 1/30/93.]

WAC 388-151-092 Under what conditions does the department impose civil penalties against me? (1) Before imposing a civil penalty, the department must provide written notification to you by personal service, by the licensor or another person, or certified mail that includes:

(a) A description of the violation and citation of the applicable requirement or law;

(b) A statement of what you must do to achieve compliance;

(c) The date by which the department requires compliance;

(d) The maximum allowable penalty if you do not achieve timely compliance;

(e) The means to contact any technical assistance services provided by the department or others; and

(f) Notice of when, where, and to whom you may file a request with the department to extend the time to achieve compliance for good cause.

(2) The length of time you have to comply depends on:

(a) The seriousness of the violation;

(b) The potential threat to the health, safety and welfare of children in care; or

(c) Previous opportunities to correct the deficiency.

(3) The department may impose a civil penalty based on but not limited to these reasons:

(a) The department previously has imposed an enforcement action for the same or similar type of violation of the same statute or rule on your child care center; or

(b) The department has previously given your child care center notice of the same or similar type of violation of the same statute or rule; or

(c) The violation represents a potential threat to the health, safety, and/or welfare of children in care.

(4) The department may impose a civil penalty in addition to or in conjunction with other disciplinary actions against a child care license including probation, suspension, or other action.

(5) You must pay the civil fine within twenty-eight days after receipt of the notice or later as specified by the department.

(6) The department may forgive the fine if the you come into compliance during the notification period.

(7) You, as the center or person against whom the department assesses a civil fine, have a right to an adjudicative proceeding under RCW 43.20A.215.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-092, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-092, filed 10/1/96, effective 11/1/96.]

WAC 388-151-093 What is the amount of the civil penalty the department may impose? Whenever the department imposes a civil monetary penalty, the department must impose a penalty of two hundred and fifty dollars per violation per day. The department may assess and collect the penalty with interest for each day of noncompliance.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-093, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-093, filed 10/1/96, effective 11/1/96.]

WAC 388-151-094 Must I post the department's notice of civil penalty? (1) You must post the final notice of a civil penalty in a conspicuous place in the facility.

(2) You must continue to post the notice until the department receives your payment.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-094, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-094, filed 10/1/96, effective 11/1/96.]

WAC 388-151-095 May the department assess civil penalties on unlicensed programs? If the department receives information that a school-age program is operating without a license, the department will investigate. The department may contact the program, send a letter, or make an on-site visit to determine that the agency is operating without a license. Where the department has determined that an agency is operating without a license, the department must send written notification to the unlicensed program by certified mail or other means showing proof of service. This notification must contain the following:

(1) Notice to the agency of the basis for the department's determination that the agency is providing child care without a license and the need for the department to license the agency;

(2) The citation of the applicable law;

(3) The assessment of seventy-five dollars per day penalty for each day the agency provides unlicensed care. The department makes the fine effective and payable within thirty days of the agency's receipt of the notification;

(4) How to contact the office of child care policy;

(5) The unlicensed agency's need to submit an application to the office of child care policy within thirty days of receipt of the department's notification;

(6) That the department may forgive the penalty if the agency submits an application within thirty days of the notification; and

(7) The unlicensed agency's right to an adjudicative proceeding as a result of the assessment of a monetary penalty and the appropriate procedure for requesting an adjudicative proceeding.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-095, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-095, filed 10/1/96, effective 11/1/96.]

WAC 388-151-096 May the department impose civil penalties for separate violations? Each violation of a law or rule constitutes a separate violation. The department may penalize each violation. The department may impose a penalty for each day the violation continues.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-096, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-096, filed 10/1/96, effective 11/1/96.]

WAC 388-151-097 What if I do not pay the civil [penalty?] The department may suspend, revoke or not renew a license for failure to pay a civil monetary penalty the department has assessed within ten days after such assessment becomes final.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-097, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-097, filed 10/1/96, effective 11/1/96.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-151-098 Under what circumstances may the department issue a probationary license? (1) The department must base the decision to issue a probationary license on the following factors:

(a) Willful or negligent noncompliance by you,

(b) History of noncompliance,

(c) Extent of deviation from the requirements,

(d) Evidence of a good faith effort to comply,

(e) Any other factors relevant to the unique situation.

(2) Where the negligent or willful violation of the licensing law does not present an immediate threat to the health and well-being of the children but would be likely to do so if allowed to continue, the department may issue a probationary license in addition to civil penalties or other sanctions. Such situations may include:

(a) Substantiation that a child (or children) was abused or neglected while in the care of the center,

(b) Disapproved fire safety or sanitation report,

(c) Use of unauthorized space for child care,

(d) Inadequate supervision of children,

(e) Understaffing for the number of children in care,

(f) Noncompliance with requirements addressing:

(i) Children's health,

(ii) Proper nutrition,

(iii) Discipline,

(iv) Emergency medical plan,

(v) Sanitation and personal hygiene practices.

(3) You must notify parents of all children in care or who may apply for care when the department issues a probationary license to you:

(a) You must notify the parents or guardians of all children in care of the program's probationary status within five working days of receiving the department's notification that the department has issued a probationary license;

(b) You must notify parents and guardians in writing, and the department must approve the notice before you send the notification;

(c) You must provide documentation to the department that you have notified parents or guardians of all children in care within ten working days after you receive notification that the department has issued a probationary license. Documentation must consist of a copy of the letter you have sent to the parents;

(d) The department may issue a probationary license for up to six months, and at the department's discretion, the department may extend the probationary license for an additional six months.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-098, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-098, filed 10/1/96, effective 11/1/96.]

WAC 388-151-100 What must I include in the center's activity program? (1) You must implement an activity program designed to meet the developmental, cultural, and individual needs of the children you serve. You must ensure the program contains a range of learning experiences for the children to:

(a) Gain self-esteem, self-awareness, conflict resolution, self-control, and decision-making abilities;

(b) Develop socially, emotionally, intellectually, and physically;

(c) Learn about nutrition, health, and personal safety; and

(d) Experiment, create, and explore.

(2) You must ensure the center's program offers variety and options including a balance between:

(a) Child-initiated and staff-initiated activities;

(b) Free choice and organized events;

(c) Individual and group activities; and

(d) Quiet and active experiences.

(3) You must ensure that the center's program provides the child daily opportunities for small and large muscle activities and outdoor play.

(4) You must operate the center's program under a regular schedule of activities with allowances for a variety of special events. You must implement a planned program of activities by using a current, written activity schedule that includes staff classroom planning time.

(5) You must manage child and staff movements from one planned activity or care area to another to achieve smooth, unregimented transitions by:

(a) Establishing familiar routines;

(b) Contributing to learning experiences; and

(c) Maintaining staff-to-child ratio and group size guidelines.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-100, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-100, filed 12/30/92, effective 1/30/93.]

WAC 388-151-110 What learning and play materials must I provide? You must provide the children in care a variety of easily accessible, developmentally appropriate equipment and materials of sufficient quantity to implement the center's program. You must ensure that materials are culturally relevant and promote:

(1) Social development;

(2) Communication ability;

(3) Self-help skills;

(4) Large and small muscle development; and

(5) Creative expression.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-110, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-110, filed 12/30/92, effective 1/30/93.]

WAC 388-151-120 How must my child care center staff interact with the children? (1) You must furnish the children a nurturing, respectful, supportive, and responsive environment through frequent interactions between the children and staff:

(a) Supporting the children in developing an understanding of self and others by assisting the children to share ideas, experiences, and feelings;

(b) Providing age-appropriate opportunities for growth and development of the children's social and communication skills, including encouraging the children to ask questions;

(c) Helping the children solve problems;

(d) Fostering creativity and independence in routine activities, including showing tolerance for mistakes; and

(e) Treating equally all children in care regardless of race, religion, culture, sex, and ability.

(2) You must furnish the children in care a pleasant and social atmosphere at meal and snack times. Your staff must provide good models for nutrition habits and social behavior.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-120, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-120, filed 12/30/92, effective 1/30/93.]

WAC 388-151-130 How must I discipline the children and manage the children's behavior? (1) You must guide the children's behavior based on an understanding of the individual child's needs and stage of development. You must support the child's developmentally appropriate social behavior, self-control, and respect for the rights of others.

(2) You must ensure that your behavior management and discipline practices are fair, reasonable, consistent, and related to the child's behavior. Your staff must not administer cruel, unusual, hazardous, frightening, or humiliating discipline.

(3) You must be responsible for implementing the behavior management and discipline practices of the center.

(4) You must prohibit and prevent any person on the premises from:

(a) Biting, jerking, shaking, spanking, slapping, hitting, striking, or kicking the child, or exercising other means of inflicting physical or emotional pain, or causing bodily harm;

(b) The use of a physical restraint method injurious to the child;

(c) The use of a mechanical restraint, locked time-out room, or closet;

(d) The use of verbal abuse; or

(e) The withholding of food as a punishment.

(5) In emergency situations, you or your staff person may use limited physical restraint not injurious to the child when:

(a) Protecting a person on the premises from physical injury;

(b) Obtaining possession of a weapon or other dangerous object; or

(c) Protecting property from serious damage.

(6) You must document any incident involving the use of physical restraint and notify the child's parent of the use of the restraint.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-130, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-130, filed 12/30/92, effective 1/30/93.]

WAC 388-151-150 What does the department require for evening and nighttime care? (1) For the center offering school-age child care during evening and nighttime hours, you must, in addition to meeting daytime regulations, adapt the program, equipment, and staffing pattern to meet the physical and emotional needs of the child away from home at night.

(2) You must maintain the same staff-to-child ratio in effect during daytime care. At all times, your staff must keep the child within continuous visual or auditory range.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-150, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-150, filed 12/30/92, effective 1/30/93.]

WAC 388-151-160 What does the department require for off-site trips? (1) You may transport or permit the supervised off-site travel of children to participate in field trips or engage in other off-site activities only with written parental consent.

(2) The parent's consent may be:

(a) For a specific date and trip; or

(b) A blanket authorization describing the full range of trips the child may take. In such a case, you must notify the parent in advance about each trip.

(3) For group field trips, you must ensure that:

(a) Emergency information and medical treatment authorization for each child in the group accompanies the child;

(b) A first aid kit is available;

(c) You maintain a written list of children participating; and

(d) You maintain required staff-child ratios.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-160, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-160, filed 12/30/92, effective 1/30/93.]

WAC 388-151-165 What does the department require for transportation? When you furnish transportation for the child in care:

(1) You must maintain the motor vehicle in a safe operating condition and ensure that the Washington state patrol has approved the vehicle, when applicable;

(2) You or the driver must carry liability and medical insurance;

(3) The driver must have a current driver's license, valid for the classification of motor vehicle the driver operates, and current first aid and CPR certification;

(4) You must ensure that a minimum of one staff person other than the driver is present in the motor vehicle, when necessary, to comply with the staff-to-child ratio requirement; and

(5) You must ensure that the number of passengers does not exceed the seat belt capacity of the motor vehicle.

(6) You do not need seat belts for buses approved by the Washington state patrol.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-165, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-165, filed 12/30/92, effective 1/30/93.]

WAC 388-151-170 What does the department require for parent communication? (1) You must orally:

(a) Explain the center's policies and procedures to the parent;

(b) Orient the parent to the center's philosophy, program, and facilities;

(c) Communicate to the parent issues relating to the child's care and individual practices concerning the child's special needs; and

(d) Encourage parent participation in center activities.

(2) You must give the parent the following written policy and procedure information:

(a) Enrollment and admission requirements;

(b) The fee and payment plan;

(c) A typical activity schedule, including hours of operation;

(d) Meals and snacks served, including guidelines on food brought from the child's home;

(e) Signing in and signing out requirements;

(f) Child abuse reporting law requirements;

(g) Behavior management and discipline;

(h) Nondiscrimination statement;

(i) Religious activities, if any;

(j) Transportation and field trip arrangements;

(k) Policy on homework, study time, and space necessary to accommodate these activities;

(l) Practices concerning an ill child;

(m) Medication management;

(n) Medical emergencies;

(o) Statement that the parent has free access during hours of operation; and

(p) Written procedure for supervision of children during transitions.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-170, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-170, filed 12/30/92, effective 1/30/93.]

WAC 388-151-180 What staff patterns and qualifications does the department require? (1) General qualifications. You, your staff, volunteers, and other persons associated with the operation of the center who have access to the child in care must:

(a) Be of good character;

(b) Demonstrate the understanding, ability, personality, emotional stability, and physical health suited to meet the cultural, emotional, mental, physical, and social needs of the children in care; and

(c) Not have committed or been convicted of child abuse or any crime involving harm to another person.

(2) Program director. You must serve as or employ a director responsible for the overall management of the center's facility and operation. The director must:

(a) Be twenty-one years of age or older;

(b) Serve as administrator of the center, ensuring compliance with licensing requirements;

(c) Have knowledge of development of school-age children as evidenced by professional references, education, experience, and on-the-job performance;

(d) Have the management and supervisory skills necessary for the proper administration of the center, including:

(i) Record maintenance;

(ii) Financial management; and

(iii) Maintenance of positive relationships with staff, children, parents, and the community.

(e) Employ, provide, or arrange for fulfillment of clerical, accounting, maintenance, transportation, and food service responsibilities so the child care staff is free to concentrate on program implementation and maintaining the required staff-to-child ratio;

(f) Have completed thirty or more college quarter credits or combination of one-third clock hours and two-thirds college credits, in early childhood education/child development, elementary education, social work, other child-related field, including, but not limited to, art, music, dance, recreation, physical education, education, home economics, psychology, social services, child development associate (CDA), or nutrition;

(g) Have two or more years of successful experience working with school-age children as evidenced by professional references and on-the-job performance;

(h) Have planning, coordination, and supervisory skills to implement a high quality, developmentally appropriate program; and

(i) Have completed one of the following prior to or within the first six months of licensure or employment except as provided in subsection (2)(i) of this section:

(i) Twenty clock hours or two college quarter credits of basic training. The Washington state training and registry system (STARS) must approve the training; or

(ii) Current CDA or equivalent credential or twelve or more college quarter credits in a child development associate sequence; or

(iii) Forty-five or more college quarter credits in early childhood education, child development, school-age care, elementary education, special education, or recreation; or

(iv) An associate of arts (AA) or associate of applied science (AAS) or higher college degree in early childhood education, child development, school-age care, elementary education, special education, or recreation.

(3) Site coordinator. You may employ a site coordinator responsible for being on site with children, program planning and program implementation. The program director must provide regular supervision of the site coordinator.

(4) The same person may serve as the site coordinator and program director when qualified for both positions. The site coordinator must:

(a) Be twenty-one years of age or older;

(b) Have completed thirty or more college quarter credits or combination of one-third clock hours and two-thirds college credits in early childhood education/child development, elementary education social work, other child-related field including, but not limited to, art, music, dance, relevant to school age children, recreation, physical education, education, music, art, psychology, social services, home economics, CDA, or nutrition;

(c) Serve as staff supervisor;

(d) Have demonstrated knowledge in:

(i) Behavior management skills specific to school-age children;

(ii) Program management skills; and

(iii) School-age child activity planning and coordinating skills.

(e) Have a minimum of two years experience working with school-age children, or possess equivalent experience.

(f) Have completed one of the following prior to or within the first six months of licensure or employment:

(i) Twenty clock hours or two college quarter credits of initial training. STARS must approve the training; or

(ii) Current CDA or twelve or more college quarter credits in child development, associate sequence;

(iii) Forty-five or more college quarter credits in early childhood education, child development, school-age care, elementary education, special education, or recreation; or

(iv) An associate of arts (AA) or associate of applied science (AAS) or higher college degree in early childhood education, child development, school-age care, elementary education, special education, or recreation.

(5) The program director or site coordinator must normally be on the premises while children are in care. If temporarily absent from the center, the director and site coordinator must leave a competent, designated staff person in charge.

(6) The director and site coordinator may also serve as child care staff when that role does not interfere with the director's or site coordinator's management and supervisory responsibilities.

(7) Center staffing. You may employ a lead school-age child care staff person to be in charge of a child or a group of children. Lead school-age child care staff must:

(a) Be eighteen years of age or older;

(b) Possess a high school education or equivalent;

(c) Have school-age child development knowledge and experience; and

(d) Have the ability to implement the activity program.

(8) You may use a child care assistant, volunteer, or trainee. The assistant, volunteer, or trainee must support staff. The school age child care assistant, volunteer, or trainee must:

(a) Be sixteen years of age or older; and

(b) Care for children only under direct supervision.

(9) You must ensure that you and your program director or site coordinator assigns no person under eighteen years of age sole responsibility for a group of children. You, your program director, or your site coordinator may assign the assistant, eighteen years of age or older, sole responsibility for a child or group of children for a brief period of time.

(10) You may count the assistant, volunteer, or trainee in the staff-to-child ratio when that person meets staff requirements.

(11) The licensee may utilize youth volunteers fourteen to fifteen years of age. The youth volunteers:

(a) Must not be counted as staff at any time.

(b) Must not count in the staff-child ratio;

(c) Must meet all requirements in WAC 388-151-470(4); and

(d) Must be under the direct supervision of a lead staff person.

(12) The lead staff person must not supervise more than one youth volunteer at one time.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-180, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 98-24-052, § 388-151-180, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-180, filed 12/30/92, effective 1/30/93.]

WAC 388-151-190 What group size and staff-child ratios must I maintain? (1) You must maintain, at minimum, a 1:15 staff-child ratio and a maximum group size of thirty or fewer children.

(2) You must conduct activities for each group in a specific classroom or other defined space within a larger area.

(3) You must ensure that a qualified staff person or team of staff supervises each group.

(4) The department may approve reasonable variations to group size limitations if you maintain required staff-to-child ratios, dependent on:

(a) Staff qualifications;

(b) Program structure; and

(c) Usable space.

(5) You must provide appropriate supervision and keep the child from harm. The children must be in continuous visual or auditory range, except during transitions, including:

(a) Moving from indoors to outdoors;

(b) Moving from room to room; and

(c) When the child uses the restroom.

(6) You must have a written plan to ensure the children's safety during transitions.

(7) When only one staff person is present, you must ensure that a second staff person is readily available in case of an emergency.

(8) You must ensure that each group of children is supervised by a staff person who has completed one of the following prior to or within the first six months of employment:

(a) Twenty clock hours or two college quarter credits of initial training. Training must be approved by the Washington state training and registry system (STARS); or

(b) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education, child development, school-age care, elementary education, special education, or recreation; or

(c) An associate of arts (AA) or associate of applied science (AAS) or higher college degree in early childhood education, child development, school-age care, elementary education, special education, or recreation.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-190, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 98-24-052, § 388-151-190, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-190, filed 12/30/92, effective 1/30/93.]

WAC 388-151-200 What requirements must I meet for center staff development and training? (1) You must have an orientation system making employees, volunteers, and trainees aware of program policies and practices. You must provide staff an orientation including, but not limited to:

(a) Licensing rules required under this chapter;

(b) Goals and philosophy of the center;

(c) Planned daily activities and routines;

(d) Age-appropriate child guidance and behavior management methods;

(e) Child abuse and neglect prevention, detection, and reporting policies and procedures;

(f) Special health and developmental needs of the individual child;

(g) Fire prevention and safety procedures; and

(h) Personnel policies.

(2) You must provide or arrange regular training opportunities for the child care staff to:

(a) Promote ongoing employee education;

(b) Enhance practice skills;

(c) Increase cultural awareness; and

(d) Accommodate special health and developmental needs of the individual child.

(3) You must conduct periodic staff meetings for planning and coordination purposes.

(4) You must ensure that:

(a) A staff person with basic, standard, current first aid and cardiopulmonary resuscitation (CPR) training, or department of health approved training is present at all times while the child is in care; and

(b) Staff's CPR training includes methods appropriate for school-age children in care.

(5) You must provide or arrange appropriate education and training for child care staff on the prevention and transmission of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

(6) You must ensure that the person preparing full meals for the center has a valid food handler permit.

(7) You must ensure that the director, site coordinator and, where the program serves more than one group of children, at least one staff person for every group of children, complete:

(a) Ten clock hours or one college quarter credit of training annually, approved by Washington state registry and training system (STARS), beginning one year after licensure or employment in your licensed child care facility; and

(b) For the director and the site coordinator, five of the ten hours of training must be in program management and administration.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-200, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 98-24-052, § 388-151-200, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-200, filed 12/30/92, effective 1/30/93.]

WAC 388-151-210 What must my required health care plan contain? (1) You must maintain current written health policies and procedures for staff orientation and use by staff, and for the parent.

(2) Your health care plan must include, but is not limited to, information about your center's procedures concerning:

(a) Communicable disease prevention, reporting, and management;

(b) Action taken for medical emergencies;

(c) First aid;

(d) Care of minor illnesses;

(e) Medication management;

(f) General hygiene practices;

(g) Hand washing practices; and

(h) Food and food services.

(3) You must use the services of an advisory physician, physician's assistant, or registered nurse to assist in the development and approval of the center's health care plan.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-210, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-210, filed 12/30/92, effective 1/30/93.]

WAC 388-151-220 What steps must I take to address health supervision and infectious disease prevention? (1) Before or on the child's first day of attendance, you must have on file a record of immunization status.

(2) Your staff must observe the child daily for signs of illness. You must care for or discharge to the child's home the ill child based on your policies concerning ill children.

(3) If a child becomes ill while in care:

(a) You must furnish a separate care area with an appropriate rest surface and bedding, as needed; and

(b) Your staff must sanitize equipment the child uses if staff suspects the child has a communicable disease.

(4) You may use the separate care room or area for other purposes when not needed for separation of the child.

(5) Your staff must ensure that the child washes hands:

(a) Before the child eats;

(b) Before the child participates in food activities; and

(c) After the child's toileting.

(6) Your staff must follow your center's policies for cleaning and disinfecting the environment.

(7) You must have extra clothing available for circumstances arising during outdoor play.

(8) Your staff must ensure that the children do not share personal hygiene or grooming items.

(9) You must have on file, upon employment, for each center employee, volunteer, and other person having regular contact with the children in care results of a negative tuberculin (TB) skin test, by the Mantoux method, or results of a chest x-ray. You need not require the TB test or chest x-ray for an individual if, such a test is against medical advice. The department does not require periodic retesting.

(10) You must not permit a person with a reportable communicable disease to be on duty in the center or have contact with the child in care unless a health care provider approves the contact in writing.

(11) Staff must wash hands:

(a) After personal toileting;

(b) After attending to an ill child;

(c) After nose blowing;

(d) After smoking; and

(e) Before serving or preparing food.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-220, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-220, filed 12/30/92, effective 1/30/93.]

WAC 388-151-230 What requirements must I meet for medication management? You may have a policy of not giving medication to the child in care. If your center's health care plan includes giving medication to the child in care, you:

(1) Must give medications, prescription and nonprescription, only on the written approval of a parent, person, or agency having authority by court order to approve medical care;

(2) Must give prescription medications:

(a) Only as specified on the prescription label; or

(b) As authorized, in writing, by a physician or other person legally authorized to prescribe medication.

(3) Must give the following classifications of nonprescription medications, with written parent authorization, only at the dose, duration, and method of administration specified on the manufacturer's label for the age or weight of the child needing the medication:

(a) Antihistamines;

(b) Nonaspirin fever reducers/pain relievers;

(c) Nonnarcotic cough suppressants;

(d) Decongestants;

(e) Anti-itching ointments or lotions, intended specifically to relieve itching;

(f) Diaper ointments and powders, intended specifically for use in the diaper area of the child; and

(g) Sun screen.

(4) Must give other nonprescription medication:

(a) Not included in the categories listed in subsection (3) of this section; or

(b) Taken differently than indicated on the manufacturer's label; or

(c) Lacking labeled instructions, only when disbursement of the nonprescription medication is as required under subsection (4)(a), (b), and (c) of this section:

(i) Authorized, in writing, by a physician; or

(ii) Based on established medical policy approved, in writing, by a physician or other person legally authorized to prescribe medication.

(5) Must accept from the child's parent, guardian, or responsible relative only medicine in the original container, labeled with:

(a) The child's first and last names;

(b) The date the prescription was filled; or

(c) The medication's expiration date; and

(d) Legible instructions for administration, such as manufacturer's instructions or prescription label.

(6) Must keep medication, refrigerated or nonrefrigerated, in an orderly fashion and inaccessible to the child;

(7) Must store external medication in a compartment separate from internal medication;

(8) Must keep a record of medication disbursed;

(9) Must return to the parent or other responsible party, or must dispose of medications no longer being taken; and

(10) May, at your option, permit self-administration of medication by a child in care if:

(a) The child is physically and mentally capable of properly taking medication without assistance;

(b) You include in the child's file a parental or physician's written statement of the child's capacity to take medication [without] assistance; and

(c) You have stored the child's medications and other medical supplies so the medications and medical supplies are inaccessible to other children in care.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-230, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-230, filed 12/30/92, effective 1/30/93.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-151-240 What nutrition requirements must I meet? (1) You must provide food meeting the nutritional needs of the children in care, taking into consideration each child's:

(a) Age and development level;

(b) Cultural background; and

(c) Child's special health care needs, if any.

(2) You must provide only pasteurized milk or pasteurized milk products.

(3) You may serve school-age children powdered Grade A milk, provided you complete the dry milk mixture, service, and storage in a safe and sanitary manner.

(4) You may furnish a child nutrient concentrates, nutrient supplements, a modified diet, or an allergy diet only with the written permission of the child's health care provider. The licensee must obtain from the parent or the child's health care provider a written list of foods the child must not consume.

(5) You must:

(a) Record food and portion sizes planned and served; and

(b) Post menus showing two weeks or more of food variety before repeating menus.

(6) You may make nutritional substitutions of comparable nutrient value to the menu.

(7) You must use the following meal pattern to furnish food in age-appropriate servings to provide the child:

(a) Access to a breakfast, if the child arrives on the premises before 7:00 a.m.;

(b) A snack if the child is in care for one to three hours before or after school; and

(c) Food at intervals not less than two hours and not more than three and one-half hours apart.

(8) You must furnish the child in care food that complies with the meal pattern of the United States Department of Agriculture Child and Adult Care Food Program or the National School Lunch Program.

(9) The children's snacks must include one or more dairy or protein source provided daily and must contain a minimum of two of the following four components at each snack:

(a) A dairy product;

(b) A protein food;

(c) Bread or bread alternate; or

(d) Fruit or vegetable or juice containing a minimum of fifty percent real juice.

(10) You must have available food supplies to supplement food brought from the child's home that is deficient in meeting nutrition requirements.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-240, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-240, filed 12/30/92, effective 1/30/93.]

WAC 388-151-250 What requirements must I meet for kitchen and food service? (1) You must ensure the proper storage, preparation, and service of food to meet program needs.

(2) You must meet food service standards by ensuring that;

(a) The staff person preparing full meals has a valid food handler permit;

(b) The staff person preparing and serving meals washes hands before handling food;

(c) Hand-washing facilities are located in or adjacent to food preparation areas;

(d) Your program stores food in a sanitary manner; especially milk, shell-fish, meat, poultry, eggs, and other protein food sources;

(e) Your program stores food requiring refrigeration at a temperature no warmer than forty-five degrees Fahrenheit;

(f) Your program stores frozen food at a maximum temperature of zero degrees Fahrenheit;

(g) You have equipped your refrigerators and freezers with thermometers and that your staff regularly cleans and defrosts your facility's refrigerators and freezers;

(h) Your staff cooks food to correct temperatures;

(i) Your staff washes raw food thoroughly with clean running water;

(j) Your staff rapidly cools and refrigerates cooked food to be stored after preparation;

(k) Your program keeps food in original containers or in clean, labeled containers and stores the food off the floor;

(l) Your staff discards packaged, canned, and bottled food with a past expiration date;

(m) Your staff discards food in dented cans or torn packages; and

(n) You notify parents when your program serves food containing sulfiting agents.

(3) Children in care may participate in food preparation as an education activity when:

(a) You make kitchen equipment inaccessible to the children, except during planned and supervised kitchen activities; and

(b) Your staff supervises food preparation activities.

(4) You must install and maintain kitchen equipment and clean reusable utensils in a safe and sanitary manner by:

(a) Sanitizing reusable utensils in a dishwasher or through use of a three-compartment dishwashing procedure; and

(b) Using only single-use clean cloths, solely, for wiping food service, preparation, and eating surfaces.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-250, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-250, filed 12/30/92, effective 1/30/93.]

WAC 388-151-260 What requirements must I meet for drinking and eating equipment? You must:

(1) Provide children with single-use cups, individual drinking cups or glasses, or inclined jet-type drinking fountains;

(2) Prohibit your child care center from using bubbler-type drinking fountains and common drinking cups or glasses; and

(3) Provide the children with durable eating utensils appropriate in size and shape for the children in care.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-260, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-260, filed 12/30/92, effective 1/30/93.]

WAC 388-151-280 What general safety, maintenance, and site requirements must I meet? You must:

(1) Operate the center:

(a) On an environmentally safe site;

(b) In a neighborhood free from conditions detrimental to the children's welfare; and

(c) In a location accessible to health and emergency service.

(2) Ensure that you maintain indoor and outdoor premises in a safe and sanitary condition, free of hazards, and in good repair;

(3) Ensure that furniture and equipment are safe, stable, durable, and age-appropriate;

(4) Maintain a flashlight or other emergency lighting device in working condition;

(5) Finish or cover rough or untreated wood surfaces;

(6) Maintain one or more telephones in working order, readily accessible to staff and children;

(7) Supply bathrooms and other rooms subject to moisture with washable, moisture-impervious flooring;

(8) Ensure staff can gain rapid access in an emergency to a bathroom or other room children may occupy;

(9) Shield light bulbs and tubes in child-accessible areas;

(10) Keep the premises free from rodents, fleas, cockroaches, and other insects and pests;

(11) Ensure no firearm or other weapon is on the premises;

(12) Maintain adequate storage space for play and teaching equipment, supplies, records, and children's possessions and clothing;

(13) Safely store or make inaccessible to the children cleaning supplies, toxic substances, paint, poisons, aerosol containers, and items bearing warning labels;

(14) Label a container filled from a stock supply to identify contents;

(15) Comply with fire safety regulations adopted by the state fire marshal's office.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-280, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-280, filed 12/30/92, effective 1/30/93.]

WAC 388-151-290 What must I do to ensure water safety in my facility? (1) You must maintain the following water safety precautions when the children in your care use an on-premises swimming pool, wading pool, or natural body of water, or enter the water on a field trip by ensuring;

(a) The on-premises pool or natural body of water is inaccessible to the children when not in use;

(b) During the children's use of a wading pool, an adult with current CPR training supervises the child at all times; and

(c) During the children's use of a swimming pool or natural body of water, a certified lifeguard is present at all times, in addition to required staff.

(2) You must, on a daily basis, empty and clean portable wading pools, when in use.

(3) You may permit the children to use or access a hot tub, spa tank, or whirlpool only under direct supervision and with written parental permission.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-290, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-290, filed 12/30/92, effective 1/30/93.]

WAC 388-151-310 What first aid supplies must I have available in my child care center? (1) You must maintain on the premises adequate first aid supplies conforming with your center's first aid policies and procedures.

(2) Your first aid supplies must include unexpired syrup of ipecac. Your staff may administer syrup of ipecac only on the advice of a physician or the poison control center.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-310, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-310, filed 12/30/92, effective 1/30/93.]

WAC 388-151-320 What requirements must I meet for an outdoor play area? You must:

(1) Provide a safe and equipped outdoor play area of sufficient size to meet the needs of the children in care. The play area must:

(a) Be reachable by a safe route and method;

(b) Promote the children's active play, physical development, and coordination;

(c) Be free of any dangerous condition and provide safe child entry and exit; and

(d) Be adaptable to the child or children with special needs.

(2) You must ensure that the center's activity schedule affords the child sufficient daily time to participate actively in outdoor play.

(3) The licensor may accept the playground that is on public school property and has been inspected by the school district or state or local health departments.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-320, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-320, filed 12/30/92, effective 1/30/93.]

WAC 388-151-330 What requirements must I meet for indoor space? (1) Your school-age child care center must have adequate, usable space indoors to ensure that children are not crowded. You must provide a minimum of thirty-five square feet per child of usable space.

(2) Your facility must have an identifiable space of its own during hours of operation, which may include moveable furnishings and equipment.

(3) You must arrange indoor space to encourage a variety of developmentally appropriate activities including:

(a) Interest areas for focused activities;

(b) Open areas for large motor activities;

(c) Areas where children can work individually, in small groups, and in large groups; and

(d) Private spaces where children can rest, play, and work alone or with a friend.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-330, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-330, filed 12/30/92, effective 1/30/93.]

WAC 388-151-340 What are the department's requirements for toilets and hand-washing sinks? (1) You must supply hand-washing sinks and toilets for the children equal to, at minimum, the number the state or local building code requires. You must meet the following minimum ratios:

(a) For toilets: 1:100 for boys and 1:35 for girls,

(b) For urinals: 1:30.

(2) You must supply the children with warm, running water for handwashing at a temperature range no less than eighty-five degrees Fahrenheit and no more than one hundred twenty degrees Fahrenheit.

(3) You must locate the children's hand-washing facilities in or adjacent to rooms used for toileting.

(4) You must provide toileting privacy for the children.

(5) You must ensure that rooms used for toileting are ventilated to the outdoors.

(6) You must provide the children with soap and individual towels or other appropriate devices for washing and drying the children's hands and faces.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-340, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-340, filed 12/30/92, effective 1/30/93.]

WAC 388-151-380 What kind of program atmosphere must I provide? You must:

(1) Provide a cheerful environment for the children by placing visually stimulating decorations, pictures, or other attractive materials at appropriate heights for the children in care;

(2) Maintain a safe and developmentally appropriate noise level;

(3) Locate fixtures and provide lighting intensities promoting visibility and comfort for the children in care;

(4) Maintain the temperature within the center at sixty-eight degrees Fahrenheit or more; and

(5) Regulate the temperature and ventilate the center for the health and comfort of the children in care.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-380, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-380, filed 12/30/92, effective 1/30/93.]

WAC 388-151-390 What requirements must I meet regarding nondiscrimination? (1) You must comply with federal and state regulatory and statutory requirements, defined under chapter 49.60 RCW, regarding nondiscrimination in employment practices and client services.

(2) Consistent with state and federal laws, you must respect and facilitate all rights of the children in care.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-390, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-390, filed 12/30/92, effective 1/30/93.]

WAC 388-151-410 What special requirements regarding American Indian children must I meet? When five percent or more of your center's child enrollment consists of Indian children, you must, in consultation with the parent, establish a plan to provide social service resources and staff training programs designed to meet the social and cultural needs of such children. You may coordinate with tribal, Indian health service, and Bureau of Indian Affairs social service staff and appropriate urban Indian and Alaskan native consultants.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-410, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-410, filed 12/30/92, effective 1/30/93.]

WAC 388-151-420 What are my responsibilities regarding child abuse, neglect, and exploitation? You and your staff must protect the children in care from child abuse, neglect, or exploitation, as required under chapter 26.44 RCW. If you or your staff have reasonable cause to believe that a child has suffered abuse or neglect, you or your staff must report the alleged incident to law enforcement or the department's child protective services (CPS) section in accordance with RCW 26.44.030.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-420, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-420, filed 12/30/92, effective 1/30/93.]

WAC 388-151-430 What requirements does the department have regarding prohibited substances and tobacco products? (1) During operating hours or when children are in care, you, your staff, and volunteers on your center premises or caring for the children off-site must not be under the influence of, consume, or possess an:

(a) Alcoholic beverage; or

(b) Illegal drug.

(2) You must prohibit smoking in the center and in motor vehicle when you, your staff, or volunteers transport children. You may permit on-premises smoking only outdoors, away from the building, when the children are not present.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-430, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-430, filed 12/30/92, effective 1/30/93.]

WAC 388-151-440 What are the department's limitations regarding persons on premises? (1) During center operating hours or while children are in care, only you, your employees, and your volunteers, or an authorized representative of a governmental agency, school district, or an approved adult related to the child in care may have unsupervised access to the children in care.

(2) You must allow the parent of a child in care unsupervised access only to the parent's own child.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-440, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-440, filed 12/30/92, effective 1/30/93.]

WAC 388-151-450 What child records and information must I maintain? You must maintain, on the premises, organized and confidential records and information concerning each child in care. You must ensure each child's record contains, at a minimum:

(1) Registration data:

(a) Name, birth date, dates of enrollment and termination, and other identifying information;

(b) Name, address, and home and business telephone numbers of the parent and other person for you to contact in case of emergency; and

(c) A completed enrollment application signed by the parent, guardian, or responsible relative.

(2) Authorizations:

(a) Name, address, and telephone number of any other person authorized to remove the child in care from the center;

(b) Written parental consent for transportation provided by the center, including field trips and swimming, when the child participates in these activities. A parent-signed blanket consent form may authorize the child's off-site travel; and

(c) Written parental consent, or court order, for providing medical care and emergency surgery, except for such care authorized by law.

(3) Medical and health data:

(a) Date and kind of illness or injury occurring on the premises including the treatment given by your staff;

(b) Medication given by your staff indicating dosage, date, time, and name of dispensing staff person; and

(c) A health history obtained when you or your staff enrolls the child for care. The history includes:

(i) The date of the child's last physical examination;

(ii) Allergies;

(iii) Special health or developmental problems and other pertinent health information;

(iv) Name, address, and telephone number of child's health care provider or facility; and

(v) A record of immunization status.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-450, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-450, filed 12/30/92, effective 1/30/93.]

WAC 388-151-460 What program records must I maintain? You must maintain the following documentation on the premises:

(1) The daily attendance record:

(a) The parent, or other person authorized by the parent to take the child to or from the center, must sign in the child on arrival and must sign out the child at departure, using a full, legal signature;

(b) When the child leaves the center to attend school or other off-site activity as authorized by the parent, your staff person must sign out the child and sign in the child on return to the center; and

(c) Signed agreements between a program director and a parent where school-age child is allowed to leave the center on his own, must be verified by signature and dated by the director and parent. Staff may sign a child in/out whose parent has agreed in writing to let the child leave the center.

(2) A copy of the report sent to the department about any illness or injury to the child in care requiring medical treatment or hospitalization;

(3) The twelve-month record indicating the date and time you conducted the required monthly fire evacuation drills;

(4) A written plan for staff development specifying the content, frequency, and manner of planned training;

(5) Activity program plan records;

(6) A list of each child's allergies and dietary restrictions, if any;

(7) Any incident involving the use of physical restraint;

(8) A record of medication your staff gives to any child; and

(9) A record of accidents and injuries.

(10) Personnel records as described in WAC 388-151-470(4).

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-460, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-460, filed 12/30/92, effective 1/30/93.]

WAC 388-151-470 What personnel policies and records must I develop and maintain? (1) Each employee and volunteer having unsupervised or regular access to the child in care must complete and submit to you or your director by the date of hire:

(a) An application for employment on a department-prescribed form or its equivalent; and

(b) A criminal history and background inquiry form:

(i) You must submit this form to the department for each employee and volunteer, within seven calendar days of the employee's first day of employment so that the department may complete a criminal and background history check; and

(ii) The department must discuss the inquiry information with you or your director, when applicable.

(c) A Federal Bureau of Investigation (FBI) check, for you or any employee, or volunteer, if you, the employee, or volunteer has lived in the state for less than three years.

(2) Each employee serving as a program director, site coordinator, or staff person required to complete training under WAC 388-151-190(8) must complete and submit a Washington state training and registry system (STARS) profile form to you or your director by the date of hire. You must submit this form to STARS within seven calendar days of the employee's first day of employment, so that the department may track the employee's compliance with training requirements.

(3) You must have written personnel policies describing staff benefits, if any, duties, qualifications, grievance procedures, pay dates, and nondiscrimination policies.

(4) You must maintain on the premises a personnel record keeping system, including a file for you and each staff person and volunteer containing:

(a) An employment application including work and education history;

(b) Documentation of criminal history and background inquiry form submission, or FBI fingerprint check, if applicable;

(c) A record of Mantoux method tuberculin skin test results, x-ray, or an exemption to the skin test or x-ray;

(d) Documentation on HIV/AIDS education and training;

(e) A record of participation in staff development training;

(f) Documentation of orientation program completion;

(g) Documentation of a valid food handler permit, when applicable;

(h) Documentation of current first aid and CPR training, when applicable; and

(i) Documentation of basic and annual training required under WAC 388-151-180 (2)(i) and (4)(f), 388-151-190(8) and 388-151-200(7).

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-470, filed 12/22/00, effective 1/22/01. Statutory Authority: RCW 74.15.030. 98-24-052, § 388-151-470, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-470, filed 12/30/92, effective 1/30/93.]

WAC 388-151-480 What requirements must I meet for reporting of death, injury, illness, epidemic, or child abuse? You or your staff must report immediately:

(1) A death, serious injury requiring medical treatment, or illness requiring hospitalization of a child in care, by telephone and in writing, to the child's parent and the department;

(2) An instance when you or your staff has reason to suspect the occurrence of physical, sexual, or emotional child abuse, child neglect, or child exploitation as required under chapter 26.44 RCW, by telephone, to child protective services or local law enforcement; and

(3) An occurrence of food poisoning or communicable disease, as required by the state board of health, by telephone, to the local public health department.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-480, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-480, filed 12/30/92, effective 1/30/93.]

WAC 388-151-490 Under what circumstances must I report circumstantial changes to the department? A school-age child care center license is valid only for the address, person, and organization named on the license. You must promptly report to the department a major change affecting your center's classification, delivery of safe, developmentally appropriate services, or continued eligibility for licensure. A major change includes the:

(1) Center's address, location, space, or phone number;

(2) Maximum number and ages of children served as compared to current license specifications;

(3) Change of ownership, chief executive officer, licensee, director, or site coordinator;

(4) Name of the licensed corporation or name by which the center is commonly known or changes in the center's articles of incorporation and bylaws;

(5) Occurrence of a fire, major structural change, or damage to the premises; and

(6) Plans for major remodeling of the center including planned use of space not previously department-approved.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-490, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-490, filed 12/30/92, effective 1/30/93.]

WAC 388-151-500 What informational items must I post in my center? (1) You must post the following items, clearly visible to the parents of children in care and your staff:

(a) The center's child care license issued under this chapter;

(b) A list of all staff names;

(c) A typical activity schedule including operating hours;

(d) Food menus;

(e) Evacuation plans and procedures including a diagram of exiting routes; and

(f) Emergency telephone numbers, including 911 and local law enforcement, highlighted and posted by the telephone with the center's address.

(2) For your staff, you must post:

(a) Dietary restrictions for particular children; and

(b) Handwashing practices.

[Statutory Authority: RCW 74.15.020. 01-02-031, § 388-151-500, filed 12/22/00, effective 1/22/01. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-500, filed 12/30/92, effective 1/30/93.]

WAC 388-151-991 Waiver of fees. Any person or agency subject to license fees under chapter 440-44 WAC, and organizations in the person's or agency's behalf, may submit a sworn, notarized petition seeking waiver of fees for a licensee or distinguishable class of licensee.

The petition shall be mailed or delivered to the office of the secretary. Following receipt of the petition, the secretary may require submission of additional information considered relevant.

[00-23-088, recodified as § 388-151-991, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-002, filed 6/4/82.]

WAC 388-151-992 Fee payment and refunds. (1) Fees are due with applications for initial license or renewal. The department will not proceed on applications until required fees are paid.

Except as otherwise provided in these rules, fees shall be paid for a minimum of one year.

(2) Fees for licenses issued for other than yearly periods shall be prorated based on the stated annual fee.

(3) When the department issues a license for more than one year:

(a) Fees may be paid for the entire licensing period by paying at the rate established at the time the application was submitted, or

(b) If the licensee does not pay the fee for the entire license period, annual fees shall be due thirty days prior to each annual anniversary date of the license, at the annual fee rate established by these rules at the time such fee is paid.

(4) Except as otherwise provided in these rules, if an application is withdrawn prior to issuance or denial, one-half of the fee shall be refunded.

(5) If there is a change of or by the licensee requiring a new license, the fee paid for a period beyond the next license anniversary date shall be refunded. Changes requiring a new license shall require a new application and payment of fee as provided herein.

(6) If there is a change by the applicant or licensee that requires an amendment placing the licensee in a higher fee category, the additional fee shall be prorated for the remainder of the license period.

(7) Fees becoming due on or after the effective date of this chapter shall be at the rates provided herein.

(8) To the extent fees are reduced through regular rule adoption of this chapter on or before December 31, 1982, fees shall be refunded.

(9) Fee payments shall be by mail. Payment shall be by check, draft, or money order made payable to the department of social and health services.

[00-23-088, recodified as § 388-151-992, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-010, filed 6/4/82.]

WAC 388-151-993 Denial, revocation, suspension, and reinstatement. (1) If a license is denied, revoked, or suspended, fees shall not be refunded.

(2) Application for license after denial or revocation must include fees as provided for in these rules.

(3) Failure to pay fees when due will result in suspension or denial of license.

[00-23-089, recodified as § 388-151-993, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-015, filed 6/4/82.]

Chapter 388-155 WAC

MINIMUM LICENSING REQUIREMENTS FOR FAMILY CHILD DAY CARE HOMES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-155-210 Health care plan. [Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-210, filed 2/1/91, effective 3/4/91.] Repealed by 00-06-040, filed 2/28/00, effective 3/30/00. Statutory Authority: RCW 74.15.030.

388-155-260 Drinking and eating equipment. [Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-260, filed 2/1/91, effective 3/4/91.] Repealed by 00-06-040, filed 2/28/00, effective 3/30/00. Statutory Authority: RCW 74.15.030.

WAC 388-155-005 Authority. The following rules are adopted under chapters 74.12 and 74.15 RCW.

[Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-155-005, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-005, filed 2/1/91, effective 3/4/91.]

WAC 388-155-010 Definitions. As used and defined under this chapter:

"American Indian child" means any unmarried person under the age of eighteen who is:

(1) A member of or eligible for membership in a federally recognized Indian tribe, or who is Eskimo, Aleut or other Alaska Native and a member of an Alaskan native regional Corporation or Alaska Native Village;

(2) Determined or eligible to be found to be Indian by the Secretary of the Interior, including through issuance of a certificate of degree of Indian blood, or by the Indian health service;

(3) Considered to be Indian by a federally recognized or nonfederally recognized Indian tribe; or

(4) A member or entitled to be a member of a Canadian tribe or band, Metis community, or nonstatus Indian community from Canada.

"Assistant" means a child care giver employed by the licensee to supervise a child served at the home.

"Capacity" means the maximum number of children the licensee is authorized to have on the premises at a given time.

"Child" means a person seventeen years of age and under.

"Child abuse or neglect" means the injury, sexual abuse, sexual exploitation, or negligent treatment or maltreatment of a child by a person under circumstances indicating the child's health, welfare, and safety is harmed.

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

"Department of health" means the state department of health.

"Family abode" means "a single dwelling unit and accessory buildings occupied for living purposes by a family which provides permanent provisions for living, sleeping, eating, cooking, and sanitation."

"Family child care home" means a facility in the family residence of the licensee providing regularly scheduled care for twelve or fewer children, within a birth through eleven-years-of-age range exclusively, for periods less than twenty-four hours unless care in excess of twenty-four hours is necessary due to the nature of the parent's work.

"Family child day care home" means the same as **"family child care home"** and "a child day care facility, licensed by the state, located in the family abode of the person or persons under whose direct care and supervision the child is placed, for the care of twelve or fewer children, including children who reside at the home."

"Family residence" means the same as **"family abode."**

"Home" means the same as **"family child care home."**

"License" means a permit issued by the department authorizing by law the licensee to operate a family child care home and certifying the licensee meets minimum requirements under licensure.

"Licensee" means the person, organization, or legal entity responsible for operating the home.

"Premises" means the buildings where the home is located and the adjoining grounds over which the licensee has control.

"Provider" means the same as **"licensee."**

"The Washington state training and registry system (STARS)" means the entity approved by the department to determine the classes, courses, and workshops licensees and staff may take to satisfy training requirements.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-010, filed 2/28/00, effective 3/30/00; 98-24-052, § 388-155-010, filed 11/25/98, effective 12/26/98; 91-04-048 (Order 3136), § 388-155-010, filed 2/1/91, effective 3/4/91.]

WAC 388-155-020 Scope of licensing. (1) The person operating a family child care home shall be subject to licensing by authority under chapter 74.15 RCW, unless exempted by RCW 74.15.020(4).

(2) The person operating a family child care home and qualifying for exemption from requirements of this chapter under RCW 74.15.020(4) shall not be subject to licensure. The person claiming an exemption must provide the department proof of entitlement to the exemption on the department's request.

(3)(a) RCW 74.15.020 (4)(c)(i) exempts from licensing persons who care for a neighbor's or friend's child or children, with or without compensation, where:

(i) Care is provided for less than twenty-four hours; and

(ii) Such activity is not conducted on an ongoing, regularly scheduled basis for the purpose of engaging in business, which includes, but is not limited to advertising such care.

(b) For purposes of this section:

(i) **"Advertising"** means attempting to solicit child care clients, either directly or indirectly, through written, or electronic means;

(ii) **"Engaging in business"** shall exclude those persons providing child care for only one family of children or who can demonstrate that their gross earnings from child care will not exceed one thousand dollars in any one calendar year;

(iii) **"Friend"** means someone with whom the care provider had a personal relationship prior to the time care was sought, offered, or provided;

(iv) **"Neighbor"** means a person with whom the care provider has relationship by virtue to living in close proximity to the person;

(v) **"Ongoing"** means that care is provided for a number of consecutive weeks or months or there is no specific time frame for ending child care;

(vi) **"Regularly scheduled"** means that the child comes at usually planned times and/or days and/or the provider makes her/himself available to provide care at fixed or planned intervals.

(4) The department shall not license the home legally exempt from licensing. However, at the applicant's request, the department shall investigate and may certify the home as meeting licensing and other pertinent requirements. In such cases, the department's requirements and procedures for licensure shall apply equally to certification.

(5) The department may certify a family day care home for payment without further investigation if the home is:

(a) Licensed by an Indian tribe; or

(b) Certified by the Federal Department of Defense.

The home must be licensed or certified in accordance with national or state standards or standards approved by the department and be operated on the premises over which the entity licensing or certifying the home has jurisdiction.

(6) The person or organization desiring to serve state-paid children must:

(a) Be licensed or certified;

(b) Follow billing policies and procedures in *Child Care Subsidies, A Booklet for Providers*, DSHS 22-877(X); and

(c) Bill the department at the person's or organization's customary rate or the DSHS rate, whichever is less.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-020, filed 2/28/00, effective 3/30/00; 96-20-095, § 388-155-020, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-155-020, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 91-15-084 (Order 3205), § 388-155-020, filed 7/23/91, effective 8/23/91; 91-04-048 (Order 3136), § 388-155-020, filed 2/1/91, effective 3/4/91.]

WAC 388-155-040 Local ordinances and codes. The department shall issue or deny a license on the basis of the applicant's compliance with minimum licensing and procedural requirements. Local officials shall be responsible for enforcing city ordinances and county codes, such as zoning and building regulations.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-040, filed 2/1/91, effective 3/4/91.]

WAC 388-155-050 Waivers. (1) In an individual case, the department, for good cause, may waive a specific requirement and may approve an alternate method of achieving the specific requirement's intent if the:

(a) Licensee or applicant submits to the department a written waiver request fully explaining the circumstances necessitating the waiver; and

(b) Department determines waiver approval will not jeopardize the safety or welfare of the child in care or detract from the quality of services the licensee delivers.

(2) The department may approve a waiver request only for a specific purpose or child and for a specific period of time not exceeding the expiration date of the license.

(3) The department may limit or restrict a license issued in conjunction with a waiver.

(4) The licensee shall maintain on the premises a copy of the written waiver approval.

(5) The department's denial of a waiver request shall not be subject to appeal under chapter 34.05 RCW.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-050, filed 2/1/91, effective 3/4/91.]

WAC 388-155-060 Dual licensure. The department shall not issue a family child care home license to the applicant having a foster family home license or other license involving full-time care or permit simultaneous care for the child and adult on the same premises. An exception may be granted if the applicant or licensee:

(1) Demonstrates evidence that care of one client category will not interfere with the quality of care provided to another category of clients;

(2) Requests and obtains a waiver permitting dual licensure;

(3) Maintains the most stringent maximum capacity limitation for the client categories concerned; and

(4) Where the licensee desires to exceed the most stringent maximum capacity limitation, requests an additional waiver to subsection (3) above. This additional waiver request may be written on one form with the request for dual licensing.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-060, filed 4/26/96, effective 5/27/96. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-060, filed 2/1/91, effective 3/4/91.]

WAC 388-155-070 Application and reapplication for licensure—Orientation, training and investigation. (1) The person, organization, or legal entity applying for a license or relicensure under this chapter and responsible for operating the home must:

(a) Attend orientation and training programs provided, arranged, or approved by the department;

(b) Comply with application procedures the department prescribes; and

(c) Submit to the department:

(i) A completed department-supplied application for family child care home license, including required attachments, ninety or more days before the:

(A) Beginning of licensed care;

(B) Expiration of a current license;

(C) Relocation of a home; or

(D) Change of licensed capacity category.

(ii) A completed criminal history and background inquiry form for each applicant, assistant, volunteer, or member of the household sixteen years of age or older having unsupervised or regular access to the child in care;

(iii) Fingerprint cards if residing in Washington state for less than three years; and

(iv) The annual licensing fee.

(2) In addition to the required application materials specified under subsection (1) of this section, the applicant for initial licensure must submit to the department:

(a) A department-supplied employment and education resume of the applicant and assistant including a transcript or its equivalent documenting early childhood education class completion, where appropriate; and

(b) Three references for the applicant.

(3) The applicant for a license under this chapter shall be eighteen years of age or older.

(4) The department may, at any time, require additional information from the applicant, licensee, assistant, volunteer, member of their household and other person having access to the child in care as the department deems necessary, including, but not limited to:

(a) Sexual deviancy evaluations;

(b) Substance and alcohol abuse evaluations;

(c) Psychiatric evaluations;

(d) Psychological evaluations; and

(e) Medical evaluations.

(5) The department may perform investigations of the applicant, licensee, assistant, volunteer, member of their household, and other person having access to the child in care as the department deems necessary, including accessing criminal histories and law enforcement files.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-070, filed 2/28/00, effective 3/30/00. Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-070, filed 4/26/96, effective 5/27/96. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-070, filed 2/1/91, effective 3/4/91.]

WAC 388-155-080 Issuance of license. (1) The department shall issue the applicant or licensee a license for a specific number of children dependent on the:

(a) Department's evaluation of the home's premises and physical accommodations;

(b) Number and skills of the licensee, assistant, and volunteers; and

(c) Ages and characteristics of the children served.

(2) The department:

(a) May issue the applicant or licensee a license to care for fewer children than the home's maximum capacity; and

(b) Shall not issue the applicant or licensee a license for the care of more children than permitted under this chapter.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-080, filed 2/1/91, effective 3/4/91.]

WAC 388-155-083 Fees. The licensee must pay a fee of twenty-four dollars per year. The fee is payable to DSHS and may be paid either annually or once every three years.

[Statutory Authority: RCW 43.20B.110. 01-02-032, § 388-155-083, filed 12/22/00, effective 1/22/01.]

WAC 388-155-085 Initial license. (1) The department may issue an initial license to an applicant not currently licensed to provide child day care when the applicant:

(a) Can demonstrate compliance with the rules contained in this chapter pertaining to the health and safety of the child in care; but

(b) Cannot demonstrate compliance with the rules pertaining to:

(i) Provider-child interactions,

(ii) Capacity,

(iii) Behavior management,

(iv) Activity and routines,

(v) Child records and information, and

(vi) Other rules requiring department observation of the applicant's ability to comply with rules.

(c) Can provide a plan, acceptable to the department, to comply with rules found in subsection (1)(b) of this section.

(2) The department may issue an initial license to an applicant for a period not to exceed six months, renewable for a period not to exceed two years.

(3) The department shall evaluate the applicant's ability to comply with all rules contained in this chapter during the period of initial licensure prior to issuing a full license.

(4) The department may issue a full license to the applicant demonstrating compliance with all rules contained in this chapter at any time during the period of initial licensure.

(5) The department shall not issue a full license to the applicant who does not demonstrate the ability to comply

with all rules contained in this chapter during the period of initial licensure.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-085, filed 10/1/96, effective 11/1/96.]

WAC 388-155-090 License denial, suspension, or revocation. (1) Before granting a license and as a condition for continuance of a license, the department shall consider the ability of the applicant and licensee to meet the requirements of this chapter. If more than one person is the applicant or licensee, the department:

(a) Shall consider the persons' qualifications separately and jointly; and

(b) May deny, suspend, revoke, or not renew the license based on the failure of one of the persons to meet the requirements.

(2) The department shall deny, suspend, revoke, or not renew the license of a person who:

(a) Has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130, is ineligible to provide care because of a criminal history under chapter 388-330 WAC, or allows such a person on the premises;

(b) Commits or was convicted of a felony reasonably related to the competency of the person to meet the requirements of this chapter;

(c) Engages in illegal use of a drug or excessive use of alcohol;

(d) Commits, permits, aids, or abets the commission of an illegal act on the premises;

(e) Commits, permits, aids, or abets the abuse, neglect, exploitation, or cruel or indifferent care to a child in care;

(f) Refuses to permit an authorized representative of the department, state fire marshal, department of health, or state auditor's office to inspect the premises; or

(g) Refuses to permit an authorized representative of the department, the department of health, or the state auditor's office access to records related to operation of the home or to interview an assistant or a child in care.

(3) The department may deny, suspend, revoke, or not renew a license of a person who:

(a) Seeks to obtain or retain a license by fraudulent means or misrepresentation, including, but not limited to:

(i) Making a materially false statement on the application; or

(ii) Omitting material information on the application.

(b) Provides insufficient staff in relation to the number, ages, or characteristics of children in care;

(c) Allows a person unqualified by training, experience, or temperament to care for or be in contact with a child in care;

(d) Violates any condition or limitation on licensure including, but not limited to:

(i) Permitting more children on the premises than the number for which the home is licensed; or

(ii) Permitting on the premises a child of an age different from the ages for which the home is licensed.

(e) Fails to provide adequate supervision to a child in care;

(f) Demonstrates an inability to exercise fiscal responsibility and accountability with respect to operation of the home;

(g) Misappropriates property of a child in care;

(h) Knowingly permits on the premises an employee or volunteer who has made a material misrepresentation on an application for employment or volunteer service;

(i) Refuses or fails to supply necessary, additional department-requested information; or

(j) Fails to comply with any provision of chapter 74.15 RCW or this chapter.

(4) The department shall not issue a license to a person who has had denied, suspended, revoked, or not renewed a license to operate a facility for the care of children or adults, in this state or elsewhere, unless the person demonstrates by clear, cogent, and convincing evidence the person has undertaken sufficient corrective action or rehabilitation to warrant public trust and to operate the home in accordance with the rules of this chapter.

(5) The department's notice of a denial, revocation, suspension, or modification of a license and the applicant's or licensee's right to a hearing shall be governed under RCW 43.20A.205.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-155-090, filed 4/26/96, effective 5/27/96. Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-155-090, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-090, filed 2/1/91, effective 3/4/91.]

WAC 388-155-092 Civil penalties. (1) Before imposing a civil penalty, the department shall provide written notification by personal service, including by the licensor, or certified mail which shall include:

(a) A description of the violation and citation of the applicable requirement or law;

(b) A statement of what is required to achieve compliance;

(c) The date by which the department requires compliance;

(d) The maximum allowable penalty if timely compliance is not achieved;

(e) The means to contact any technical assistance services provided by the department or others; and

(f) Notice of when, where, and to whom a request to extend the time to achieve compliance for good cause may be filed with the department.

(2) The length of time in which to comply shall depend on:

(a) The seriousness of the violation;

(b) The potential threat to the health, safety and welfare of children in care; or

(c) Previous opportunities to correct the deficiency.

(3) The department may impose a civil penalty based on but not limited to these reasons:

(a) The child care home has previously been subject to an enforcement action for the same or similar type of violation of the same stature or rule; or

(b) The child care home has previously been given notice of the same or similar type of violation of the same statute or rule; or

(c) The violation represents a potential threat to the health, safety, and/or welfare of children in care.

(4) The department may impose a civil penalty in addition to or in conjunction with other disciplinary actions against a child care license including probation, suspension, or other action.

(5) The civil fine shall be payable twenty-eight days after receipt of the notice or later as specified by the department.

(6) The fine may be forgiven if the agency comes into compliance during the notification period.

(7) The center or person against whom the department assesses a civil fine has a right to an adjudicative proceeding as governed by RCW 43.20A.215.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-092, filed 10/1/96, effective 11/1/96.]

WAC 388-155-093 Civil penalties—Amount of penalty. Whenever the department imposes a civil monetary penalty per WAC 388-155-092(3), the department shall impose a penalty of seventy-five dollars per violation per day. The department may assess and collect the penalty with interest for each day of noncompliance.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-093, filed 10/1/96, effective 11/1/96.]

WAC 388-155-094 Civil penalty—Posting of notice of penalty. (1) The licensee shall post the final notice of a civil penalty in a conspicuous place in the facility.

(2) The notice shall remain posted until payment is received by the department.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-094, filed 10/1/96, effective 11/1/96.]

WAC 388-155-095 Civil penalties—Unlicensed programs. Where the department has determined that an agency is operating without a license, the department shall send written notification by certified mail or other means showing proof of service. This notification shall contain the following:

(1) Advising the agency of the basis of determination of providing child care without a license and the need to be licensed by the department;

(2) The citation of the applicable law;

(3) The assessment of seventy-five dollars per day penalty for each day unlicensed care is provided. The fine would be effective and payable within thirty days of receipt of the notification;

(4) How to contact the office of child care policy;

(5) The need to submit an application to the office of child care policy within thirty days of receipt of the notification;

(6) That the penalty may be forgiven if the agency submits an application within thirty days of the notification; and

(7) The right of an adjudicative proceeding as a result of the assessment of a monetary penalty and the appropriate procedure for requesting an adjudicative proceeding.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-095, filed 10/1/96, effective 11/1/96.]

WAC 388-155-096 Civil penalties—Separate violations. Each violation of a law or rule constitutes a separate violation and may be penalized as such.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-096, filed 10/1/96, effective 11/1/96.]

WAC 388-155-097 Civil penalties—Penalty for nonpayment. The department may suspend, revoke or not renew a license for failure to pay a civil monetary penalty it has assessed within ten days after such assessment becomes final.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-097, filed 10/1/96, effective 11/1/96.]

WAC 388-155-098 Probationary license. (1) The department must base the decision as to whether a probationary license will be issued upon the following factors:

(a) Willful or negligent noncompliance by the licensee,

(b) History of noncompliance,

(c) Extent of deviation from the requirements,

(d) Evidence of a good faith effort to comply,

(e) Any other factors relevant to the unique situation.

(2) Where the negligent or willful violation of the licensing requirements does not present an immediate threat to the health and well-being of the children but would be likely to do so if allowed to continue, a probationary license may be issued as well as civil penalties or other sanctions. Such situations may include:

(a) Substantiation that a child (or children) was abused or neglected while in the care of the home,

(b) Disapproved fire safety or sanitation report,

(c) Use of unauthorized space for child care,

(d) Inadequate supervision of children,

(e) Understaffing for the number of children in care,

(f) Noncompliance with requirements addressing:

(i) Children's health,

(ii) Proper nutrition,

(iii) Discipline,

(iv) Emergency medical plan,

(v) Sanitation and personal hygiene practices.

(3) Licensee must notify parents when a probationary license is issued:

(a) The licensee must notify the parents or guardians of all children in care that it is in probationary status within five working days of receiving notification he or she has been issued a probationary license;

(b) The notification must be in writing and must be approved by the department prior to being sent;

(c) The licensee must provide documentation to the department that parents or guardians of all children in care have been notified within ten working days of receiving notification that he or she has been issued a probationary license;

(d) The department may issue a probationary license for up to six months, and at the discretion of the department it may be extended for an additional six months.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-098, filed 2/28/00, effective 3/30/00; 96-20-095, § 388-155-098, filed 10/1/96, effective 11/1/96.]

WAC 388-155-100 Activities and routines. (1) The provider must offer activities and routines designed to meet

the developmental, cultural, and individual needs of the child served. The provider must ensure that the activities and routines allow the child to:

(a) Gain self-esteem, self-awareness, self-control, and decision-making abilities;

(b) Develop socially, emotionally, intellectually, and physically;

(c) Learn about nutrition, health, and personal safety; and

(d) Experiment, explore, and play.

(2) The provider must establish familiar routines for meals, rest, and play, with allowances for a variety of special events.

(3) The provider must ensure the home's activities offer variety and options, including a balance between:

(a) Child-initiated and provider-initiated activities;

(b) Free play and organized events;

(c) Individual and group activities;

(d) Quiet and active experiences; and

(e) Interactive and passive activities.

(4) The provider must ensure the home's daily routine affords the child opportunities for small and large muscle activities and outdoor play.

(5) The child may remain in care no more than ten hours per day except as necessitated by the parent's working hours and commute time.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-100, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-100, filed 2/1/91, effective 3/4/91.]

WAC 388-155-110 Learning and play materials. The provider must ensure the child access to a variety of easily accessible, developmentally appropriate learning and play materials of sufficient quantity to implement the home's daily activities. The provider must ensure material is culturally relevant and promotes:

(1) Social development;

(2) Intellectual ability;

(3) Language development and communication;

(4) Self-help skills;

(5) Sensory stimulation;

(6) Large and small muscle development; and

(7) Creative expression.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-110, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-110, filed 2/1/91, effective 3/4/91.]

WAC 388-155-120 Provider-child interactions. (1) The provider/assistant must furnish the child a nurturing, respectful, supportive, and responsive environment through frequent interactions with the child:

(a) Supporting the child in developing an understanding of self and others by assisting the child to share ideas, experiences, and feelings;

(b) Providing age-appropriate opportunities for intellectual growth and development of the child's social and language skills, including encouraging the child to ask questions;

(c) Helping the child solve problems;

(d) Fostering creativity and independence in routine activities, including showing tolerance for mistakes; and

(e) Treating children in care equally regardless of race, religion, abilities, and family structure.

(2) The provider must:

(a) Furnish the child a pleasant and educational environment at meal and snack times; and

(b) Provide good models for nutrition habits and social behavior by:

(i) Eating with children, when feasible; and

(ii) Encouraging conversation among children.

(3) The provider must ensure the child is supervised by continuous visual or auditory contact.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-120, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-120, filed 2/1/91, effective 3/4/91.]

WAC 388-155-130 Behavior management and discipline. (1) The licensee must guide the child's behavior based on an understanding of the individual child's needs and stage of development. The licensee must promote the child's developmentally appropriate social behavior, self-control, and respect for the rights of others.

(2) The licensee must ensure behavior management and discipline practices are fair, reasonable, consistent, and related to the child's behavior. The licensee must not administer cruel, unusual, hazardous, frightening, or humiliating discipline.

(3) The licensee must be responsible for implementing the behavior management and discipline practices of the home. The child in care must not determine or administer behavior management or discipline.

(4) The licensee must prohibit and prevent:

(a) Corporal punishment by any person on the premises, including hitting, biting, jerking, shaking, spanking, slapping, striking, or kicking the child, or other means of inflicting physical pain or causing bodily harm;

(b) The use of a physical restraint method injurious to the child;

(c) The use of a mechanical restraint, locked time-out room, closet, highchair, carseat, or infant seat for disciplinary purposes;

(d) The withholding of food as a punishment.

(5) In emergency situations, the licensee competent to use de-escalation and restraint methods may use limited physical restraint when:

(a) Protecting a person on the premises from physical injury;

(b) Obtaining possession of a weapon or other dangerous object; or

(c) Protecting property from serious damage.

(6) The licensee must document any incident involving the use of physical restraint.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-130, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-130, filed 2/1/91, effective 3/4/91.]

WAC 388-155-140 Rest periods. (1) The provider must offer a supervised rest period to the child:

(a) Five years of age and under remaining in care more than six hours; or

(b) Showing a need for rest.

(2) The provider must plan quiet activities for the child not needing rest.

(3) The provider must allow the child twenty-four months of age and under to follow an individual sleep schedule.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-140, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-140, filed 2/1/91, effective 3/4/91.]

WAC 388-155-150 Evening and nighttime care. (1) For the home regularly offering child care during evening and nighttime hours, the licensee must:

(a) Adapt the activities, routines, and equipment to meet the physical and emotional needs of the child away from home at night.

These must include:

(i) Arrangements made for bathing as needed;

(ii) Individual bedding appropriate for overnight sleeping;

(iii) Appropriate night wear and individual toiletry items for each child;

(iv) Separate dressing and sleeping areas for boys and girls ages six years and older and demonstrating a need for privacy.

(b) The licensee must maintain staff-child ratios during sleeping hours.

(c) The licensee must have a plan approved by the licensor to ensure the physical safety and emotional well-being of children during sleeping hours.

(2) The licensee must arrange child grouping so the sleeping child remains asleep during the arrival or departure of another child.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-150, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-150, filed 2/1/91, effective 3/4/91.]

WAC 388-155-160 Off-site trips. (1) The licensee may transport or permit the off-site travel of the child to attend school, participate in field trips, or engage in other off-site activities only with written parental consent.

(2) The parent's consent may be:

(a) For a specific date and trip; or

(b) A blanket authorization describing the full range of trips the child may take. In such case, the licensee shall notify the parent in advance about the trip.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-160, filed 2/1/91, effective 3/4/91.]

WAC 388-155-165 Transportation. When the licensee provides transportation for the child in care:

(1) The licensee must ensure the motor vehicle is maintained in a safe operating condition;

(2) The licensee must ensure the motor vehicle is equipped with appropriate safety devices and individual seat belts or safety seats for each child to use when the vehicle is in motion according to Washington state patrol recommendations;

(3) The licensee must ensure the number of passengers does not exceed the seating capacity of the motor vehicle;

(4) The licensee or driver must carry motor vehicle liability and medical insurance. The driver must have a current Washington driver's license, valid for the classification of motor vehicle operated;

(5) The licensee or assistant supervising the child in the motor vehicle must have current first aid and cardiopulmonary resuscitation training;

(6) The licensee, assistant, or driver must not leave the child unattended in the motor vehicle;

(7) The licensee must ensure the assistant is present in the motor vehicle when capacity guidelines require an assistant; and

(8) The licensee must keep a first aid kit, health history, and emergency medical consent for each child in the vehicle while transporting children.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-165, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-165, filed 2/1/91, effective 3/4/91.]

WAC 388-155-170 Parent communication. (1) The licensee must:

(a) Explain to the parent and to any assistants the provider's policies, procedures, and health care practices;

(b) Orient the parent and assistants to the home and activities, and to location of items required to be posted;

(c) Advise the parent of the child's progress and issues relating to the child's care and individual practices concerning a child's special needs; and

(d) Encourage parent participation in the home's activities.

(2) The licensee must give the parent the following written policy and procedure information:

(a) Enrollment and admission requirements;

(b) The fee and payment plan;

(c) A typical activity schedule, including hours of operation;

(d) Typical meals and snacks served, including guidelines on food brought from the child's home;

(e) Permission for free access by the child's parent to all home areas used by the child;

(f) Child abuse reporting requirements;

(g) Behavior management and discipline;

(h) Nondiscrimination statement;

(i) Religious activities, if any;

(j) Transportation and field trip arrangements;

(k) Typical staffing plan when provider is absent;

(l) Health care practices, including but not limited to information about the home's general health practices concerning:

(i) Injury prevention;

(ii) Medication management:

(iii) First aid, including medical emergencies;

(iv) Practices concerning an ill child;

(v) Communicable disease prevention, management, and reporting;

(vi) Handwashing practices.

(m) If licensed for the care of the young child:

(i) Proper infant sleep position and bedding to prevent Sudden Infant Death Syndrome (SIDS);

(ii) Diapering

(iii) Toilet training; and

(iv) Feeding.

(n) Disaster response plan; and

(o) Practices regarding nighttime care including staffing, if applicable.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-170, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-170, filed 2/1/91, effective 3/4/91.]

WAC 388-155-180 Staffing—Qualifications. (1) General qualifications. The licensee, assistant, volunteer, and other person associated with the operation of the home who has access to the child in care must:

(a) Be of good character;

(b) Have the understanding, ability, personality, emotional stability, and physical health suited to meet the cultural emotional, mental, physical, and social needs of the child in care; and

(c) Not have committed or been convicted of child abuse or any crime involving physical harm to another person.

(2) The licensee must:

(a) Be eighteen years of age or older;

(b) Be the primary child care provider during the majority of child care business hours;

(c) Ensure compliance with minimum licensing requirements under this chapter; and

(d) Have completed one of the following prior to or within the first six months of initial licensure except as provided in (e) of this subsection:

(i) Twenty clock hours or two college quarter credits of basic training approved by the Washington state training and registry system (STARS); or

(ii) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education or child development; or

(iii) Associate of arts or AAS or higher college degree in early childhood education, child development, school age care, elementary education or special education.

(e) Licensees already licensed on the effective date of this rule must complete the training required in WAC 388-150-180 (2)(d) prior to or within twelve months after the effective date of this rule.

(3) The assistant must be:

(a) Fourteen years of age or older; or

(b) Eighteen years of age or older if assigned sole responsibility for the child in care; and

(c) Competent to exercise appropriate judgements.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-180, filed 2/28/00, effective 3/30/00; 98-24-052, § 388-155-180, filed 11/25/98, effective 12/26/98; 91-04-048 (Order 3136), § 388-155-180, filed 2/1/91, effective 3/4/91.]

WAC 388-155-190 Capacity. (1) The department shall determine the maximum capacity of the family child care home based on the:

(a) Licensee's experience and training;

(b) Assistant's qualifications;

(c) Number, ages, and characteristics of the children cared for;

(d) Number and ages of the licensee's own children and other children residing in the home eleven years of age and under;

(e) Usable indoor and outdoor space; and

(f) Supply of toys and equipment.

(2) The department may license the family child care home according to the following table:

NUMBER OF PROVIDERS REQUIRED	AGE RANGE IN YEARS	MAXIMUM NUMBER OF CHILDREN UNDER TWO YEARS OF AGE	MAXIMUM NUMBER OF CHILDREN
(a) Licensee	Birth - 11	2	6
(b) Licensee with one year experience	2 - 11	None	8
(c) Licensee with one year experience	5 - 11	None	10
(d) Licensee with one year experience plus assistant	Birth - 11	4	9
(e) Licensee with two years' experience and one early childhood education (ECE) class	3 - 11	None	10
(f) Licensee with two years' experience and one ECE class plus assistant	Birth - 11	4	12

So that the:

(a) Unassisted licensee may provide care for a maximum of six children, birth through eleven years of age, with two or fewer children under two years of age; or

(b) Unassisted licensee with one year of experience operating a licensed family child care home or the equivalent experience may provide care for a maximum of eight children, two years through eleven years of age; or

(c) Unassisted licensee with one year of experience operating a licensed family child care home or the equivalent experience may provide care for a maximum of ten children, five years through eleven years of age; or

(d) Licensee with one year of experience as a licensed family child care home provider or the equivalent experience and an assistant may provide care for seven through nine children, birth through eleven years of age, with four or fewer children under two years of age; or

(e) Unassisted licensee with two years of experience operating a licensed family child care home or the equivalent experience and one class in ECE, or the equivalent education, may provide care for a maximum of ten children, three years through eleven years of age; or

(f) Licensee with two years of experience operating a licensed family child care home or the equivalent experience, one class in ECE or the equivalent education, and a qualified assistant may provide care for a maximum of twelve children, birth through eleven years of age, with four or fewer children under two years of age.

(3) The licensee shall ensure an assistant is on the premises when:

(a) Three or more children under two years of age are in care;

(b) Seven or more children are in care and any child in care is under two years of age; or

(c) More than ten children are in care.

(4) The department's determination of capacity shall include all children eleven years of age or under on the premises.

(5) The licensee shall ensure the assistant is eighteen years of age or older when the assistant is solely responsible for the child in care.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-190, filed 2/1/91, effective 3/4/91.]

WAC 388-155-200 Development and training. (1) The licensee must have an orientation system making the new employee and volunteer aware of policies and practices. The licensee must provide the new employee or volunteer an orientation including, but not limited to:

(a) Minimum licensing rules required under this chapter;

(b) Goals and philosophy of the home;

(c) Daily activities and routines;

(d) Child guidance and behavior management methods;

(e) Child abuse and neglect prevention, detection, and reporting policies and procedures;

(f) Special health and developmental needs of the individual child;

(g) The health care practices;

(h) Fire prevention and safety procedures;

(i) Duties of assistants and/or volunteer; and

(j) Location of items required to be posted.

(2) The licensee must:

(a) Obtain basic, standard first aid, and cardiopulmonary resuscitation (CPR) training, approved by the department of health. CPR training must include methods appropriate for child age groups in care;

(b) Ensure that first aid and CPR training is current; and

(c) Annually, beginning one year after licensure, complete ten clock hours or one college quarter credit of training. Training must be approved by the Washington state training and registry system (STARS). For those already licensed on the effective date of this rule, this requirement for annual training shall begin one year after the effective date of this rule.

(3) The licensee must ensure the assistant eighteen years of age or older obtains basic, standard first aid, and CPR training approved by the department of health if the assistant will be solely responsible for the child in care.

(4) The licensee and assistant must obtain appropriate education and training on the prevention and transmission of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

(5) The licensee must encourage the assistant to participate in training opportunities to promote ongoing education and enhance practice skills.

(6) The licensee must conduct periodic meetings for planning and coordination purposes when applicable.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-200, filed 2/28/00, effective 3/30/00; 98-24-052, § 388-155-200, filed 11/25/98, effective 12/26/98; 91-04-048 (Order 3136), § 388-155-200, filed 2/1/91, effective 3/4/91.]

WAC 388-155-220 Health supervision and infectious disease prevention. (1) The licensee must encourage the parent to arrange a physical examination for the child who has not had regular health care or a physical examination within one year before enrollment.

(2) The licensee must encourage the parent to obtain health care for the child when necessary. The licensee must not be responsible for providing or paying for the child's health care.

(3) Before or on the child's first day of attendance, the parent must present a certificate of immunization status form prescribed by the department of health proving the child's full immunization for:

(a) Diphtheria;

(b) Tetanus;

(c) Pertussis (whooping cough);

(d) Poliomyelitis;

(e) Measles (rubeola);

(f) Rubella (German measles);

(g) Mumps;

(h) Haemophilus Influenzae Type B (HIB);

(i) Hepatitis B; and

(j) Other diseases prescribed by the department of health.

(4) The licensee may accept the child without all required immunizations on a conditional basis if immunizations are:

(a) Initiated before or on enrollment; and

(b) Completed as rapidly as medically possible.

(5) The licensee may exempt the immunization requirement for the child if the parent or guardian:

(a) Signs a statement expressing a religious, philosophical, or personal objection; or

(b) Furnishes a physician's statement of a valid medical reason for the exemption.

(6) The licensee must observe the child daily for signs of illness. The licensee must care for or discharge home the ill child based on the home's policies concerning an ill child.

(a) When the child has a severe illness or is injured, tired, or upset, the licensee must separate the child from other children and attend the child continuously until:

(i) The licensee secures appropriate health care for the child; or

(ii) The licensee makes an arrangement to return the child to the parent; or

(iii) The child is able to rejoin the group.

(b) The licensee must provide a quiet, separate care room or area allowing the child requiring separate care an opportunity to rest.

(c) The licensee must sanitize equipment used by the child, if the licensee suspects the child has a communicable disease.

(d) The licensee may use the separate care room or area for other purposes when not needed for separation of the child.

(7) The licensee must wash, or assist the child to wash hands according to the home's handwashing procedures.

(8) The licensee must clean and disinfect toys, equipment, furnishings, and facilities according to the home's cleaning and disinfecting policies.

(9) The licensee must have appropriate extra clothing available for the child who wets or soils clothes.

(10) The licensee must ensure the child does not share personal hygiene or grooming items.

(11) Each licensee, assistant, volunteer, and adult member of the household having regular contact with the child in care must have a tuberculin (TB) skin test, by the Mantoux method, upon employment or initial licensure, unless against medical advice.

(a) The person whose TB skin test is positive (ten millimeters or more size) must have a chest x-ray with results indicating the person does not have active TB, within thirty days following the skin test.

(b) The licensee must not require the person to obtain routine periodic TB retesting or x-ray (biennial or otherwise) after entry testing unless directed to obtain retesting by the person's health care provider or the local health department.

(12) The licensee must not permit the person with a reportable communicable disease to be on duty in the home or have contact with the child in care unless approved by a health care provider.

(13) The licensee and assistant must wash hands according to the home's handwashing practices.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-220, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-220, filed 2/1/91, effective 3/4/91.]

WAC 388-155-230 Medication management. (1) The home may have a policy of not giving medication to the child in care, unless a child has a medically recognized special need requiring medication.

(2) If the home's health care practices include giving medication to the child in care, the licensee:

(a) Must give medications, prescription and nonprescription, only on the written approval of a parent, or of a person or agency having authority by court order to approve medical care;

(b) Must give prescription medications:

(i) Only as specified on the prescription label; or

(ii) As authorized by a physician or other person legally authorized to prescribe medication.

(c) Must give the following classifications of nonprescription medications, with written parent authorization, including a start date and ending date, not to exceed one month, only at the dose, duration, and method of administration specified on the manufacturer's label for the age or weight of the child needing the medication:

(i) Antihistamines;

(ii) Nonaspirin fever reducers/pain relievers;

(iii) Nonnarcotic cough suppressants;

(iv) Decongestants;

(v) Anti-itching ointments or lotions, intended specifically to relieve itching;

(vi) Diaper ointments and powders, intended specifically for use in the diaper area of the child; and

(vii) Sun screen.

(d) Must have written instructions from a physician for nonprescription medications if:

(A) A specific dosage is not given on the label for the age and weight of the child in care;

(B) It is not listed in subsection (2)(c);

(C) It lacks labeled instructions; or

(D) It is taken differently than indicated on the manufacturer's label.

The written instructions must include dosage and description of the child's symptoms warranting the medication.

(e) Must accept from the child's parent, guardian, or responsible relative only medicine in the original container, labeled with:

(i) The child's first and last names;

(ii) The date the prescription was filled; or

(iii) The medication's expiration date; and

(iv) Legible instructions for administration, such as manufacturer's instructions or prescription label.

(f) Must keep medication, refrigerated or nonrefrigerated, in an orderly fashion, inaccessible to the child;

(g) Must keep class II narcotics in locked storage.

(h) Must store external medication in a compartment separate from internal medication;

(i) Must keep a record of medication disbursed;

(j) Must return medications no longer being taken to the parent or other responsible party, or must dispose of them;

(k) May at the licensee's option, permit self-administration of medication by a child in care if the:

(i) Child is physically and mentally capable of properly taking medication without assistance;

(ii) Licensee includes in the child's file a parental or physician's written statement of the child's capacity to take medication without assistance; and

(iii) Licensee ensures the child's medications and other medical supplies are stored so the medications and medical supplies are inaccessible to another child in care.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-230, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-230, filed 2/1/91, effective 3/4/91.]

WAC 388-155-240 Nutrition. (1) The licensee must provide food meeting the nutritional needs of the child in care, taking into consideration the:

(a) Number of children in care;

(b) Child's age and developmental level;

(c) Child's cultural background;

(d) Child's special need; and

(e) Hours of care on the premises.

(2) The licensee must provide only pasteurized milk or a pasteurized milk product.

(3) The licensee must provide only whole milk to the child twenty-three months of age or under except with the written permission of the child's parent.

(4) The licensee may serve the child twenty-four months of age or older powdered Grade A milk mixed in the home provided the licensee completes the dry milk mixture, service, and storage in a safe and sanitary manner, using water from an approved source.

(5) The licensee may provide the child nutrient concentrates, nutrient supplements, a modified diet, or an allergy diet only with written permission of the child's health care provider. The licensee must obtain from the parent or child's health care provider a written list of foods the child cannot consume.

(6) The licensee must use the following meal pattern to provide food to the child in care in age-appropriate servings:

(a) Providing the child in care for ten or less hours:

(i) Two or more snacks and one meal; or

(ii) Two meals and one snack.

(b) Providing the child in care for ten or more hours, two or more meals and two snacks;

(c) Providing the child arriving after school a snack;

(d) Providing the child with food at not less than two-hour intervals, and not more than three and one-half hours apart; and

(e) Allowing the occasional serving of party foods not meeting nutritional requirements.

(7) The licensee shall provide the child in care food which complies with the meal pattern of the United States Department of Agriculture Child and Adult Care Food Program, with the addition of:

(a) A minimum of one serving of Vitamin C fruit, vegetable, or juice, provided daily; and

(b) Servings of food high in Vitamin A, provided three or more times weekly.

(8) The licensee must provide:

(a) Dinner to the child in evening care when the child did not receive dinner at home before arriving;

(b) A bedtime snack to the child in nighttime care; and

(c) Breakfast to the child in nighttime care if the child remains at the home after the child's usual breakfast time.

(9) The licensee must monitor foods brought from the child's home for consumption by the child, all children, or a group of children in care ensuring safe storage and nutritional adequacy.

(10) For the home permitting sack lunches, the licensee must have food supplies available to supplement food deficient in meeting nutrition requirements brought from the child's home and to nourish the child arriving without food.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-240, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-240, filed 2/1/91, effective 3/4/91.]

WAC 388-155-250 Kitchen and food service. (1) The licensee must provide and maintain equipment for the proper storage, preparation, and service of food.

(2) The licensee must make potentially hazardous appliances and sharp or pointed utensils inaccessible to the child when the child is not under direct supervision.

(3) The child may participate in food preparation as an educational activity.

(4) The licensee must install and maintain kitchen equipment and clean reusable utensils in a safe and sanitary manner by:

(a) Washing and sanitizing reusable utensils in a dishwasher or through use of a manual dishwashing procedure;

(b) Using only single-use or clean cloths, used solely for wiping food service, preparation, and eating surfaces; and

(c) Using an approved sanitizer, such as bleach and water, in the kitchen.

(5) The licensee must provide the child individual drinking cups, glasses, or disposable single-use cups.

(6) The licensee must provide the child durable eating utensils appropriate in size and shape for the child in care.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-250, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-250, filed 2/1/91, effective 3/4/91.]

WAC 388-155-270 Care of young children. (1) Diapering and toileting. The licensee must ensure:

(a) The diaper-changing area is:

(i) Separate from food preparation areas; and

(ii) Easily accessible to a handwashing sink other than a sink used for food preparation;

(iii) Sanitized between use for different children; or

(iv) Protected by a disposable covering discarded after each use.

(b) The diaper-changing area is impervious to moisture and washable.

(2) The licensee must:

(a) Use a nonabsorbent pad large enough for the child's upper body and buttocks;

(b) Use reusable diapers, a commercial diaper service, or disposable diapers;

(c) Place soiled diapers without rinsing into a separate, cleanable, covered container provided with a waterproof liner before transporting to a laundry, parent, or acceptable disposal;

(d) Remove soiled diapers from the home daily or more often unless the licensee uses a commercial diaper service;

(e) Use disposable towels or clean, reusable towels laundered between use for different children for cleaning the child; and

(f) Wash hands after diapering the child or helping the child with toileting.

(3) The licensee must:

(a) Consult with the child's parent regarding initiating toilet training;

(b) Locate potty chairs on washable, nonabsorbent surfaces in appropriate toileting area when in use; and

(c) Sanitize toilet training equipment after each use.

(4) Feeding. The licensee and the infant's parent must agree on a schedule for feedings:

(a) The licensee or parent may provide the child's bottle feeding in the following manner:

(i) A filled bottle brought from home;

(ii) Whole milk or formula in ready-to-feed strength; or

(iii) Formula requiring no preparation other than dilution with water, mixed on the premises, following manufacturer's directions.

(b) The licensee must prepare the child's bottle and nipple in a sanitary manner in an area separate from the diapering area.

(c) The licensee must sanitize the child's bottle and nipple between uses.

(d) The licensee must label the bottle with the child's name and date prepared, if more than one bottle-fed child is in care.

(e) The licensee must refrigerate a filled bottle if the child does not consume the contents immediately and discard the bottle's contents if the child does not consume the contents within twelve hours.

(f) To ensure safety and promote nurturing, the licensee and assistant must:

(i) Hold the child in a semi-sitting position for feeding, if the child is unable to sit in a high chair, unless such is against medical advice;

(ii) Interact with the child;

(iii) Not prop a bottle;

(iv) Not give a bottle to the reclining child; and

(v) Take the bottle from the child when the child finishes feeding.

(g) The licensee must provide semi-solid food for the child, upon consultation with the parent, as recommended by the child's health care provider.

(5) Sleeping equipment. The licensee must furnish the child a single-level crib, infant bed, bassinet, or play pen for napping until such time the parent and licensee agree the child can safely use a mat, cot, or other approved sleep equipment.

(6) The licensee must ensure the young child has a sturdy crib, infant bed, bassinet, or play pen:

(a) Made of wood, metal, or plastic with secure latching devices; and

(b) Constructed with two and three-eighths inches or less space between vertical slats when the crib is used for a child six months of age or younger; and

(c) The licensee must follow the recommendations of the American Academy of Pediatrics (1-800-CRIB [1-800-505-CRIB]), placing infants on their backs each time for sleep. The provider may use a different sleep position if the parent requests it in writing.

(7) The licensee must ensure the child's crib mattress, infant bed, bassinet, or play pen mattress is:

(a) Snug fitting, preventing the infant from being caught between the mattress and crib side rails; and

(b) Waterproof, easily sanitized, and in good repair.

(8) Activities and equipment. The licensee must provide the young child a daily opportunity for:

(a) Large and small muscle development;

(b) Crawling and exploring;

(c) Sensory stimulation;

(d) Social interaction;

(e) Development of communication; and

(f) Learning self-help skills.

(9) The licensee must provide safe, noningestible, suitable toys and equipment for the young child's mental and physical development.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-270, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-270, filed 2/1/91, effective 3/4/91.]

WAC 388-155-280 General safety, maintenance, and site. (1) The licensee must operate the home on an environmentally safe site.

(2) The licensee must maintain the indoor and outdoor premises in a safe and sanitary condition, free of hazards, and in good repair. The licensee must ensure furniture and equipment are safe, stable, durable, and free of sharp, loose, or pointed parts.

(3) The licensee must:

(a) Install handrails or safety devices at child height adjacent to steps, stairways, and ramps;

(b) Maintain a flashlight or other emergency lighting device in working condition;

(c) Ensure there is no flaking or deteriorating lead-based paint on interior and exterior surfaces, equipment, and toys accessible to the child;

(d) Finish rough or untreated wood surfaces; and

(e) Maintain one or more telephones in working order.

(4) The licensee must supply bathrooms and other rooms subject to moisture with washable, moisture-impervious flooring or routinely cleaned floor covering.

(5) The licensee must equip child-accessible electrical outlets with nonremovable safety devices or covers preventing electrical injury.

(6) The licensee must ensure staff can gain rapid access in an emergency to a bathroom or other room occupied by the child.

(7) The licensee must keep the premises free from rodents, fleas, cockroaches, and other insects and pests, using the least toxic method available, and notifying children's parents in advance of chemical usage.

(8) The licensee must use an appropriate method for drawing clean mop water and disposing waste water.

(9) Firearms, ammunition, and other weapons must be kept in secure, locked storage, at all times when not in use. They must be accessible only to authorized persons. Secure locked storage means a locked storage container, gun cabinet, gun safe, or other storage area made of strong, unbreakable material. If the cabinet has a glass or other breakable front, then the guns need to be secured with a cable or chain placed through the trigger guards securing the guns in the storage unit.

(10) The licensee must ensure a person with current first aid and infant-child CPR training is on the premises at all times.

(11) The licensee must store separate from food products and make inaccessible to children cleaning supplies, toxic substances, paint, poisons, aerosol containers, and items bearing warning labels indicating a product is hazardous, if a person is exposed to, or consumes the product.

(12) The licensee must label a container filled from a stock supply to identify contents.

(13) The licensee must ensure that any animal or pet on the premises has not demonstrated aggressive behavior. If a pet or animal has demonstrated aggressive behavior, it must be inaccessible to children in care at all times.

(14) The use of wheeled baby walkers is prohibited.

(15) The use of trampolines, including rebounders, is prohibited.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-280, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-280, filed 2/1/91, effective 3/4/91.]

WAC 388-155-290 Water supply, sewage, and liquid wastes. (1) The licensee must obtain water from:

(a) A public water supply that is regulated by Washington state department of health drinking water operations or the local health authority, as appropriate;

(b) An individual water supply operated and maintained in a manner acceptable to the local health authority; or

(c) Commercially bottled water in cases where (a) or (b) of this subsection are unsatisfactory.

(2) The licensee must ensure sewage and liquid wastes are discharged into:

(a) A public sewer system; or

(b) An independent sewage system maintained so as not to create a public health nuisance as determined by the local health authority.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-290, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-290, filed 2/1/91, effective 3/4/91.]

WAC 388-155-295 Water safety. (1) The licensee must maintain the following water safety precautions when the child uses an on-premises swimming pool or wading pool. The licensee must ensure:

(a) The on-premises pool is inaccessible to the child when not in use; and

(b) An adult with current CPR training supervises the child at all times.

(2) The licensee must ensure a certified lifeguard is present during the child's use of an off-premises swimming pool.

(3) The licensee must empty and clean a portable wading pool daily, when in use.

(4) An adequate, department-approved cover or barrier, installed at the manufacturer's specification must be in place to prevent the child access at all times to heated tubs, whirlpools, spas, tanks, or similar equipment.

(5) A five foot high fence with gates, locked when not in use, is required to prevent access to water hazards, such as swimming pools, lakes, streams, or natural or artificial pools.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-295, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-295, filed 2/1/91, effective 3/4/91.]

WAC 388-155-310 First-aid supplies. (1) The licensee must maintain first-aid supplies on the premises conforming with the home's first-aid policies and procedures.

(2) The home's first-aid supplies must include unexpired syrup of ipecac which may be administered only on the advice of a poison control center.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-310, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-310, filed 2/1/91, effective 3/4/91.]

WAC 388-155-320 Outdoor play area. (1) The licensee must provide a safe and securely-fenced or department-approved, enclosed outdoor play area:

(a) Adjoining directly the indoor premises; or

(b) Reachable by a safe route and method; and

(c) Promoting the child's active play, physical development, and coordination; and

(d) Protecting the child from unsupervised exit with an enclosure at least forty-eight inches high; and

(e) Preventing child access to roadways and other dangers.

(2) The licensee must ensure the home's activity schedule affords the child sufficient daily time to participate actively in outdoor play.

(3) The licensee must provide a variety of age appropriate play equipment for climbing, pulling, pushing, riding, and balancing activities. The licensee must arrange, design, construct, and maintain equipment and ground cover to prevent the child's injury. The licensee's quantity of outdoor play equipment must offer the child a range of outdoor play options.

[(4) Preschool children and younger must be in visual and auditory range when outside.

(5) School-age children must be in auditory range when outside.]

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-320, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-320, filed 2/1/91, effective 3/4/91.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-155-330 Indoor play area. (1) The home's indoor premises shall contain adequate space for child play and sufficient space to house developmentally appropriate activities for the number and age range of children served. The licensee shall provide a minimum of thirty-five square feet of usable floor space per child, exclusive of a bathroom, hallway, and closet.

(2) The licensee may use and consider the napping area as child care space if mats and cots are removed when not in use. The licensee may consider the kitchen usable space if:

(a) Appliances and utensils do not create a safety hazard;

(b) Toxic or harmful substances are not accessible to the child;

(c) Food preparation and storage sanitation is maintained; and

(d) The space is used safely and appropriately as a child care activity area.

(3) The licensee may use a room for multiple purposes such as playing, dining, napping, and learning activities, provided:

(a) The room is of sufficient size; and

(b) The room's use for one purpose does not interfere with use of the room for another purpose.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-330, filed 2/1/91, effective 3/4/91.]

WAC 388-155-340 Toilets, handwashing sinks, and bathing facilities. (1) The licensee must provide a minimum of one indoor flush-type toilet and one adjacent handwash sink.

(2) The licensee must supply the child warm running water for handwashing at a temperature range no less than eighty-five degrees Fahrenheit and no more than one hundred and twenty degrees Fahrenheit.

(3) The licensee must provide toileting privacy for the child of opposite sex six years of age and older and for other children demonstrating a need for privacy.

(4) The licensee must provide toilets and handwashing sinks of appropriate height and size for the child in care or furnish safe, easily cleanable platforms impervious to moisture so the child can reach the toilet and handwashing sink.

(5) The licensee must ensure a room used for toileting is ventilated.

(6) When a home serves the child not toilet-trained, the licensee must provide developmentally appropriate equipment for the toileting and toilet training of the young child. The licensee must sanitize the equipment after each child's use.

(7) The licensee must provide the child with soap and individual cloth or paper towels for washing and drying the child's hand and face.

(8) If the home is equipped with a bathing facility, the licensee must:

(a) Ensure the young child is supervised while using the bathing facility; and

(b) Equip the bathing facility with a conveniently located grab bar or other safety device such as a nonskid pad.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-340, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-340, filed 2/1/91, effective 3/4/91.]

WAC 388-155-350 Laundry. (1) The licensee must use an effective method through temperature or chemical measures for adequately sanitizing the child's laundry contaminated with urine, feces, lice, scabies, or other infectious material.

(2) The licensee must store the child's soiled laundry separately from clean laundry.

(3) Hazardous laundry supplies and soiled items must be inaccessible to children.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-350, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-350, filed 2/1/91, effective 3/4/91.]

WAC 388-155-360 Nap and sleep equipment. (1) The licensee must provide a clean, separate, firm mat, cot, bed, mattress, play pen, or crib for each child five years of age and under remaining in care for six or more hours and for the child requiring a nap or rest period.

(2) The licensee must ensure the child's mat or cot is of sufficient length, width, and thickness to provide adequate comfort for the child to nap. The licensee must ensure the cot surface is of a material which can be cleaned with a detergent solution, disinfected, and allowed to air dry. The licensee may use a washable sleeping bag meeting the mat requirements for the toilet-trained child.

(3) The licensee must clean the child's nap equipment as needed and between use by different children.

(4) The licensee must separate the child's nap equipment when in use to facilitate child comfort and health and staff access.

(5) The licensee must ensure the child's bedding:

(a) Consists of a clean sheet or blanket to cover the sleeping surface and a clean, suitable cover for the child;

(b) Is laundered weekly or more often and between use by different children; and

(c) Is stored separately from bedding used by another child.

(6) The licensee must not use the upper bunk of a double deck bed for a preschool age or younger child.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-360, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-360, filed 2/1/91, effective 3/4/91.]

WAC 388-155-370 Storage. (1) The licensee shall provide accessible individual space for the child to store clothes and personal possessions.

(2) The licensee shall provide sufficient space to store equipment, supplies, records, files, cots, mats, and bedding.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-370, filed 2/1/91, effective 3/4/91.]

WAC 388-155-380 Home atmosphere. (1) The licensee shall provide a cheerful learning environment for the child consistent with a family home environment by placing visually stimulating decorations, pictures, or other attractive materials at appropriate heights for the child.

(2) The licensee shall maintain a safe and developmentally appropriate noise level, without inhibiting normal ranges of expression by the child, so provider and child can be clearly heard and understood in normal conversation.

(3) The licensee shall locate light fixtures and provide lighting intensities promoting good visibility and comfort for the child in care.

(4) The licensee shall maintain the temperature within the home at:

(a) Sixty-eight degrees Fahrenheit or more during the child's waking hours; and

(b) Sixty degrees Fahrenheit or more during the child's napping or sleeping hours.

(5) The licensee shall ventilate the home for the health and comfort of the child in care.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-380, filed 2/1/91, effective 3/4/91.]

WAC 388-155-390 Discrimination prohibited. The licensee must comply with federal and state regulatory and statutory requirements, defined under chapter 49.60 RCW, regarding nondiscrimination in employment practices and client services, to prohibit discrimination because of race, creed, color, national origin, sex, marital status, age, or the presence of any sensory, mental, or physical disability or use of a trained guide dog or service animal by a disabled person.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-390, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-390, filed 2/1/91, effective 3/4/91.]

WAC 388-155-400 Religious activities. (1) Consistent with state and federal laws, the licensee must respect and facilitate the rights of the child in care to observe the tenets of the child's faith.

(2) The licensee must not punish or discourage the child for exercising these rights.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-400, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-400, filed 2/1/91, effective 3/4/91.]

WAC 388-155-410 Additional requirements regarding American Indian children. When one or more American Indian child receives care at the home, the licensee must in consultation with the parent, establish a plan to provide social service resources and training designed to meet the social and cultural needs of such children. The licensee may coordinate with tribal, Indian Health Service, Bureau of Indian Affairs social service staff, and appropriate urban Indian and Alaskan native consultants.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-410, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-410, filed 2/1/91, effective 3/4/91.]

WAC 388-155-420 Child abuse, neglect, and exploitation. The licensee and assistant shall protect the child in care from child abuse, neglect, or exploitation as required under chapter 26.44 RCW.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-420, filed 2/1/91, effective 3/4/91.]

WAC 388-155-430 Prohibited substances. (1) During operating hours or when the child is in care, the licensee, assistant, and volunteers on the premises in child care areas, or caring for the child off-site must not be under the influence of or consume an:

(a) Alcoholic beverage; or

(b) Illegal drug.

(2) The licensee must prohibit smoking in:

(a) All areas of the home used by the child during hours of operation when the child is in care; and

(b) A motor vehicle when the licensee or assistant transports a child.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-430, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-430, filed 2/1/91, effective 3/4/91.]

WAC 388-155-440 Limitations to persons on premises. (1) During home operating hours or while the child is in care, the only persons having regular or unsupervised access to the child in care are:

(a) The child's parent,

(b) The licensee,

(c) An employee,

(d) The licensee's family member,

(e) A volunteer, or

(f) A governmental agency representative having specific, verifiable authority for the access.

(2) The licensee must allow the parent of the child in care unsupervised access only to his or her own child.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-440, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-440, filed 2/1/91, effective 3/4/91.]

WAC 388-155-450 Child records and information. The licensee must maintain organized confidential records and information on the premises concerning each child in care. The licensee must ensure the child's record contains, at a minimum:

(1) Registration data:

(a) Name, birthdate, dates of enrollment and termination; and

(b) Name, address, and home and business telephone number of the parent and other person to be contacted in case of emergency.

(2) Authorizations:

(a) Name, address, and telephone number of the person authorized to remove from the home the child under care;

(b) Written parental consent for transportation provided by the home, including field trips and swimming, when the child participates in these activities. A parent-signed blanket consent form may authorize the child's off-site travel; and

(c) Written parental consent, or court order, for providing medical care and emergency surgery, except for such care authorized by law.

(3) Medical and health data:

(a) A health history, obtained when the licensee enrolls the child for care. The history includes:

(i) The date of the child's last physical examination;

(ii) Allergies;

(iii) Special health problems and other pertinent health information;

(iv) Immunization history as required under WAC 388-155-220;

(v) Name, address, and telephone number of the child's health care provider or facility; and

(vi) Special developmental problems.

(b) Date and kind of illness and injury occurring on the premises, including the treatment given by the licensee; and

(c) Medication given indicating dosage, date, time, and name of the dispensing person.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-450, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-450, filed 2/1/91, effective 3/4/91.]

WAC 388-155-460 Home records. The licensee must maintain the following documentation on the premises:

(1) The attendance records, completed daily, including arrival and departure times;

(2) A copy of the report sent to the licensor about the illness or injury to the child in care requiring medical treatment or hospitalization;

(3) The twelve-month record indicating the date and time the licensee conducted the required monthly fire evacuation drills;

(4) The twelve-month record indicating the date the licensee tested the battery-powered smoke detector monthly; and

(5) Attendance records and invoices for state-paid children for at least five years.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-460, filed 2/28/00, effective 3/30/00. Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-155-460, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-460, filed 2/1/91, effective 3/4/91.]

WAC 388-155-470 Personnel records. (1) Each assistant and volunteer having unsupervised or regular access to

the child in care must complete and submit to the licensee by the date of hire:

(a) An application for employment on a department-prescribed form, or its equivalent; and

(b) A criminal history and background inquiry form.

(i) The licensee must submit this form to the department for the employee and volunteer, within seven calendar days of the assistant's or volunteer's first day of employment, permitting a criminal and background history check.

(ii) The department must discuss the result of the criminal history and background inquiry information with the licensee, when applicable.

(2) The licensee, assistant, and volunteer must have on file at the home:

(a) An employment application, including work and education history;

(b) Documentation of criminal history and background inquiry form submission;

(c) A record of the tuberculin skin test results, x-ray, or an exemption to the skin test or x-ray;

(d) Documentation of HIV/AIDS education and training;

(e) Documentation of current first aid and CPR training, when applicable; and

(f) Documentation of basic and annual training required under WAC 388-155-180 (2)(d) and 388-155-200 (2)(c), when applicable.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-470, filed 2/28/00, effective 3/30/00; 98-24-052, § 388-155-470, filed 11/25/98, effective 12/26/98; 91-04-048 (Order 3136), § 388-155-470, filed 2/1/91, effective 3/4/91.]

WAC 388-155-480 Reporting of death, injury, illness, epidemic, or child abuse. The licensee shall report immediately:

(1) A death, serious injury requiring medical treatment, or illness requiring hospitalization of a child in care, by telephone and in writing, to the parent, licensor, and child's social worker, if any;

(2) An instance when the licensee or assistant has reason to suspect the occurrence of physical, sexual, or emotional child abuse, child neglect, or child exploitation, as required under chapter 26.44 RCW, by telephone, to child protective services or local law enforcement; or

(3) An occurrence of food poisoning or communicable disease, as required by the state board of health, by telephone, to the local public health department.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-480, filed 2/1/91, effective 3/4/91.]

WAC 388-155-490 Reporting of circumstantial changes. A family child care home license is valid only for the person and address named on the license. The licensee must promptly report to the licensor major changes in premises, activities and routines, the assistant, or members of the household affecting the home's capacity classification, delivery of safe, developmentally appropriate services, or continued eligibility for licensure. A major change includes the:

(1) Home's address, location, or phone number;

(2) Maximum number and age ranges of children the licensee wishes to serve as compared to current license specifications;

(3) Number and qualifications of the home's staff that may affect competencies to implement the specified activities and routines, including the death, retirement, or incapacity of a licensee;

(4) Name by which the home is commonly known;

(5) Occurrence of a fire, major structural change, or damage to the premises from any cause;

(6) Plans for major remodeling of the home, including planned use of space not previously department-approved; and

(7) Report of a person moving in or out of the household.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-490, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-490, filed 2/1/91, effective 3/4/91.]

WAC 388-155-500 Posting requirements. The licensee must post the following items, clearly visible to the parents and the assistant:

(1) The home's child care license issued under this chapter;

(2) Evacuation plans and procedures;

(3) Emergency telephone numbers; and

(4) A department-issued final notice of penalty.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-500, filed 2/28/00, effective 3/30/00; 91-04-048 (Order 3136), § 388-155-500, filed 2/1/91, effective 3/4/91.]

WAC 388-155-600 Occupancy restrictions. (1) Any home used for child day care purposes for fewer than thirteen children is considered to be a Group R, Division 3 occupancy per the state building code. Family child day care homes must meet the minimum construction and fire and safety requirements for one and two family dwellings.

If a portion of the home is used for purposes other than a dwelling, such as a garage, automotive repair shop, cabinet and/or furniture making or refinishing or similar use, a fire wall is required between the dwelling and the other use.

(2) Only one exit door from a family child day care home need be of the pivoted or side hinged swinging type. Approved sliding doors may be used for other exits.

(3) In family child day care home, each floor level used for family child day care purposes must be provided with two exits, usually located at opposite ends of the building or floor.

(4) Basements located more than four feet below grade level must not be used for family child day care purposes unless one of the following conditions exists:

(a) Two exit stairways from the basement open directly to the exterior of the building without entering the first floor; or

(b) One of the two required exits discharges directly to the exterior from the basement level and the other exit is an interior stairway with a self-closing door installed at the top or bottom leading to the floor above; or

(c) One of the two required exits is an operable window or door, approved for emergency escape or rescue, that opens directly to a public street, public alley, yard or exit court and the other may be an approved interior or exterior stairway; or

(d) A residential sprinkler system is provided throughout the entire home in accordance with standards of the National Fire Protection Association.

(5) The family child care home licensee must ensure that any floor located more than four feet above grade level is not occupied by children for family child day care purposes except for the use of toilet facilities while under supervision of a staff person.

Family child day care may be allowed on the second story if one of the following conditions exists:

(a) There are two exit stairways from the second story which open directly to the exterior of the building without entering the first floor; or

(b) There is an exit which discharges directly to the exterior from the second story level, and a second interior stairway with a self-closing door installed at the top or bottom of the interior stair leading to the floor below; or

(c) A residential sprinkler system is provided throughout the entire building in accordance with standards of the National Fire Protection Association.

(6) The maximum travel distance from any point in the home to an exterior exit door must not exceed one hundred fifty feet.

(7) Every room used for child care (except bathrooms) must have:

(a) At least one operable window or door approved for emergency escape or rescue which must open directly into a public street, public alley, yard or exit court. The units must be operable from the inside to provide a full clear opening without the use of separate tools.

The net clear openable area of an escape or rescue window must be a minimum of 5.7 square feet. The net clear openable height dimension must be a minimum of twenty-four inches. The net clear openable width dimension must be a minimum of twenty inches. An escape or rescue window must have a finished sill height of not more than forty-four inches above the floor; or

(b) Doors leading to two separate exit ways; or

(c) A door leading directly to the exterior of the building.

(8) A stationary platform may be used under a window to attain the forty-four inches above the floor.

(9) Exit doors must be easy to open to the full open position.

(10) Exit doors and windows must be able to be opened from the inside without having to use a key. Use of night latches, dead bolts, security chains, manually operated edge or surface mounted flush bolts and surface bolts is prohibited during child care hours.

The locking arrangement on outside exit doors must be such that they will automatically unlock when the doorknob is turned from the inside.

(11) The licensee must ensure that obstructions are not placed in corridors, aisles, doorways, doors, stairways or ramps.

(12) Space which is accessible only by ladder, folding stairs or trap doors, must not be used for family child day care purposes.

(13) Every bathroom door lock must be designed to permit the opening of the locked door from the outside in an emergency. The opening device must be readily accessible to the staff.

(14) Every closet door latch must be such that children can open the door from inside the closet.

[Statutory Authority: RCW 74.15.030. 00-06-040, § 388-155-600, filed 2/28/00, effective 3/30/00. Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-600, filed 4/26/96, effective 5/27/96.]

WAC 388-155-605 Hazardous areas. Rooms or spaces containing a commercial-type kitchen, boiler, maintenance shop, janitor closet, laundry, woodworking shop, flammable or combustible storage, painting operation, or parking garage shall be separated from the family child day care home or any exits by a fire wall.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-605, filed 4/26/96, effective 5/27/96.]

WAC 388-155-610 Single station smoke detectors. (1) Smoke detectors shall be located in all sleeping and napping rooms in family child day care homes.

(2) In family child day care homes with more than one story, and in family child day care homes with basements, a smoke detector shall be installed on each story and in the basement.

(3) In family child day care homes where a story or basement is split into two or more levels, the smoke detector shall be installed in the upper level, except that when the lower level contains a sleeping or napping area, a smoke detector shall be located on each level.

(4) When sleeping or napping rooms are on an upper level, the smoke detector shall be placed on the ceiling of the upper level in close proximity to the stairway and in each sleeping/napping room.

(5) In a family child day care home where the ceiling height of a room open to the hallway serving sleeping or napping rooms exceeds that of the hallway by twenty-four inches or more, smoke detectors shall be installed in both the hallway and the sleeping/napping room.

(6) Smoke detectors shall sound an alarm audible in all areas of the building.

(7) In new construction, required smoke detectors shall receive their primary power from the building wiring when such wiring is served from a commercial source. Wiring shall be permanent and without a disconnecting switch other than those required for overcurrent protection.

(8) Smoke detectors may be battery operated when installed in existing buildings or buildings without commercial power.

(9) Where battery operated smoke detectors are installed, at least one extra battery of the type and size specified for the battery operated smoke detector shall be maintained upon the premises.

(10) Single station smoke detectors shall be tested at monthly intervals or in a manner specified by the manufacturer. Records of such testing shall be maintained upon the premises.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-610, filed 4/26/96, effective 5/27/96.]

WAC 388-155-620 Alternate means of sounding a fire alarm. In addition to single station smoke detectors, family child day care homes shall provide an alternate means for sounding a fire alarm. A police type whistle or similar device is adequate for meeting this requirement, provided that whatever method is selected is limited to an evacuation emergency only.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-620, filed 4/26/96, effective 5/27/96.]

WAC 388-155-630 Fire extinguisher. (1) At least one approved 2A, 10B:C rated fire extinguisher shall be provided on each floor level occupied for day care use. Such extinguisher shall be located in the area of the normal path of egress. The maximum travel distance to an extinguisher shall not exceed seventy-five feet.

(2) Fire extinguishers shall be operationally ready for use at all times.

(3) Fire extinguisher shall be kept on a shelf or mounted in the bracket provided for this purpose so that the top of the extinguisher is not more than five feet above the floor.

(4) The licensee shall ensure that fire extinguishers receive annual maintenance certification by a firm specializing in and licensed to do such work. Maintenance means a thorough check of the extinguisher to include examination of:

(a) Mechanical parts;

(b) Extinguishing agent; and

(c) Expelling means.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-630, filed 4/26/96, effective 5/27/96.]

WAC 388-155-640 Fire prevention. (1) The licensee shall ensure that the local fire department is requested to visit the family child day care home to become familiar with the facility and to assist in planning evacuation or emergency procedures. Where a fire department does not provide this service, the licensee shall document this contact.

(2) Furnace rooms shall be maintained free of lint, grease and rubbish accumulations and other combustibles and suitably isolated, enclosed or protected.

(3) Flammable or combustible materials shall be stored away from exits and in areas which are not accessible to children. Combustible rubbish shall not be allowed to accumulate and shall be removed from the building or stored in closed, metal containers.

(4) The licensee shall keep all areas used for child care clean and neat, making sure that all waste generated daily is removed from the building and disposed of in a safe manner outside the building. All containers used for the disposal of waste material shall be of noncombustible materials with tops. Electrical motors shall be kept dust-free.

(5) Open-flame devices capable of igniting clothing shall not be left on, unattended or used in a manner which could result in an accidental ignition of children's clothing. Candles shall not be used.

(6) A flashlight shall be available for use as an emergency power source.

(7) All electrical circuits, devices and appliances shall be properly maintained. Circuits shall not be overloaded. Extension cords and multi-plug adapters shall not be used in lieu of permanent wiring and proper receptacles.

(8) The use of portable space heaters of any kind is prohibited.

(9) Approved numbers or addresses shall be placed on all new and existing homes and in the driveway to the house when the house is not visible from the road. The numbers or address shall be in such a position as to be plainly visible and legible from the street or road fronting the property. Said numbers shall contrast with their background.

(10) Fireplaces, woodstoves, similar devices and their connections shall be approved by the local building official. If the woodstove is used as a sole source of heat or is used during hours of operation, such devices shall be cleaned, maintained and inspected on at least an annual basis by a person or firm specializing in such work and licensed.

Where open flames and/or hot surfaces are accessible, approved barriers shall be erected to prevent children from coming in contact with the open flames and/or hot surfaces.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-640, filed 4/26/96, effective 5/27/96.]

WAC 388-155-650 Sprinkler system maintenance. Sprinkler systems, if installed, shall be tested on an annual basis by a person or agency qualified by licensing. The results of the system test shall be documented on forms provided by the licensor and maintained at the home for inspection by the licensor.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-650, filed 4/26/96, effective 5/27/96.]

WAC 388-155-660 Fire evacuation plan. Each home shall develop written fire evacuation plans. The evacuation plan shall include an evacuation floor plan, identifying exit doors and windows, that shall be posted at a point clearly visible to the assistant and parents. Plans shall include the following:

(1) Action to be taken by the person discovering a fire;

(2) Method to be used for sounding an alarm on the premises;

(3) Action to be taken for evacuation of the building and assuring accountability of the children; and

(4) Action to be taken pending arrival of the fire department.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-660, filed 4/26/96, effective 5/27/96.]

WAC 388-155-670 Fire evacuation drill. A fire evacuation drill shall be conducted at least once each month. A written record, the fire safety record and evacuation plan, shall be maintained and posted on the premises indicating the date, time and other required entries on the form. Such forms are available from the office of child care policy.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-670, filed 4/26/96, effective 5/27/96.]

WAC 388-155-680 Staff training. The licensee and each employee or assistant shall be familiar with all elements

of the fire evacuation plan and must be capable of accomplishing the following:

(1) Operation of fire extinguisher installed on the premises.

(2) Testing smoke detectors (single station types).

(3) Conducting frequent inspections of the home to identify fire hazards and take action to correct any hazards noted during the inspection. Such inspections should be conducted on a monthly basis and records kept on the premises for review by the licensor.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-680, filed 4/26/96, effective 5/27/96.]

WAC 388-155-991 Waiver of fees. Any person or agency subject to license fees under chapter 440-44 WAC, and organizations in the person's or agency's behalf, may submit a sworn, notarized petition seeking waiver of fees for a licensee or distinguishable class of licensee.

The petition shall be mailed or delivered to the office of the secretary. Following receipt of the petition, the secretary may require submission of additional information considered relevant.

[00-23-088, recodified as § 388-155-991, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-002, filed 6/4/82.]

WAC 388-155-992 Fee payment and refunds. (1) Fees are due with applications for initial license or renewal. The department will not proceed on applications until required fees are paid.

Except as otherwise provided in these rules, fees shall be paid for a minimum of one year.

(2) Fees for licenses issued for other than yearly periods shall be prorated based on the stated annual fee.

(3) When the department issues a license for more than one year:

(a) Fees may be paid for the entire licensing period by paying at the rate established at the time the application was submitted, or

(b) If the licensee does not pay the fee for the entire license period, annual fees shall be due thirty days prior to each annual anniversary date of the license, at the annual fee rate established by these rules at the time such fee is paid.

(4) Except as otherwise provided in these rules, if an application is withdrawn prior to issuance or denial, one-half of the fee shall be refunded.

(5) If there is a change of or by the licensee requiring a new license, the fee paid for a period beyond the next license anniversary date shall be refunded. Changes requiring a new license shall require a new application and payment of fee as provided herein.

(6) If there is a change by the applicant or licensee that requires an amendment placing the licensee in a higher fee category, the additional fee shall be prorated for the remainder of the license period.

(7) Fees becoming due on or after the effective date of this chapter shall be at the rates provided herein.

(8) To the extent fees are reduced through regular rule adoption of this chapter on or before December 31, 1982, fees shall be refunded.

(9) Fee payments shall be by mail. Payment shall be by check, draft, or money order made payable to the department of social and health services.

[00-23-088, recodified as § 388-155-992, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-010, filed 6/4/82.]

WAC 388-155-993 Denial, revocation, suspension, and reinstatement. (1) If a license is denied, revoked, or suspended, fees shall not be refunded.

(2) Application for license after denial or revocation must include fees as provided for in these rules.

(3) Failure to pay fees when due will result in suspension or denial of license.

[00-23-088, recodified as § 388-155-993, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-015, filed 6/4/82.]

Chapter 388-160 WAC

MINIMUM LICENSING REQUIREMENTS FOR OVERNIGHT YOUTH SHELTERS

WAC

WAC 388-160-010 Authority. The following minimum licensing requirements for overnight youth shelter rules are adopted under chapter 74.15 RCW, Agencies for care of children, expectant mothers, developmentally disabled.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-010, filed 7/21/93, effective 8/21/93.]

WAC 388-160-020 Definitions. (1) Terms defined under this chapter shall have the same meanings as definitions described under chapter 74.15 RCW, except as otherwise provided herein.

(2) "Capacity" means the maximum number of persons under care at a given moment in time.

(3) "Child" and "juvenile" means any person under the chronological age of eighteen years of age.

(4) "Department" means the department of social and health services.

(5) "Full-time care provider" or "full-time care facility" means a foster family home, group care facility, maternity home, crisis residential center, and juvenile detention facility for a child or expectant mothers.

(6) "Overnight youth shelter" means a licensed facility operated by a nonprofit agency providing overnight shelter to a homeless or runaway youth because of family problems or dysfunctions. Overnight youth shelters do not provide domiciliary care during daytime hours.

(7) "Youth" means a child or young adult through twenty years of age.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-020, filed 7/21/93, effective 8/21/93.]

WAC 388-160-030 Exceptions to rules. (1) In individual cases the department, at its discretion for good cause, may waive specific requirements and may approve alternative methods of achieving the intent of specific requirements.

(2) The department may neither waive specific requirements nor approve alternate methods of achieving the content of specific requirements if it jeopardizes the safety or welfare of the person in care, as described under subsection (1) of this section.

(3) The department may approve a waiver request only for a specific purpose or child and for a specific period of time not exceeding the expiration date of the license. The licensee may apply anew for the waiver when reapplying for a license.

(4) The department may limit or restrict a license issued to a licensee or applicant in conjunction with a waiver.

(5) The licensee or applicant applying for a waiver shall do so in writing and the licensee shall maintain a copy of the waiver.

(6) The department's denial of a licensee's or applicant's waiver request shall not be subject to appeal under chapter 34.05 RCW.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-030, filed 7/21/93, effective 8/21/93.]

WAC 388-160-040 Effect of local ordinances. (1) The department shall issue or deny a license on the basis of an applicant's compliance with the department's minimum licensing requirements.

(2) The department shall not enforce local ordinances, such as zoning regulations and local building codes.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-040, filed 7/21/93, effective 8/21/93.]

WAC 388-160-050 Fire standards. Overnight youth shelters shall conform to the rules and regulations adopted by the Washington state fire marshal's office establishing minimum standards for fire prevention and the protection of life and property against fire as required under RCW 74.15.050 and WAC 212-12-001. The Washington state fire marshal's standards are contained in the current state building code.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-050, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-050, filed 7/21/93, effective 8/21/93.]

WAC 388-160-060 Certification of exempt agency. An agency legally exempt from licensing may not be licensed. However, at the agency's request, the department may certify an agency as meeting licensing and other pertinent requirements to enable an agency to be eligible for the receipt of funds or for other legitimate purposes if the department's investigation finds the agency in compliance with the licensing requirements. In such cases, unless otherwise clearly evident from the text, the department's requirements and procedures for an agency's licensing apply equally to certification.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-060, filed 7/21/93, effective 8/21/93.]

WAC 388-160-070 Application or reapplication for license or certification—Investigation. (1) A person or organization applying for a license or for certification under this chapter shall:

(a) Submit the application on forms prescribed by the department;

(b) Comply with department procedures;

(c) Initiate the application in the name of the person or legal entity responsible for the agency's operation; and

(d) Include with the application:

(i) Employment and educational history of the person charged with the active management of the agency;

(ii) Completed forms enabling the department to:

(A) Perform a criminal history check;

(B) Check the department's master files for each staff or volunteer of the agency having unmonitored access to the child, expectant mother, or developmentally disabled person; and

(C) Share this information with the applicant or licensee.

(2) The department may:

(a) Require additional information from the applicant, licensee, their staff, and persons having access to a child

under care as the department deems necessary including, but not limited to:

(i) Sexual deviancy evaluations;

(ii) Substance and alcohol abuse evaluations;

(iii) Psychiatric evaluations;

(iv) Psychological evaluations; and

(v) Medical evaluations.

(b) Perform corollary investigations of the applicant, licensee, and their staff, and as the department deems necessary, including accessing of criminal histories and law enforcement files.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-070, filed 7/21/93, effective 8/21/93.]

WAC 388-160-080 Limitations on licenses and dual licensure. The department shall not issue a license to an applicant for both an overnight youth shelter and another category of residential care which the department licenses or is licensed by another department. The department may authorize an exception only if it is clearly evident that care of one category of client does not interfere with the safety and quality of care provided to other client categories.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-080, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-080, filed 7/21/93, effective 8/21/93.]

WAC 388-160-090 General qualifications of licensee, applicant, and persons on the premises. (1) The applicant, licensee, staff, and other person on the premises shall be a person of good character.

(2) The licensee or applicant shall demonstrate that the licensee or applicant, child care staff, volunteer, and other person having access to a person under care have the understanding, ability, physical health, emotional stability, and personality suited to meet the physical, mental, emotional, and social needs of the person under care.

(3) A person shall be disqualified from providing care if the department determines that the person is ineligible to provide care under chapter 388-330 WAC or that person has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130.

(4) The department may, at any time, require the licensee or person on the premises to provide additional information so the department can determine whether the licensee, adoptive applicant, child care staff, volunteer, and other person having access to a child in care meet the qualifications under subsections (1), (2), and (3) of this section. The department may require the licensee or person on the premises to provide additional information including, but not limited to:

(a) Sexual deviancy evaluations;

(b) Substance and alcohol abuse evaluations;

(c) Psychiatric evaluations;

(d) Psychological evaluations; and

(e) Medical evaluations.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-160-090, filed 4/26/96, effective 5/27/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-090, filed 7/21/93, effective 8/21/93.]

WAC 388-160-100 Age of licensee. An applicant for an overnight youth shelter license under this chapter shall be twenty-one or more years of age.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-100, filed 7/21/93, effective 8/21/93.]

WAC 388-160-110 Posting of license. All licensees shall post the license issued under this chapter at the overnight youth shelter in a place accessible and conspicuous to the public.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-110, filed 7/21/93, effective 8/21/93.]

WAC 388-160-120 Licensure—Denial, suspension, or revocation. (1) Before granting a license and as a condition for continuance of a license, the department shall consider the ability of each applicant, licensee, and chief executive officer, if any, to operate the agency under the law and this chapter. The department shall consider such persons separately and jointly as applicants or licensees and if any one be deemed disqualified by the department under chapter 74.15 RCW or this chapter, the department may deny, suspend, revoke, or not renew the license. The department shall deny, suspend, revoke, or not renew a license for the following reasons:

(a) The department shall disqualify any person engaging in illegal use of drugs or excessive use of alcohol;

(b) The department shall disqualify any person who has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130, is ineligible to provide care because of a criminal history under chapter 388-330 WAC, or allows such person on the premises;

(c) The department shall disqualify any person convicted of a felony or released from a prison within seven years of the date of application for the license because of the conviction, when:

(i) The person's conviction is reasonably related to the person's competency to exercise responsibilities for ownership, operation, or administration of an agency; and

(ii) The department determines, after investigation, the person has not been sufficiently rehabilitated to warrant public trust.

(d) The department shall not grant a license to an applicant who, in this state or elsewhere:

(i) Has been denied a license to operate an agency for the care of a child, an expectant mother, or a developmentally disabled adult; or

(ii) Had a license to operate such an agency suspended or revoked.

(2) An applicant of an overnight youth shelter may establish by clear, cogent, and convincing evidence the ability to operate an agency under this chapter. The department may waive the provision and license the applicant as described under subdivision (1)(d) of this section.

(3) The department may deny, suspend, revoke, or not renew a license for failure to comply with the provisions of chapter 74.15 RCW and rules contained in this chapter. The department shall deny, suspend, revoke, or not renew a license for the following reasons:

(a) Obtaining or attempting to obtain a license by fraudulent means or misrepresentation, including:

(i) Making materially false statements on the application; or

(ii) Material omissions which would influence appraisal of the applicant's or provider's suitability.

(b) Permitting, aiding, or abetting the commission of any illegal act on the premises;

(c) Permitting, aiding, or abetting the abuse, neglect, exploitation, or cruel or indifferent care to a person under care;

(d) Repeatedly:

(i) Providing insufficient personnel relative to the number and types of persons under care; or

(ii) Allowing a person unqualified by training, experience, or temperament to care for, or be in contact with, the person under care.

(e) Misappropriation of the property of a person under care;

(f) Failure or inability to exercise fiscal responsibility and accountability in respect to operation of the agency;

(g) Failure to provide adequate supervision to a person under care;

(h) Refusal to admit authorized representatives of the department, department of health, or state fire marshal to inspect the premises;

(i) Refusal to permit:

(A) Authorized representatives of the department and the department of health to have access to the records necessary for the operation of the agency; or

(B) The department representatives to interview agency staff and clients.

(j) Knowingly having an employee or volunteer on the premises who has made misrepresentation or significant omissions on the application for employment or volunteer service; and

(k) Refusal or failure to supply necessary additional department-requested information.

(4) The department may deny, suspend, revoke, or not renew or modify a license for violation of any condition or limitation upon licensure including, but not limited to, providing care for:

(a) More children than the number for which the agency is licensed; or

(b) Children of ages different from the ages for which the agency is licensed.

(5) The department shall deny, suspend, or revoke a licensee's license when the applicant, licensee, or person on the premises is a perpetrator of child abuse or has been convicted of a crime as listed under WAC 388-330-030(1). The department may grant a licensee or provider a waiver if it is demonstrated by clear, cogent, and convincing evidence that such person is rehabilitated and is able to comply with licensing requirements. In making this determination, the department shall consider:

(a) The seriousness and circumstances of the person's illegal act;

(b) The number of crimes of which the person was convicted;

(c) The amount of time passed since the person committed the illegal act;

(d) The age of the person at the time of convictions;

(e) Whether the person has entered and successfully completed all appropriate rehabilitative services, including those services ordered by a court;

(f) The behavior of the person since the illegal act was committed;

(g) Recommendations of persons closely associated with the person;

(h) The duties the person would perform at the agency, and the vulnerability of the persons under care; and

(i) Other evidence of rehabilitation.

If the department licenses or approves a person under this section, the department may place limitations or conditions on the person in the performance of the person's duties at the agency.

(6) The department's notice of a denial, revocation, suspension, or modification of a license shall be governed by RCW 43.20A.205. The provider's right to an adjudicative proceeding is in the same law.

(a) A provider contesting a department licensing decision shall within twenty-eight days of receipt of the decision:

(i) File a written application for an adjudicative proceeding by a method showing proof of receipt with the office of appeals; and

(ii) Include in or with the application:

(A) A specific statement of the issues and law involved;

(B) The grounds for contesting the department decision; and

(C) A copy of the department decision.

(b) The proceeding shall be governed by the Administrative Procedure Act chapter 34.05 RCW, RCW 43.20A.205, this chapter, and chapter 388-08 WAC. If any provision of this chapter conflicts with chapter 388-08 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-160-120, filed 4/26/96, effective 5/27/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-120, filed 7/21/93, effective 8/21/93.]

WAC 388-160-130 Licensed capacity. (1) The number of persons for whom the department will license an agency is dependent upon the evaluation of:

(a) The physical accommodations of the agency;

(b) The numbers and skills of the licensee, staff, family members and volunteers; and

(c) The ages and characteristics of the persons to be served.

(2) The department shall not license an agency for the care of more persons than permitted by the rules regarding the category of care for which the license is sought.

(3) The department may license an agency for the care of fewer persons than normally permitted by the rules based on the evaluation of items listed under subsection (1) of this section.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-130, filed 7/21/93, effective 8/21/93.]

WAC 388-160-140 Discrimination prohibited. The licensee shall comply with federal and state statutory and regulatory requirements regarding nondiscrimination in employment practices and client services as described under chapter 49.60 RCW.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-140, filed 7/21/93, effective 8/21/93.]

WAC 388-160-150 Religious activities. The overnight youth shelter licensee shall:

(1) Respect the rights of persons in care to observe the tenets of the person's faith and shall facilitate those rights consistent with state and federal laws;

(2) Not punish a person in care for exercising these rights;

(3) Submit to the department a written description of any religious policies and practices.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-150, filed 7/21/93, effective 8/21/93.]

WAC 388-160-160 Discipline. (1) The overnight youth shelter licensee shall state disciplinary practices in writing. Discipline shall be a responsibility of the licensee or staff, and shall not be prescribed or administered by persons under care. Discipline shall be based on an understanding of the person's needs and stage of development. A person's discipline shall be designed to help the person develop inner control, acceptable behavior, and respect for the rights of others.

(2) The licensee shall ensure a person's discipline is fair, reasonable, consistent, and related to the person's behavior. A licensee shall not administer cruel and unusual discipline, discipline hazardous to health, and frightening or humiliating discipline.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-160, filed 7/21/93, effective 8/21/93.]

WAC 388-160-170 Corporal punishment. (1) Corporal punishment is prohibited.

(2) Prohibited corporal punishment shall not include the use of such amounts of physical restraint as may be reasonable and necessary to:

(a) Protect a person on the premises from physical injury;

(b) Obtain possession of a weapon or other dangerous object; and

(c) Protect property from serious damage.

(3) The licensee of an overnight youth shelter shall not use mechanical restraints including, but not limited to:

(a) Handcuffs;

(b) Belt restraints; and

(c) Locked time-out rooms.

(4) The licensee shall not use physical restraints which could be injurious including, but not limited to:

(a) Large adult sitting on or straddling a small child;

(b) Sleeper holds;

(c) Arm twisting;

(d) Hair holds; and

(e) Throwing a child or youth against a wall, furniture, or other large immobile object.

(5) Staff employed in a facility where it may be necessary to restrain a child shall be trained in the use of appropriate restraining techniques.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-170, filed 7/21/93, effective 8/21/93.]

WAC 388-160-180 Abuse, neglect, or exploitation. An overnight youth shelter licensee shall protect persons, while in the licensee's care, from child abuse or neglect as defined under RCW 26.44.020(12).

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-180, filed 7/21/93, effective 8/21/93.]

WAC 388-160-190 Site and telephone. An overnight youth shelter licensee shall locate the shelter on a well-drained site free from hazardous conditions and accessible to other facilities necessary to carry out its program. The licensee shall ensure the shelter has one or more telephones on the premises accessible for emergency use at all times.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-190, filed 7/21/93, effective 8/21/93.]

WAC 388-160-200 Equipment, safety, and maintenance. (1) An overnight youth shelter licensee shall:

(a) Maintain the physical plant, premises, and equipment in a clean and sanitary condition, free of hazards, and in good repair;

(b) Provide handrails on stairs as determined necessary by the department;

(c) Have available one or more emergency light sources, such as a flashlight, in operational condition; and

(d) Provide toilet rooms and other rooms subject to moisture with washable, moisture impervious floors.

(2) Shelter staff members shall have a means to gain rapid access to any bedroom, toilet room, shower room, bathroom, or other room occupied by youth should an emergency need arise.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-200, filed 7/21/93, effective 8/21/93.]

WAC 388-160-210 Firearms and other weapons. An overnight youth shelter licensee shall ensure no firearms or other weapons are on the premises except those confiscated and secured from youth upon admission and these shall be locked up.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-210, filed 7/21/93, effective 8/21/93.]

WAC 388-160-220 Prohibited substances. (1) During operating hours when youth are in care, the overnight shelter licensee, staff, and volunteers on shelter premises or caring for youth off-site shall not be under the influence of, consume, or possess an:

(a) Alcoholic beverage; or

(b) Illegal drug.

(2) The overnight shelter licensee shall prohibit smoking in:

(a) A transport vehicle when shelter staff are transporting youth in care; and

(b) The shelter when youth are in care; except, the licensee may permit a person to smoke only in a designated smoking room which is ventilated to the outside in such a manner that passive tobacco smoke cannot contaminate the indoor shelter air.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-220, filed 7/21/93, effective 8/21/93.]

WAC 388-160-230 Storage. An overnight youth shelter provider shall ensure a shelter provides:

(1) Suitable space as needed for the storage of:

(a) Clothing and personal possessions of youth in care;

(b) Records and files;

(c) Cots;

(d) Mats and bedding; and

(e) Cleaning supplies and other materials.

(2) A secure area for cleaning supplies, toxic substances, poisons, aerosols, and items bearing warning labels, which is inaccessible to youth. The provider shall ensure all containers filled from a stock supply bear a label identifying the product name and concentration.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-230, filed 7/21/93, effective 8/21/93.]

WAC 388-160-240 Bedrooms and sleeping areas. An overnight youth shelter licensee shall ensure the shelter:

(1) Provides sleeping areas not less than fifty square feet per occupant of unobstructed floor area with ceiling height of not less than seven feet, six inches;

(2) Not use hallways and kitchens as sleeping rooms;

(3) Maintains a space not less than thirty inches between sleeping youths;

(4) Provides sleeping areas separated by a visual barrier five or more feet high for each sex of youth in care; and

(5) In facilities caring for youth sixteen through twenty years of age, separates youths under eighteen years of age from youths eighteen through twenty years of age by a supervised open space or a physical barrier to prevent contact.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-240, filed 7/21/93, effective 8/21/93.]

WAC 388-160-250 Kitchen facilities. An overnight youth shelter licensee shall ensure the shelter providing food service:

(1) Provides for the proper storage, preparation, and service of food to meet the needs of the program;

(2) Has facilities and implements practices as required under chapter 246-215 WAC, rules and regulations of the state board of health, which governs food service sanitation.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-250, filed 7/21/93, effective 8/21/93.]

WAC 388-160-260 Housekeeping sink. An overnight youth shelter shall have and use:

(1) A method of drawing clean mop water; and

(2) An appropriate method of waste water disposal.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-260, filed 7/21/93, effective 8/21/93.]

WAC 388-160-270 Laundry. An overnight youth shelter shall:

(1) Provide for separate storage of soiled linen and clean linen;

(2) Have access to laundry washing and drying facilities, which may include using on-premises or off-site equipment;

(3) Locate laundry equipment, if on the premises, in an area separate from the kitchen; and

(4) Sanitize laundry using a hot water temperature of at least one hundred thirty degrees Fahrenheit or an effective chemical method, or have the laundry done by a commercial service.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-270, filed 7/21/93, effective 8/21/93.]

WAC 388-160-280 Toilets, handwashing sinks, and bathing facilities. An overnight youth shelter shall provide:

(1) Two or more indoor flush-type toilets, each with one nearby handwashing sink with hot and cold running water;

(2) Toilets and handwashing sinks in a ratio of one toilet and sink for each eight persons on the premises plus the major fraction thereof, allowing four additional persons before requiring additional fixtures;

(3) Privacy for persons of the opposite sex at toilets, and bathing facilities, if provided;

(4) Hot and cold running water not exceeding one hundred twenty degrees Fahrenheit at handwashing sinks, and bathing facilities, if provided;

(5) A conveniently located grab bar or nonslip floor surfaces in bathing facilities, if provided;

(6) Urinals in lieu of toilets only if the urinals do not replace more than one-third of the total required toilets; and

(7) Soap and individual towels, disposable towels, or other approved single-use hand drying devices at handwashing sinks, and any bathing facilities if bathing facilities are provided.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-280, filed 7/21/93, effective 8/21/93.]

WAC 388-160-290 Lighting. An overnight youth shelter shall provide and locate fixtures for the comfort and safety of the youth in care.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-290, filed 7/21/93, effective 8/21/93.]

WAC 388-160-300 Pest control. An overnight youth shelter shall keep the premises free from rodents, flies, cockroaches, and other insects.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-300, filed 7/21/93, effective 8/21/93.]

WAC 388-160-310 Sewage and liquid wastes. An overnight youth shelter shall discharge sewage and liquid wastes into:

(1) A public sewer system; or

(2) A local health authority or department approved independent sewage system.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-310, filed 7/21/93, effective 8/21/93.]

WAC 388-160-320 Water supply. An overnight youth shelter shall provide:

(1) A potable water supply approved by the local health authority or department; and

(2) Disposable paper cups, individual drinking cups or glasses, or inclined-jet drinking fountains.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-320, filed 7/21/93, effective 8/21/93.]

WAC 388-160-340 Health and emergency policies and procedures. An overnight youth shelter shall have:

(1) Current written health policies and procedures including, but not limited to, first aid, infection control, care of minor illnesses, and general health practices and actions to be taken in event of medical and other emergencies;

(2) These health policies and procedures readily available for staff orientation and for implementation; and

(3) Emergency phone numbers posted next to the phone.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-340, filed 7/21/93, effective 8/21/93.]

WAC 388-160-350 First aid. An overnight youth shelter shall:

(1) Have one or more persons having completed a current basic Red Cross first-aid course or a department-approved first-aid course, and current training in cardiopulmonary resuscitation (CPR) present at all times youth are in care;

(2) Maintain documentation of persons having completed the first aid and CPR training on the premises; and

(3) Keep first-aid supplies readily available to shelter staff.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-350, filed 7/21/93, effective 8/21/93.]

WAC 388-160-360 Medication management. An overnight youth shelter shall:

(1) Secure any medication brought into the shelter by a youth so it is unavailable to other youth in care;

(2) Supervise self-administration of a medication according to the prescription or manufacturer's label on the original medication container; and

(3) Return a medication of a youth when the youth leaves the facility, or properly dispose of the medication if left behind by the youth.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-360, filed 7/21/93, effective 8/21/93.]

WAC 388-160-370 Staff health. Each licensee, employee, adult volunteer, and other adult persons having regular contact with persons in care shall have a tuberculin skin test, by the Mantoux method, upon overnight youth shelter employment or licensing unless medically contraindicated.

(1) A person whose TB skin test is positive (ten millimeters or more induration) shall have a chest X-ray within ninety days following the skin test.

(2) A person shall not require a routine periodic retesting or X-ray (biennial or otherwise) after the entry testing.

(3) A person shall not require an entry test whose TB skin test has been documented as negative (less than ten millimeters) within the last two years, and such person shall not require a routine periodic retesting or biennial X-ray or otherwise.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-370, filed 7/21/93, effective 8/21/93.]

WAC 388-160-380 HIV/AIDS education and training. An overnight youth shelter shall provide or arrange for appropriate education and training of employees on the prevention, transmission, and treatment of HIV and AIDS as prescribed by the department of health. Such education and training shall be consistent with the curriculum manual *KNOW-HIV/AIDS Prevention Education for Health Care Facility Employees*, January 1991, published by the Washington state HIV/AIDS program, department of health.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-380, filed 7/21/93, effective 8/21/93.]

WAC 388-160-390 Nutrition. An overnight youth shelter providing meals shall consider the age, cultural background, and nutritional requirements of youth served when preparing meals.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-390, filed 7/21/93, effective 8/21/93.]

WAC 388-160-400 Bedding. An overnight youth shelter providing youth sleeping equipment and bedding shall maintain the equipment and bedding in good repair and in a clean and sanitary manner. The shelter shall accept the use of sleeping and bedding equipment personally provided by youth in care.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-400, filed 7/21/93, effective 8/21/93.]

WAC 388-160-410 Overnight youth shelters—Purpose and limitations. The purpose of the overnight youth shelter shall be to provide youth an emergency sleeping arrangement. The overnight youth shelter shall make every effort to refer a youth to appropriate services. The overnight youth shelter providing shelter for a teen parent with child shall assure adequate quarters and services for infants and very young children. The overnight youth shelter may be licensed to provide care for either:

(1) Children from thirteen through seventeen years of age; or

(2) Youths sixteen through twenty years of age.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-410, filed 7/21/93, effective 8/21/93.]

WAC 388-160-420 Governing body/citizens board for overnight youth shelters. (1) Every overnight youth shelter shall have a governing body/citizens board which shall comply with all laws and rules concerning nonprofit boards of directors.

(2) The shelter facility shall keep on file a list of the current membership of the governing body citizens board.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-420, filed 7/21/93, effective 8/21/93.]

WAC 388-160-430 Intake. (1) An overnight youth shelter shall provide an intake consisting of an initial assessment of entering youth and shall include, but not be limited to:

(a) Recent history;

(b) Outstanding warrants;

(c) Physical and medical needs, including medication;

(d) Whether parents are aware of the youth's whereabouts and want the youth at home;

(e) School status;

(f) Adult to contact, if one is available;

(g) Immediate need for counseling; and

(h) Options for the near future.

(2) The overnight youth shelter shall notify the department of social and health services (DSHS) or the police of an unaccompanied child twelve years of age or younger who is requesting service.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-430, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-430, filed 7/21/93, effective 8/21/93.]

WAC 388-160-440 Groupings. (1) The overnight youth shelter shall provide sleeping areas for males and females which are separated by partitions.

(2) In facilities caring for youths sixteen through twenty years of age, sleep areas for those sixteen and seventeen years of age shall be spatially separated from those eighteen through twenty years of age to the extent permitted by the configurations of the facility.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-440, filed 7/21/93, effective 8/21/93.]

WAC 388-160-460 Staffing. (1) An overnight youth shelter shall adhere to the following staff/child ratios:

(a) A shelter licensed for youths thirteen through seventeen years of age exclusively shall have a staff/child ratio of one staff person to every eight youth or major fraction (five or more) thereof;

(b) A shelter caring for youths sixteen through twenty years of age on the premises shall have a staff/child ratio of one staff person to every six youth or major fraction (four or more) thereof.

(2) Within the ratios in subsection (1) of this section:

(a) At least one fully trained lead counselor shall be on the premises at all times children are present; and

(b) At least one staff person shall remain awake while youths are asleep. Other staff persons may be asleep, but shall be available in the shelter in case of emergency;

(c) Whenever only one staff person is on duty, there shall be a second staff person on call.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-460, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-460, filed 7/21/93, effective 8/21/93.]

WAC 388-160-470 Supervision of youth. In an open or dormitory type setting, an overnight youth shelter staff person shall be within visual and auditory range of youths at all times when the youths are within the shelter.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-470, filed 7/21/93, effective 8/21/93.]

WAC 388-160-480 Child care workers—Qualifications. (1) All overnight youth shelter child care staff and volunteers shall:

(a) Be eighteen years of age or older. Staff twenty years of age or younger shall be under the immediate supervision of staff twenty-one years of age or older;

(b) Have completed a criminal history check;

(c) Have completed a TB test, as required under WAC 388-73-142; and

(d) Have completed HIV/AIDS training as required under WAC 388-73-143 within sixty days of beginning employment or volunteer service at the shelter.

(2) Overnight youth shelter child care workers shall be of both sexes to reflect the population in care.

(3) One person with full training plus having one year's experience with high-risk adolescents shall be present at all times that youths are in care as described under section 500 (1) and (2) of this chapter.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-480, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-480, filed 7/21/93, effective 8/21/93.]

WAC 388-160-490 Program supervision. (1) The department shall require every overnight youth shelter to have a program supervisor.

(a) The program supervisor shall have a:

(i) Master's degree in social work or a related field and one year's experience with high-risk adolescents; or

(ii) Bachelor's degree and three years' experience with high-risk adolescents.

(b) The program supervisor shall provide two hours of supervision to youth shelter child care staff or volunteers for each forty hours that staff work.

(2) A master's degree level person with counseling experience with high-risk/troubled adolescents or a bachelor's degree level person with at least three years counseling experience with high-risk/troubled adolescents shall be on call at all times when the overnight youth shelter is open or when children are present. This person may be on staff, or on contract, or available by written agreement.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-490, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-490, filed 7/21/93, effective 8/21/93.]

WAC 388-160-500 Training. (1) All overnight youth shelter staff and volunteers shall receive training before providing care for youth. The overnight youth shelter shall ensure this training includes, but is not limited to:

(a) Job responsibilities;

(b) Agency administration;

(c) Supervision of youths;

(d) Basic behavior management;

(e) Fire safety procedures; and

(f) Handling emergency situations.

(2) The overnight youth shelter shall ensure that staff receive training in the following areas within sixty days of beginning employment or volunteer service:

(a) AIDS/HIV;

(b) Cultural sensitivity; and

(c) Behavior management.

(3) New overnight youth shelter staff shall work shifts with fully trained staff until the new staff's own training has been completed.

(4) An overnight youth shelter shall offer or make available to staff and volunteers in-service training to cover policies appropriate to each position, to include supervisory skills, adolescent development and problems, and meeting the needs of youths. The shelter's training should include, but not be limited to:

(a) Sexual abuse;

(b) Predatory behavior;

(c) Substance abuse;

(d) Depression;

(e) Mental health;

(f) Teen suicide; and

(g) Injurious or assaultive behavior toward oneself or others.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-500, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-500, filed 7/21/93, effective 8/21/93.]

WAC 388-160-510 Services. (1) At a minimum, all overnight youth shelters shall offer the following services to all clients:

(a) Client intake including demographic information and emergency contacts (phone number), presenting problems (school status, medical problems, family situation, suicide evaluation, history of assaultive/predatory behavior, and drug/alcohol involvement);

(b) Individual crisis intervention;

(c) Assistance in accessing emergency resources, including child protective services (CPS) and emergency medical services; and

(d) Resource information;

(2) An overnight youth shelter shall provide resource information as needed for appropriate educational, vocational, placement, housing, medical, substance abuse, mental health, other treatment agencies, and food program, or to DSHS office.

(3) If appropriate ancillary services are not provided by the licensed program, the overnight youth shelter licensee shall demonstrate working relationships with organizations providing services to targeted young people.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-510, filed 7/21/93, effective 8/21/93.]

WAC 388-160-520 Client records and information—Overnight youth shelters. The overnight youth shelter shall maintain records and information concerning persons in care in such a manner as to preserve their confidentiality. The shelter shall maintain records giving the following information on each youth under care in the same shelter in which the youth is sheltered:

(1) Identifying information, including:

(a) Name;

(b) Birth date;

(c) Date of admission;

(d) Ethnicity; and

(e) Other appropriate information.

(2) Names, addresses, and telephone numbers, if any, of parents' or other persons' home or business to contact in case of emergency;

(3) Dates and kinds of illnesses and accidents, medications and treatments prescribed, the time they are given, and by whom; and

(4) Daily log of attendance, admission, referrals, exit, and important information.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-520, filed 7/21/93, effective 8/21/93.]

WAC 388-160-530 Personnel policies and records—Overnight youth shelters. (1) Each overnight youth shelter employee and volunteer having unsupervised or regular access to the youth or child in care shall complete and submit to the licensee or director by the date of hire:

(a) An employment application on a department-prescribed form, or its equivalent; and

(b) A criminal history and background inquiry form.

(i) The licensee shall submit this form to the department for the employee and volunteer, within seven calendar days of the employee's first day of employment, permitting a criminal and background history check.

(ii) The department shall discuss the inquiry information with the licensee or director, when applicable.

(2) The overnight youth shelter licensee employing five or more persons shall have written personnel policies describing staff benefits, if any, duties, and qualifications.

(3) The overnight youth shelter licensee shall maintain a personnel recordkeeping system, having on file for the licensee, staff person, and volunteer:

(a) An employment application, including work and education history;

(b) Documentation of criminal history and background inquiry form submission;

(c) A record of a negative Mantoux, tuberculin skin tests results, X-ray, or an exemption to the skin test or X-ray;

(d) Documentation of HIV/AIDS education and training;

(e) A record of participation in staff development training;

(f) Documentation of orientation program completion;

(g) Documentation of a valid food handler permit, when applicable;

(h) Documentation of current first aid and CPR training, when applicable; and

(i) Telephone number of "on-call" master or bachelor degree level person with other emergency telephone numbers.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-530, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-530, filed 7/21/93, effective 8/21/93.]

WAC 388-160-540 Reporting of death, injury, illness, epidemic, or child abuse. The overnight youth shelter licensee or staff shall report immediately:

(1) A death, serious injury requiring medical treatment, or illness requiring hospitalization of a child in care, by telephone and in writing, to the parent if contact information is known, licensor, and child's social worker, if any;

(2) An instance when the licensee or staff has reason to suspect the occurrence of physical, sexual, or emotional child abuse, neglect, or child exploitation, by telephone, to child protective services (CPS) or local law enforcement as required under chapter 26.44 RCW; and

(3) An occurrence of food poisoning or communicable disease, as required by the state board of health, by telephone, to the local public health department.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-540, filed 7/21/93, effective 8/21/93.]

WAC 388-160-550 Reporting runaway youth. (1) Within eight hours of learning a youth staying at the shelter is away from home without parental permission, shelter staff shall report the location of the youth to:

(a) The parent;

(b) The law enforcement agency having jurisdiction in the shelter's area; or

(c) The department.

(2) The shelter staff shall:

(a) Make the report by telephone or any other reasonable means; and

(b) Document the report in writing in the youth's file.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-550, filed 10/4/96, effective 11/4/96.]

WAC 388-160-560 Reporting circumstantial changes. An overnight youth shelter's license shall be valid only for the address and organization named on the license. The overnight youth shelter licensee shall promptly report to the licensor major changes in staff, program, or premises affecting the shelter classification, delivery of safe and appropriate services, or continued eligibility for licensure. The overnight youth shelter licensee shall include as a major change:

(1) Shelter address, location, space, or phone number;

(2) Maximum number, age ranges, and sex of children the licensee wishes to serve as compared to current license specifications;

(3) Number or qualifications of the shelter's staffing pattern that may affect staff competencies to implement the specified program, including:

(a) Change in ownership, chief executive, director, or program supervisor; and

(b) The death, retirement, or incapacity of the licensee.

(4) Name of licensed corporations, or name by which the overnight youth shelter is commonly known, or changes in the shelter's articles of incorporation and bylaws;

(5) Occurrence of a fire, major structural change, or damage to the premises; and

(6) Plans for major remodeling of the shelter, including planned use of space not previously department approved.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-560, filed 7/21/93, effective 8/21/93.]

Chapter 388-165 WAC

CHILDREN'S ADMINISTRATION CHILD CARE SUBSIDY PROGRAMS

WAC

Reviser's note: Chapter 388-165 (Consolidated emergency assistance program—Social services (CEAP-SS)) was repealed by 98-01-125, filed 12/18/98. WSR 99-15-076, filed 7/20/99 reactivated and renamed this chapter.

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 388-165-108 What are the types of child care subsidies? This chapter relates to the following programs:

(1) Seasonal child care;

(2) Teen parent child care;

(3) Child protective services child care;

(4) Child welfare services child care; and

(5) Employed foster parent child care.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-108, filed 10/22/99, effective 11/22/99.]

WAC 388-165-110 Definitions. The following definitions apply to WAC 388-15-171, 388-15-174, 388-15-175 and 388-15-176.

"Child" means a person twelve years of age or younger or a person under nineteen years of age who is physically, mentally, or emotionally incapable of self care as verified by a licensed medical practitioner or masters level or above mental health professional.

"Co-payment" means the amount of money the family is responsible to pay the child care provider toward the cost of child care each month.

"Income" means the gross earned income minus the average payroll and income tax paid at that income level, plus any unearned income.

"In-home/relative child care provider" see definition for **"in-home/relative provider"** under WAC 388-290-020.

"Parent" see definition for **"parent"** under WAC 388-290-020.

"Teen parent" means a parent twenty-one years of age or younger.

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

WAC 388-165-120 Subsidized child care for teen parents. (1) The department may authorize teen parent child care within available funds for parents who:

(a) Are twenty-one years of age or younger;

(b) Are enrolled in an approved secondary education or general equivalency diploma (GED) program;

(c) Are not receiving a temporary assistance for needy families (TANF) grant; and

(d) Have an income at or below one hundred seventy-five percent of the Federal Poverty Level (FPL).

(2) All teen parents contribute to the cost of child care by making a monthly co-payment to the child care provider which is:

(a) Determined by the teen parent's income; and

(b) Calculated by using the rules under WAC 388-290-090 (2)(a), (b), and (c)(i) and (ii).

(3) The department funds child care only during the portion of the day when the child's parent(s) is unable to provide necessary care and supervision due to the parents participation in DSHS approved activities.

[99-15-076, recodified as § 388-165-120, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-171, filed 10/22/98, effective 11/22/98.]

WAC 388-165-130 Subsidized child care for seasonal workers. (1) The department may purchase seasonal child care within available funds for children residing in Washington state where:

(a) Both parents, or the single parent (in the case of the one-parent family), are currently employed or seeking work in agriculturally related work;

(b) Fifty percent or more of the family's annual income is derived from agriculturally related work;

(c) In a two-parent household, the primary wage earner is employed in agricultural work for eleven months or less with

any given employer, in the twelve months previous to the time of application;

(d) In a one-parent household, the single parent is employed in agricultural work for eleven months or less with any given employer, in the twelve months previous to the time of application; and

(e) The family's monthly income, averaged for the twelve months prior to the time of application, is at or below one hundred and seventy-five percent of the FPL.

(2) Failure of the parent(s) to meet the requirements of (b) of this subsection due to receipt of TANF within the past twelve months shall not result in ineligibility for seasonal child care.

(3) The parent(s) participates in the cost of child care by making a monthly co-payment to the child care provider which is:

(a) Determined by the parent's income averaged for the twelve months prior to the time of application; and

(b) Calculated by using the rules under WAC 388-290-090 (2)(a), (b), and (c)(i) and (ii).

(4) The department will fund child care during the portion of the day described under WAC 388-15-171(3).

[99-19-087, recodified as § 388-165-130, filed 9/17/99, effective 9/17/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-174, filed 10/22/98, effective 11/22/98.]

WAC 388-165-140 Child care for child protective services (CPS) and child welfare services (CWS). The department may purchase CPS/CWS child care within available funds for children of families in need of support as part of a CPS/CWS case plan. This service is short-term and time-limited. Social workers must determine if other resources are available to meet this need before authorizing payment by the department.

[99-15-076, recodified as § 388-165-140, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-175, filed 10/22/98, effective 11/22/98.]

WAC 388-165-179 When are DSHS child care subsidy rates in this chapter effective? (1) DSHS child care subsidy rates in this chapter are effective on or after November 1, 1999 when a family:

(a) Has a change that requires their authorization to be updated;

(b) Is newly authorized to receive child care subsidies; or

(c) Is reauthorized to continue receiving child care subsidies.

(2) DSHS child care subsidy rates are authorized at the provider's usual rate or the DSHS maximum child care subsidy rate, whichever is less.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-179, filed 10/22/99, effective 11/22/99.]

WAC 388-165-180 What are the maximum child care subsidy rates DSHS pays for child care in a licensed or certified child care center? DSHS pays directly to a licensed or certified child care center, whichever is less:

(1) The provider's usual rate for that child; or

(2) The DSHS maximum child care subsidy rate for that child as listed in the following table.

DSHS Maximum Child Care Subsidy Rate for Licensed Child Care Centers

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	$22.73	$19.85	$18.00	$16.70
	Half-Day	$11.36	$9.93	$9.00	$8.35
Region 2	Full-Day	$23.18	$20.45	$17.75	$16.82
	Half-Day	$11.59	$10.23	$8.88	$8.41
Region 3	Full-Day	$30.18	$26.00	$22.00	$19.77
	Half-Day	$15.09	$13.00	$11.00	$9.89
Region 4	Full-Day	$37.80	$29.55	$26.14	$23.40
	Half-Day	$18.90	$14.77	$13.07	$11.70
Region 5	Full-Day	$25.82	$22.18	$19.45	$17.50
	Half-Day	$12.91	$11.09	$9.73	$8.75
Region 6	Full-Day	$25.59	$22.73	$20.00	$20.00
	Half-Day	$12.80	$11.36	$10.00	$10.00

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-180, filed 10/22/99, effective 11/22/99.]

WAC 388-165-185 What are the maximum child care subsidy rates DSHS pays for child care in a licensed or certified family child care home? DSHS pays directly to a licensed or certified family child care provider, whichever is less:

(1) The provider's usual rate for that child; or

(2) The DSHS maximum child care subsidy rate for that child as listed in the following table.

DSHS Maximum Child Care Subsidy Rate for Licensed Family Child Care Homes

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	$19.00	$17.60	$17.00	$15.00
	Half-Day	$9.50	$8.80	$8.50	$7.50
Region 2	Full-Day	$18.00	$18.00	$16.00	$15.00
	Half-Day	$9.00	$9.00	$8.00	$7.50
Region 3	Full-Day	$28.00	$24.00	$22.00	$20.00
	Half-Day	$14.00	$12.00	$11.00	$10.00
Region 4	Full-Day	$30.00	$27.27	$25.00	$22.50
	Half-Day	$15.00	$13.64	$12.50	$11.25
Region 5	Full-Day	$21.00	$20.00	$19.00	$17.00
	Half-Day	$10.50	$10.00	$9.50	$8.50
Region 6	Full-Day	$20.50	$20.00	$18.00	$17.00
	Half-Day	$10.25	$10.00	$9.00	$8.50

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-185, filed 10/22/99, effective 11/22/99.]

WAC 388-165-190 When can DSHS pay in addition to the maximum DSHS child care subsidy rate? DSHS pays additional subsidies to a licensed or certified family child care home or center when:

(1) Care is for nonstandard hours (see WAC 388-165-195 and 388-165-200);

(2) The infant bonus is authorized (see WAC 388-165-205);

(3) A child has a documented special need(s) (see WAC 388-165-210, 388-165-215, or 388-165-220); or

(4) Care is not available at the DSHS rate and the provider's usual rate is authorized.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-190, filed 10/22/99, effective 11/22/99.]

WAC 388-165-195 What is nonstandard hour child care? DSHS authorizes nonstandard hour child care when fifteen or more hours of care are needed per month, that are:

(1) Before 6:00 a.m. or after 6:00 p.m. Monday through Friday; and/or

(2) Anytime on Saturday or Sunday.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-195, filed 10/22/99, effective 11/22/99.]

WAC 388-165-200 How does DSHS pay for nonstandard hour child care? DSHS authorizes the nonstandard hour bonus to licensed or certified child care providers, DSHS pays:

(1) The DSHS maximum child care subsidy rate as listed in WAC 388-165-180 or 388-165-185 or the provider's usual rate for that child, whichever is less; and

(2) The monthly nonstandard hour bonus as listed in the table below.

Monthly Nonstandard Hour Bonus	
Region 1	$74.00
Region 2	$73.00
Region 3	$91.00
Region 4	$108.00
Region 5	$80.00
Region 6	$83.00

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-200, filed 10/22/99, effective 11/22/99.]

WAC 388-165-205 Does DSHS pay a bonus for infants who receive child care subsidies? DSHS child care subsidy programs pay a two hundred and fifty dollar infant bonus directly to the licensed or certified family child care home or center if:

(1) The child care facility has not already received a bonus for that infant;

(2) The infant was first enrolled in the child care facility after August 30, 1998;

(3) The infant is less than one year old; and

(4) The provider cares for the infant a total of five or more days before the child's first birthday.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-205, filed 10/22/99, effective 11/22/99.]

WAC 388-165-210 How does DSHS determine that a child qualifies for a special needs rate? To qualify for the DSHS child care programs special needs subsidy rate the child must:

(1) Be under nineteen years old;

(2) Have a verified physical, mental, emotional, or behavioral condition that requires a higher level of care; and

(3) Have their condition and need for higher level of care verified by a health, mental health, or education professional with at least a master's degree.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-210, filed 10/22/99, effective 11/22/99.]

WAC 388-165-215 What is the DSHS child care subsidy rate for children with special needs in a licensed or certified child care center? DSHS pays child care subsidies for a child with special needs to licensed or certified child care centers as described in WAC 388-165-180 and whichever of the following is greater:

(1) The provider's documented additional cost associated with the care of that child with special needs; or

(2) The rate listed in the table below.

Licensed Child Care Centers Special Needs Rate

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	$6.82	$5.96	$5.40	$5.01
	Half-Day	$3.41	$2.98	$2.70	$2.51
Region 2	Full-Day	$6.95	$6.14	$5.33	$5.05
	Half-Day	$3.48	$3.07	$2.66	$2.52
Region 3	Full-Day	$9.05	$7.80	$6.60	$5.93
	Half-Day	$4.53	$3.90	$3.30	$2.97
Region 4	Full-Day	$11.34	$8.86	$7.84	$7.02
	Half-Day	$5.67	$4.43	$3.92	$3.51
Region 5	Full-Day	$7.75	$6.65	$5.84	$5.25
	Half-Day	$3.87	$3.33	$2.92	$2.63
Region 6	Full-Day	$7.68	$6.82	$6.00	$6.00
	Half-Day	$3.84	$3.41	$3.00	$3.00

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-215, filed 10/22/99, effective 11/22/99.]

WAC 388-165-220 What is the DSHS child care subsidy rate for children with special needs in a licensed or certified family child care home? DSHS pays child care subsidies for a child with special needs to licensed or certified family child care homes as described in WAC 388-165-195 and whichever of the following is greater:

(1) The provider's documented additional cost associated with the care of that child with special needs; or

(2) The rate listed in the table below.

Licensed Family Child Care Homes Special Needs Bonus

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	$5.70	$5.28	$5.10	$4.50
	Half-Day	$2.85	$2.64	$2.55	$2.25
Region 2	Full-Day	$5.40	$5.40	$4.80	$4.50
	Half-Day	$2.70	$2.70	$2.40	$2.25
Region 3	Full-Day	$8.40	$7.20	$6.60	$6.00
	Half-Day	$4.20	$3.60	$3.30	$3.00
Region 4	Full-Day	$9.00	$8.18	$7.50	$6.75
	Half-Day	$4.50	$4.09	$3.75	$3.38

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 5	Full-Day	$6.30	$6.00	$5.70	$5.10
	Half-Day	$3.15	$3.00	$2.85	$2.55
Region 6	Full-Day	$6.15	$6.00	$5.40	$5.10
	Half-Day	$3.08	$3.00	$2.70	$2.55

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-220, filed 10/22/99, effective 11/22/99.]

WAC 388-165-225 What is the DSHS in-home/relative child care rate for children with special need? DSHS subsidy programs pay in-home/relative child care providers for care of a child with special needs (as described in WAC 388-15-185) two dollars per hour plus whichever is greater of the following:

(1) Sixty-two cents per hour; or

(2) The provider's documented additional cost associated with the care for that child with special needs.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-225, filed 10/22/99, effective 11/22/99.]

WAC 388-165-230 What is the maximum child care subsidy rate DSHS pays for in-home/relative child care? (1) The DSHS child care subsidy programs pay toward the cost of child care directly to the parent, who is the employer. DSHS pays whichever of the following that is less:

(a) Two dollars and six cents per hours for the child who needs the greatest amount of care and one dollar and three cents per hour for the care of each additional child in the family; or

(b) The provider's usual rate for that care.

(2) DSHS may pay above the maximum rate for children who have special needs as stated in WAC 388-165-225.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-230, filed 10/22/99, effective 11/22/99.]

WAC 388-165-235 In-home/relative child care. (1) When the parent(s) chooses in-home/relative child care, the parent(s) will give the in-home/relative child care provider's name and address to the department and make the following assurances at the time child care is authorized:

(a) The in-home/relative provider is:

(i) Eighteen years of age or older;

(ii) Of sufficient physical, emotional, and mental health to meet the needs of the child in care. If requested by the department, the parent(s) must provide written evidence that the in-home child care provider of the parent's choice is of sufficient physical, emotional, and mental health to be a safe child care provider;

(iii) Able to work with the child without using corporal punishment or psychological abuse;

(iv) Able to accept and follow instructions;

(v) Able to maintain personal cleanliness; and

(vi) Prompt and regular in job attendance.

(b) The child is current on the immunization schedule as described in the National Immunization Guidelines, developed by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices;

(c) The home where care is provided is safe for the care of the child; and

(d) The in-home/relative child care provider is informed about basic health practices, prevention and control of infectious disease, immunizations, and home and physical premises safety relevant to the care of the child.

(2) The in-home/relative child care provider's primary function while on duty is to provide child care. The in-home/relative child care provider will have the following responsibilities:

(a) Provide constant care and supervision of the child for whom the provider is responsible throughout the arranged time of care in accordance with the needs of the child; and

(b) Provide developmentally appropriate activities for the child who is under the in-home/relative child care provider's care.

(3) The department provides the parent(s) with information about basic health practices, prevention and control of infectious diseases, immunizations, and building and physical premises safety relevant to the care of the child.

[99-15-076, recodified as § 388-165-235, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-176, filed 10/22/98, effective 11/22/98.]

WAC 388-165-240 What are the parent/guardian payment responsibilities when they choose in-home/relative child care? The parent is the employer of the in-home/relative provider. The parent:

(1) Pays the provider the entire amount that DSHS gives them toward the cost of care;

(2) Pays the provider the amount that was authorized for a co-payment;

(3) Requires the in-home/relative provider to sign a receipt when they receive payment;

(4) Keeps the receipts for DSHS to review at the next eligibility determination; and

(5) Keeps accurate attendance records.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-240, filed 10/22/99, effective 11/22/99.]

WAC 388-165-245 What is the responsibility of DSHS regarding child care subsidies for in-home/relative child care? (1) On all payments DSHS makes toward the cost of in-home/relative child care, DSHS pays the employer's share of:

(a) Social Security taxes;

(b) Medicare taxes;

(c) Federal Unemployment Taxes (FUTA); and

(d) State unemployment taxes (SUTA) when applicable.

(2) On all payments DSHS makes toward the cost of in-home/relative child care DSHS withholds the following taxes:

(a) Social security taxes up to the wage base limit; and

(b) Medicare taxes.

(3) If an in-home/relative child care provider receives less than one thousand one hundred dollars per family in a

calendar year, DSHS refunds all withheld taxes to the provider.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-245, filed 10/22/99, effective 11/22/99.]

WAC 388-165-250 When can DSHS pay toward the cost of in-home/relative child care provided outside the child's home? DSHS will pay toward the cost of child care provided in the relative's home by the following adult relative of the child:

(1) Siblings and stepsiblings living outside the child's home;

(2) Grandparents;

(3) Aunts;

(4) Uncles;

(5) First cousins;

(6) Great grandparents;

(7) Great aunts;

(8) Great uncles; and

(9) Extended family members as determined by law or custom of the Indian child's tribe.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-250, filed 10/22/99, effective 11/22/99.]

Chapter 388-200 WAC

FINANCIAL AND MEDICAL ASSISTANCE—GENERAL PROVISIONS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-200-1100 Grievance procedure. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1100, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1100, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-389.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-200-1150 Exception to rule. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1150, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-20-010.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-200-1160 Notification of exception to rule request and decision. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1160, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-23-387.] Repealed by 00-03-035, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035.

388-200-1400 Application of rules—Temporary assistance to needy families. [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.] Repealed by 00-22-063, filed 10/27/00, effective 11/27/00. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.04.055.

WAC 388-200-1050 Department and client responsibilities. (1) The department and the client shall:

(a) Have a dual responsibility to determine and maintain eligibility for public assistance in the initial or redetermination of eligibility for assistance;

(b) Further, the department shall provide accommodation services to clients who have a mental, neurological, physical or sensory impairment or who otherwise have limitations which seriously affect their abilities to access programs in the same manner as those who are unimpaired.

(2) The department shall have the responsibility to:

(a) Treat a client with dignity and courtesy;

(b) Give a client sufficient opportunity to make pertinent needs and accommodation needs known to the department;

(c) Inform a client what the department can, or cannot, do for the client;

(d) Respect the rights of a client under the U.S. Constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990 and all other relevant provisions of federal and state law when:

(i) Taking an application;

(ii) Determining eligibility;

(iii) Administering financial and medical assistance programs; and

(iv) Providing accommodation to individuals who have a mental, neurological, sensory, or physical impairment.

(e) Avoid practices which violate the client's privacy or subject the client to harassment;

(f) Inform a client of:

(i) The client's rights and responsibilities concerning eligibility for, and receipt of, assistance;

(ii) All factors which may affect the client's continuing eligibility for assistance;

(iii) Changes of law or rule which affect the client's eligibility; and

(iv) His or her right to reasonable accommodations.

(g) Act promptly and correctly on all known changes which affect the client's eligibility for assistance;

(h) Offer voter registration assistance to clients during face-to-face interviews at:

(i) Application;

(ii) Eligibility review or recertification; and

(iii) Change of address.

(i) Accommodate clients per WAC 388-200-1300(7).

(3) The client has the responsibility to:

(a) Report all changes in the client's circumstances which affect eligibility for assistance. The client must report changes in writing promptly and accurately; and

(b) Take any reasonable action to develop resources which will reduce or eliminate the client's need for public assistance.

[Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1050, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.04.050 and 1993 National Voter Registration Act, SSA Sect. 402 (a)(9) and 403 (a)(3). 94-23-128 (Order 3807), § 388-200-1050, filed 11/23/94, effective 1/1/95. Statutory Authority: RCW 74.08.090. 94-10-065

(Order 3732), § 388-200-1050, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-38-030, 388-38-250, 388-38-255 and 388-38-260.]

WAC 388-200-1200 Translation of written communications with a limited English proficient client. The department shall fully translate the following written communications into the primary language of the limited English proficient client:

(1) A notice requesting information or action which requires a response from the client to determine:

(a) Initial eligibility; or

(b) Continuing eligibility for assistance;

(2) A notice of approval, denial, or withdrawal of an application for assistance;

(3) A notice of termination, suspension or reduction of assistance;

(4) A notice describing client rights and responsibilities;

(5) A notice requiring a client's signature or informed consent; and

(6) A notice of an overpayment of public assistance benefits.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1200, filed 5/3/94, effective 6/3/94. Formerly WAC 388-38-045.]

WAC 388-200-1250 Gifts, bequests by will, and contributions. (1) The department may accept a gift, bequest, or contributions in cash, or otherwise, from an association or corporation.

(2) The department shall not accept a gift or contribution from a person applying for, or receiving, public assistance.

(3) The department shall not advise any person desiring information or assistance regarding the preparation of a will. The department shall advise the person to contact an attorney, or the local legal aid society.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1250, filed 5/3/94, effective 6/3/94.]

WAC 388-200-1300 Necessary supplemental accommodation services (NSA). (1) "NSA clients" are individuals, who have a mental, neurological, physical or sensory impairment or who otherwise have limitations which seriously affect their abilities to access programs in the same manner as those who are unimpaired.

(2) All department staff have a continuing responsibility to identify and assist NSA clients. Also see, WAC 388-200-1050 (2)(b), and WAC 388-200-1050 (2)(d)(iv), regarding client rights to self-identification and accommodation.

(3) The department shall screen all applicants with whom its staff come into direct contact in order to identify NSA clients.

(a) The department shall provide an explanation of NSA services to all clients upon initiation of the NSA screening.

(b) The department shall initially identify all individuals included in subsections (i) and (ii) below as NSA, unless the client declines NSA services.

(i) Clients who identify themselves as requiring NSA services in order to access the department's services and programs.

(ii) Clients in the following categories:

(A) Identified as having or claiming to have a mental health impairment;

(B) Having a developmental disability;

(C) Disabled by drug addiction or alcoholism;

(D) Unable to read or write in any language;

(E) A minor not residing with parents.

(c) The department shall initially identify as NSA all individuals who are observed to have cognitive limitations, regardless of the presence or absence of an underlying disability, which are likely to prevent them from understanding the nature of NSA services and affect their ability to access department programs.

Cognitive limitations include limitations on ability to communicate, understand, remember, process information, exercise judgement and make decisions, perform routine tasks or relate appropriately with others.

(4) The department shall mark all cases identified as NSA with a uniform NSA identifier.

(5) Clients initially identified as NSA under subsection (3)(b)(ii) and (c) above will be assessed to confirm the NSA designation.

(6) Based on client request or changes in the client's needs, the NSA designation and/or accommodation plan may be assessed and revised.

(7) An accommodation plan which specifies the auxiliary aids and services to be provided the client to improve the client's access to department programs and services will be developed for clients determined NSA.

(8) The following NSA services shall be included in the accommodation plan of clients determined NSA under subsections (3)(b)(ii) and (c) above.

(a) Arranging for or providing assistance with completion and submission of forms;

(b) Assisting in obtaining information necessary to determine eligibility or to maintain current benefits;

(c) Explaining the department's adverse actions, see WAC 388-245-1000;

(d) Assisting with requests for fair hearings;

(e) Assisting with requests for continuing benefits;

(f) Providing follow-up contact on missed appointments or deadlines;

(g) Providing notification to the NSA individual's known advocate when informational requests or adverse action notices are pending;

(h) Providing protective payments as appropriate, in accordance with WAC 388-265-1250 (3) and (6).

(9) The department shall redirect and hold warrants for NSA clients through the twentieth day of the month following the month that adverse action notice was given, when the department is unable to determine eligibility. If eligibility is determined within the twenty-day period, the department will release to the client the correct grant amount the client would have been eligible to receive for the month in which redirection occurred. See WAC 388-245-1350;

(10) The department shall consider the effects of the NSA client's limitation or impairment on the client's ability to: accept or pursue required medical treatment, accept or pursue referrals to other agencies, provide timely monthly income reports, voluntarily quit employment, participate in food stamp employment and training, or participate in the job

opportunities and basic skills (JOBS) program. The department shall find the client has good cause for refusal or failure to comply with these requirements and shall take no adverse action when the effects of the client's limitation or impairment substantially contributed to the client's noncompliance.

[Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1300, filed 12/30/96, effective 1/30/97.]

WAC 388-200-1350 Dispute resolution for clients needing supplemental accommodations. (1) An applicant or recipient has the right to file a grievance with the department in accordance with the grievance procedures provided in WAC 388-200-1100, regarding any aspect of NSA services. The department shall offer to assist a client who expresses dissatisfaction with NSA services with filing and pursuing a grievance.

(2) Department decisions as to NSA designations, accommodation plans or NSA services do not in themselves provide a basis for a fair hearing until the client has first completed the grievance process. This provision does not limit the client's rights to raise NSA designations, accommodation plans and NSA services in a fair hearing where they are relevant to other issues which are the subject of the fair hearing.

(3) Failure to follow NSA requirements does not in itself invalidate department actions, except where the applicant or recipient was denied benefits for which he/she could have established eligibility had the department followed NSA requirements.

(4) The department shall review the decision to terminate, suspend or reduce financial assistance to NSA recipients upon request. The department shall reinstate financial assistance for those months for which the department can determine that the client met program eligibility requirements and the adverse action:

(a) Was taken because of the client's failure to comply with a department requirement;

(b) The failure to comply was substantially related to the client's impairment; and

(c) Was taken no more than ninety days prior to the request.

(5) The department may reinstate assistance when the adverse action was taken more than ninety days prior to the request where administratively feasible and not prohibited by state or federal law.

[Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1350, filed 12/30/96, effective 1/30/97.]

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 388-265 WAC
PAYMENT OF GRANTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-265-1010 Grant payment—General provisions. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1010, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-015, 388-33-020, 388-33-025, 388-33-050, 388-33-051 and 388-33-055.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-265-1050 Grant authorization. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1050, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-080, 388-33-085 and 388-33-095.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-265-1100 Grant payee. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1100, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-400 and 388-33-455.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

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).

388-265-1400 Vendor payee. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1400, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-440 and 388-33-460.] Repealed by 98-24-051, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.08.090.

388-265-1550 Client notification of protective payee or vendor payee. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1550, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-444, 388-33-446 and 388-33-457.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-265-1700 Confidential information—Protective payee or vendor payee. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1700, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-449.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-265-1750 Protective payee fees. [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).] Repealed by 00-19-078, filed 9/19/00, effective 10/20/00. Statutory Authority: RCW 74.08.090, 74.08.280.

388-265-1800 Warrant endorsement. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1800, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-525.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-265-1850	Warrant delivery. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1850, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-535, 388-33-545 and 388-33-550.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-265-1900	Warrant cancellation. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1900, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-585.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-265-1950	Loss, theft, or destruction of a client's warrant. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1950, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-576.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-265-2000	Loss, theft, or destruction of a vendor warrant. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-2000, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-579.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-265-1150 Protective payee—General information. (1) A protective payee is a person or agency who manages client cash benefits to provide for basic needs - housing, utilities, clothing, child care and food. They may also provide services such as training clients in money management.

(2) Clients are assigned to protective payees for the following reasons:

(a) Emergency or temporary situations where a child is left without a caretaker (TANF/SFA);

(b) Noncooperation with WorkFirst program requirements (TANF/SFA); or

(c) Mismanagement of money (TANF/SFA or GA).

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1150, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1150, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-440 and 388-33-455.]

WAC 388-265-1155 Protective payee selection. (1) Clients may ask for a particular protective payee, but the department makes the final choice.

(2) Protective payees must contract with the department, except for employees of the department who are assigned this function as part of their job duties.

(3) A departmental employee acting as protective payee cannot:

(a) Have the client in their caseload,

(b) Have the client in the caseloads of other employees under their supervision,

(c) Be responsible for determining or issuing benefits for the client,

(d) Be the office administrator,

(e) Be a special investigator.

(4) For TANF/SFA, a department employee cannot act as protective payee when the department has legal custody or responsibility for placement and care of the child.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1155, filed 11/25/98, effective 12/26/98.]

WAC 388-265-1200 Emergency and temporary protective payees (TANF/SFA). An emergency protective payee is assigned when a caretaker relative is not available to take care of and supervise a child due to an emergency.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1200, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1200, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-420 (part).]

WAC 388-265-1250 Protective payee or vendor payment due to mismanagement of money. (1) The decision to assign a person to a protective payee because of mismanagement of funds must be based in law, such as teen parents (RCW 74.04.0052) or on documented evidence in the case file. The documentation must be current and show that the mismanagement threatens the well being of a child on TANF/SFA or of the client. Examples of evidence are:

(a) Department employees or others observe the client or client's children are hungry, ill, or not adequately clothed.

(b) Repeated requests for more money, for example emergency additional requirements, or for basic essentials such as food, utilities, clothing, and housing.

(c) A series of evictions or utility shut offs.

(d) Medical or psychological evaluations.

(e) An ADATSA alcohol/drug assessment which establishes incapacity due to alcoholism or drug addiction.

(f) Nonpayment of an in home child care provider when payment has been issued by the department for that purpose.

(g) Complaints from vendors showing a pattern of failure to pay bills or rent.

(2) A lack of money or a temporary shortage of money because of an emergency does not constitute mismanagement.

(3) When a client has a history of mismanaging money, benefits can be paid directly to vendors or through a protective payee.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1250, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-265-1250, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1250, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-420, 388-33-430, 388-33-440 and 388-33-455.]

WAC 388-265-1275 Assigning TANF/SFA or GA pregnant or parenting minors to protective payee. Clients are assigned to protective payees if the clients are:

(1) Under age 18; and

(2) Unmarried; and

(3) Pregnant or have a dependent child.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1275, filed 11/25/98, effective 12/26/98. 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 388-265-1300 Assigning TANF/SFA clients sanctioned for noncooperation or nonparticipation with WorkFirst activities to protective payees. (1) Clients in their second month of sanction for noncooperation or nonparticipation in WorkFirst work activities must be assigned to protective payees.

(2) Clients under sanction remain in protective payee status until they cooperate with WorkFirst and the sanction is removed, as long as they are receiving assistance.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1300, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1300, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-450 (part).]

WAC 388-265-1375 Transfer from protective payees to guardianship. (1) In emergency cases where a person is physically or mentally unable to manage their own funds, the client is referred to other divisions of the department for full care, including guardianship.

(2) In cases where a child is eligible for TANF/SFA and the caretaker relative does not use the benefits for adequate care of the child, the case can be referred to the attorney general to establish a limited guardianship.

(3) This process is used only if it appears there is a need for services to go beyond two years.

(4) These guardianships are limited to management of DSHS benefits.

(5) The protective payee plan is changed if a guardian is appointed. The guardian is designated as the payee.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1375, filed 11/25/98, effective 12/26/98.]

WAC 388-265-1450 Protective payee responsibility and fees. (1) The protective payee's responsibilities are to:

(a) Manage client funds to pay bills for basic needs, such as housing and utilities, and as directed in the protective payee plans;

(b) Provide money management for client when this item is included in the protective payee plans;

(c) Urge clients to comply with WorkFirst and other program requirements, such as getting a job or attending school;

(d) Provide reports to the department on client progress.

(2) Protective payee vendors are paid up to forty dollars administrative fees per assigned client per month.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1450, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1450, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-455 (part).]

WAC 388-265-1500 Protective payee plans. (1) A protective payee plan is developed for each case assigned to a protective payee.

(2) A copy of the plan is provided to:

(a) The protective payee; and

(b) The client.

(3) Protective payee status must be reviewed:

(a) After an initial three month period; and

(b) At least every six months beyond the initial period for on-going cases.

(4) Reviews include evaluation of:

(a) The need for the client to continue in protective payee status;

(b) The need to change the plan;

(c) The client's potential to assume control of their funds (or be removed from protective payee status); and

(d) Protective payee performance.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1500, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1500, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-442, 388-33-448 and 388-33-458.]

WAC 388-265-1600 Ending protective payee status and changing payees. A client may be removed from a protective payee when a:

(1) Protective payee requests the client be reassigned;

(2) Different protective payee is assigned; or

(3) Protective payee is no longer required.

[Statutory Authority: RCW 74.08.090. 98-24-051, § 388-265-1600, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1600, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-446 and 388-33-457.]

WAC 388-265-1650 Your fair hearing rights regarding protective payment. You have the right for a fair hearing if you disagree with:

(1) the department's decision to:

(a) assign payment of benefits through a protective payee,

(b) continue assignment, or

(c) change the protective payee to another provider.

(2) the contents of your protective payee plan; or

(3) the protective payee selected for you.

[Statutory Authority: RCW 74.08.090, 74.08.280. 00-19-078, § 388-265-1650, filed 9/19/00, effective 10/20/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1650, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-459.]

Chapter 388-280 WAC
UNITED STATES REPATRIATION PROGRAM

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-280-1010 Purpose. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1010, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1020 Definition. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1020, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1030 Application. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1030, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1040 Repaying repatriation assistance. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1040, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1050 Safeguarding information. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1050, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1060 Referral to other agencies. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1060, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

WAC 388-280-0010 What is the United States Repatriation Program? The United States Repatriation Program assists a U.S. citizen or dependent who is:

(1) Without financial resources; and

(2) Returned or brought back to the U.S. from a foreign country because of:

(a) Mental illness; or

(b) Destitution, physical illness, or a crisis such as war.

For the purposes of this chapter, "we" and "us" means the department of social and health services.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0010, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0020 How do I apply for repatriation assistance? You apply for repatriation assistance by contacting the U.S. State Department or us.

(1) If you contact the U.S. State Department, we consider a referral from them as an approved application.

(2) If you contact us directly, we apply for you to the U.S. Department of Health and Human Services (HHS).

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0020, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0030 Do I have to repay the repatriation assistance? Repatriation assistance is a loan. You, or your representative if you are mentally ill, must:

(1) Sign a statement recognizing repatriation assistance as a loan; and

(2) Agree to repay the funds.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0030, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0040 Are there limits to my income and resources? (1) You are ineligible to receive repatriate assistance if you have nonexempt:

(a) Income, as defined by temporary assistance for needy families (TANF) equal to or greater than the TANF need standards as described in WAC 388-450-0005; or

(b) Resources, as defined by TANF under WAC 388-470-0005 that are available to meet your resettlement needs.

(2) We consider a resource available to you when:

(a) The value can be determined;

(b) It is controlled by you; and

(c) You can use the resource to meet your needs.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0040, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0050 How long can I receive repatriation assistance? (1) If you are mentally ill, you receive temporary care until you:

(a) Can be released to the care of a relative or state agency; or

(b) Are discharged or granted release from hospitalization.

(2) If you are not mentally ill, you may receive repatriation assistance up to twelve months as follows:

(a) "Temporary assistance" meaning repatriation assistance provided during the first ninety days after you return to the United States.

(b) "Extended assistance" meaning repatriation assistance provided for up to nine months after the end of your temporary assistance. We must have approval in advance from HHS, so you must ask us to apply for extended assistance while receiving temporary assistance and be:

(i) Ineligible for any other assistance program; and

(ii) Unable to support or care for yourself due to age, illness, or lack of job skills.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0050, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0060 What services are available to me under the Repatriation Program? (1) The HHS sets limits on how much we pay for repatriation assistance. The limits are:

(a) The temporary assistance for needy families (TANF) payment standards under WAC 388-478-0015 for goods and services to meet basic needs;

(b) Up to five hundred sixty dollars per person to meet resettlement costs, if necessary, and for only one month while you receive temporary assistance.

(2) Within payment limits, repatriation assistance includes:

(a) Travel to your place of residence, limited to:

(i) One domestic trip at the lowest fare and using the most direct means;

(ii) Meals and lodging while you are traveling;

(iii) Money for incidentals; and

(iv) If you are ill or disabled, travel expenses for an escort.

(b) Goods and services necessary for your health and welfare, including:

(i) Transportation for medical treatment, hospitalization or social services;

(ii) Temporary shelter;

(iii) Meals;

(iv) Clothing;

(v) Hospitalization to treat mental or acute illness or other medical care; and

(vi) Guidance, counseling and other social services.

(c) Resettlement costs, including:

(i) Utility or housing deposits; and

(ii) Basic household goods, such as cookware or blankets.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0060, filed 9/19/00, effective 11/1/00.]

Chapter 388-290 WAC
WORKING CONNECTIONS CHILD CARE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-290-020 Subsidized child care—Definitions. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-020, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-020, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-020, filed 11/8/95, effective 12/9/95.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-025 Subsidy units and copayments. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-025, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-025, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-030 Responsibilities for the department, the consumer, and the provider under the subsidized child care program. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-030, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-035 Providers eligible for payment under the subsidized child care program. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-035, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-035, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-040 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.

388-290-050 Eligible children and consumers under the subsidized child care program. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-050, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-050, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-055 Payment for subsidized child care. [Statutory Authority: RCW 74.04.050. 98-21-005, § 388-290-055, filed 10/9/98, effective 11/9/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-055, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-060 Adequate notice requirements and effective dates. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-060, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-070 Self-employment and subsidized child care. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-070, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-080 Subsidized child care—Fair hearings. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-080, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-090 Subsidized child care—Income eligibility, copayments rates, and when to calculate copayments. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-090, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-090, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

388-290-105 Subsidized child care—Overpayments. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-105, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

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.

388-290-550 How does the department figure my adjusted earned income? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-550, filed 6/28/99, effective 7/1/99.] Repealed by 00-17-005, filed 8/2/00, effective 9/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule).

WAC 388-290-010 What is the purpose of the working connections child care program? Working connections

child care (WCCC) helps low-income families with children pay for child care to find jobs, keep their jobs, and get better jobs.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-010, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050. 98-21-005, § 388-290-010, filed 10/9/98, effective 11/9/98. Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-010, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-010, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-010, filed 11/8/95, effective 12/9/95.]

WAC 388-290-015 What basic steps does the department take to decide if I'm eligible for WCCC? We take the following basic steps to decide if you're eligible for WCCC:

"We," for the purposes of this chapter, means the department of social and health services.

(1) We determine:

(a) If you're participating in an approved activity (see WAC 388-290-125, 388-290-150, or 388-290-200);

(b) If you and your children are otherwise eligible for WCCC (see WAC 388-290-300);

(c) Your family size under WCCC guidelines (see WAC 388-290-400);

(d) Your countable income, which must be at or below two hundred twenty-five percent of the Federal Poverty Level (FPL) (see WAC 388-290-600);

(e) Your share of the child care cost, called a copayment (see WAC 388-290-650);

(2) After you make your own child care arrangements, we decide if we can pay your child care provider under WCCC guidelines (see WAC 388-290-850).

(3) We look at other WCCC program requirements, when needed (see WAC 388-290-900, 905, 910, 915, 920, 925, 930, and 935).

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-015, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-015, filed 6/28/99, effective 7/1/99.]

WAC 388-290-075 Who is a consumer in WCCC? In WCCC, **consumer** means one of the following individuals who has parental control and applies for or receives WCCC for one or more children:

(1) Parents, stepparents, or legal guardians;

(2) Adult siblings or step-siblings, first cousins, nephews or nieces;

(3) Aunts, uncles, grandparents or any of these relatives with the prefix great, such as great-aunt.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-075, filed 6/28/99, effective 7/1/99.]

WAC 388-290-125 What activities can the department pay WCCC for if I get a temporary aid for needy families (TANF) grant? (1) If you get TANF or SFA, we can pay WCCC for your hours of participation in the following activities:

(a) An approved WorkFirst activity under chapter 388-310 WAC;

(b) Employment or self-employment under WAC 388-290-200;

(c) Your education or training program if you have a prior approved JOBS plan for that program and you are:

(i) Making progress that is satisfactory or better, as defined by your program; and

(ii) Working twenty or more hours per week, or sixteen or more hours per week in a workstudy job.

(d) Your training program for up to twelve months if:

(i) You don't have a prior approved JOBS plan;

(ii) The program is adult basic education (ABE), English as a second language (ESL), high school/GED, vocational education or job skills training under chapter 388-310 WAC;

(iii) You're making progress that is satisfactory or better, as defined by your program;

(iv) You're working twenty or more hours per week, or sixteen or more hours per week in a workstudy job; and

(v) You're enrolled at least half-time in your program as defined in chapter 388-310 WAC.

(2) If required, we can also pay WCCC for:

(a) Transportation time between your place of employment or approved activity and the location of child care; and

(b) Sleep time directly related to your job, such as if you work nights and sleep days.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-125, filed 6/28/99, effective 7/1/99.]

WAC 388-290-150 What activities can the department pay WCCC for if I don't get a TANF grant? If you don't get TANF, we can pay WCCC for your hours of participation in the following activities:

If you are:	Then to get WCCC you must be:
(1) Employed or self-employed.	Employed or self-employed under WAC 388-290-200
(2) In an education or training program.	(a) Enrolled in adult basic education (ABE), English as a second language (ESL), high school/GED, vocational education or job skills training under chapter 388-310 WAC; (b) Making progress that is satisfactory or better as defined by your program; (c) Working: (i) Twenty or more hours per week; or (ii) Sixteen or more hours per week in a workstudy job; and (d) Participating in the program for no longer than thirty-six months.
(3) In same-day job search.	A TANF applicant whom we have determined has potential for immediate employment or re-employment.

If you are:	Then to get WCCC you must be:
(4) In an employment retention activity under chapter 388-310 WAC.	Engaged in employment retention: (a) For no more than one year following your exit from TANF; and (b) Working: (i) Twenty or more hours per week; or (ii) Sixteen or more hours per week in a workstudy job.
(5) In a labor exchange activity under chapter 388-310 WAC.	Engaged in labor exchange: (a) For no more than two years following your exit from TANF; and (b) Working: (i) Twenty or more hours per week; or (ii) Sixteen or more hours per week in a workstudy job.
(6) A food stamp recipient.	Eligible for the food stamp employment and training program under chapter 388-444 WAC.
(7) In the re-employ Washington workers (RWW) program, operated by the employment security department.	Enrolled in the RWW program under chapter 388-310 WAC.

(8) If required, we can also pay WCCC for:

(a) Transportation time between your place of employment or approved activity and the location of child care; and

(b) Sleep time directly related to your job, such as if you work nights and sleep days.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-150, filed 6/28/99, effective 7/1/99.]

WAC 388-290-200 Can the department pay WCCC if I'm self-employed? We can pay WCCC if you're self-employed, as follows:

(1) If you get TANF, you must have an approved self-employment plan under chapter 388-310 WAC. The amount of WCCC you can get for self-employment is equal to the number of hours in your approved plan.

(2) If you don't get TANF, for your first six months of self-employment starting from when you become eligible for WCCC, the amount of WCCC you can get each month is based on the greater of:

(a) A written statement from you on the number of hours you need based on the number of hours you work; or

(b) The number of hours equal to dividing your monthly self-employment income by the federal or state minimum wage, whichever is lower.

"Self-employment income" means your gross income from self-employment minus allowable business expenses in WAC 388-450-0085.

(3) After the first six months, the amount of WCCC you can get each month is based on the lesser of subsections (2)(a) or (b) of this section.

(4) You must make available to the department records which show all your business expenses and income.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-200, filed 6/28/99, effective 7/1/99.]

WAC 388-290-270 Can the department authorize WCCC if I'm not working or in an approved activity right now? (1) We can authorize WCCC payments for up to two weeks if you get TANF and you're waiting to enter an approved activity.

(2) We can authorize WCCC payments for up to four weeks if you experience a gap in employment, or approved activity, and you meet all the following conditions:

(a) The gap happens for reasons out of your control, such as a layoff;

(b) Employment, or the approved activity, will resume within that period or you're looking for another job; and

(c) You received WCCC immediately before the gap in employment, or approved activity.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-270, filed 6/28/99, effective 7/1/99.]

WAC 388-290-280 Can the department pay WCCC for activity fees or bonuses? (1) We can pay initial and ongoing annual registration fees up to fifty dollars per child to your child care provider, only if the fees are:

(a) Required of all parents whose child(ren) are in care with that provider; and

(b) Needed to maintain a child care arrangement.

(2) We can pay ongoing activity fees of up to twenty dollars per month per child to your child care provider if the conditions in subsections (1)(a) and (1)(b) of this section are met.

(3) We can pay child care providers a one-time bonus of up to two hundred fifty dollars for each infant they newly enroll in care if all the following conditions are met:

(a) The child being cared for is less than twelve months of age;

(b) The child care provider is licensed or certified by the department; and

(c) We expect care to be provided for five days or more.

(4) We can pay child care providers a nonstandard hour bonus under WAC 388-165-195 and 388-165-200.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-280, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-280, filed 6/28/99, effective 7/1/99.]

WAC 388-290-300 Which children and consumers can and cannot get WCCC? Depending on your circumstances, or those of your child(ren), you might be eligible for WCCC as follows:

If this situation describes you:	Then am I or my children eligible for WCCC?
(1) You are: (a) An employee of the same child care facility where your child(ren) is receiving care; and (b) Caring for your own child(ren) during the time WCCC is authorized.	No. The child(ren) in this situation are not eligible for WCCC.
(c) In sanction status;	Yes, but you can only get WCCC: (i) For an activity needed to remove the sanction; or (ii) For employment.
(d) A parent in a two-parent family and the other parent is able and available to provide care for your child(ren) while you are working, looking for work, or preparing for work. **"Able"** means an adult physically, mentally, and emotionally capable of caring for a child in a responsible manner. **"Available"** means an adult able to provide care due to not participating in an approved work activity under WAC 388-290-125, 150, and 200 during the time you need child care.	No. You are not eligible for WCCC during the time the other parent is able and available to provide child care.
(2) Your child or children is: (a) Birth through twelve years old;	Yes. The child(ren) in this situation are eligible for WCCC. If the child(ren) has a special need it must be verified according to subsection (2)(b)(ii) of this section.
(b) Thirteen to nineteen years old;	Yes, but the child(ren) must be: (i) Under court supervision; or (ii) Physically, mentally, or emotionally incapable of self-care, as verified by a doctor, nurse, nurse practitioner, or masters-level or above mental health, education, or social service professional.
(c) Not legally residing in the country.	No. The child(ren) in this situation are not eligible for WCCC.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-300, filed 6/28/99, effective 7/1/99.]

WAC 388-290-350 If I'm in an approved activity, what are the steps the department takes to figure my WCCC copayment? If you're in an approved activity, we take the following steps to figure your WCCC copayment:

(1) Determine your family size (see WAC 388-290-400);

(2) Verify and calculate all nonexempt income that is received directly by your family (see WAC 388-290-450);

(3) Add together your family's expected average monthly earned and unearned income to get total income;

(4) Subtract the amount of child support you pay out to get your family's countable income (see WAC 388-290-600).

(5) Use your family's countable income to figure your WCCC copayment (see WAC 388-290-650).

(6) Assess the minimum copayment if:

(a) You're a minor parent and meet certain guidelines (see WAC 388-290-700); or

(b) You meet other guidelines not specifically for minor parents (see WAC 388-290-750).

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-350, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-350, filed 6/28/99, effective 7/1/99.]

WAC 388-290-375 How is the income that my family receives used in WCCC? All nonexempt income that your family receives directly is used to:

(1) Determine your eligibility for WCCC;

(2) Figure your expected average monthly income; and

(3) Calculate your WCCC copayment.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-375, filed 6/28/99, effective 7/1/99.]

WAC 388-290-400 What makes up a family in the WCCC program? "Family" in WCCC means one or more individuals who live together in the same household. Only you and the people living in your household can be included in family size, as follows:

If these are the people living in my household (including myself):	Then is my household considered a family in WCCC?
(1) Related adults, other than spouses, and their respective child(ren).	No, but see subsections (2) - (4), and (6) of this section, below.
(2) Unmarried parents and their mutual child(ren).	Yes.
(3) Married parents with or without a mutual child(ren).	Yes.
(4) Married or unmarried parents and their mutual and nonmutual children, if there is at least one mutual child.	Yes.
(5) Unmarried adults with no mutual child(ren).	No, but see subsection (6) of this section, below.
(6) An unmarried parent and their child(ren).	Yes.
(7) A non-TANF minor parent living independently with one or more children.	Yes.

(8) Child(ren) related by blood, marriage, or adoption who live with a WCCC consumer who is not legally and financially responsible for the child(ren).	No. Only the child(ren) are included in family size.
(9) Child(ren) not related by blood, marriage, or adoption who live in a situation described in subsection (8) of this section, above.	No. Each unrelated child(ren) is considered a separate family.
(10) A minor parent and the minor parent's children only, who are living in a situation described in WAC 388-290-700.	Yes.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-400, filed 6/28/99, effective 7/1/99.]

WAC 388-290-450 What income does the department count in WCCC? (1) We count the following as earned income when figuring your copayment:

(a) Earnings from employment or self-employment;

(b) Military housing and food allowance;

(c) Income in-kind.

"Income in-kind" means income received in a form other than cash, such as goods, services, or room and board.

(2) We count the following as unearned income when figuring your WCCC copayment:

(a) Your TANF grant, except when exempt under WAC 388-290-475;

(b) Child support payments received;

(c) General assistance;

(d) Supplemental Security Income (SSI);

(e) Other social security payments, such as SSA and SSDI;

(f) Refugee assistance payments;

(g) Payments from the Veterans' Administration, disability payments, or payments from labor and industries (L&I);

(h) Unemployment compensation; and

(i) Other types of unearned income not exempted in WAC 388-290-475.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-450, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-450, filed 6/28/99, effective 7/1/99.]

WAC 388-290-475 What income does the department exempt in WCCC? We exempt the following when figuring your copayment:

(1) Income types in WAC 388-450-0015, WAC 388-450-0035, WAC 388-450-0040, and WAC 388-450-0055;

(2) The earned income of a child, unless otherwise indicated in WAC 388-290-400;

(3) Compensatory awards, such as an insurance settlement or court-ordered payment for personal injury, damage, or loss of property;

(4) Reimbursements, such as an income tax refund;

(5) Diversion Cash Assistance;

(6) Child support you pay out under court order, DCS administrative order, or tribal government order.

(7) The TANF grant for the first three consecutive calendar months after you start a new job. The first calendar month is the month in which you start working.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-475, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-475, filed 6/28/99, effective 7/1/99.]

WAC 388-290-500 What are the different kinds of income in WCCC the department uses to get my expected average monthly income? (1) There are two kinds of income in WCCC that the department uses to get your expected average monthly income. They are:

(a) Ongoing income; and

(b) Lump sum payments.

(2) Ongoing income means:

(a) You expect to receive the income more than once, such as a paycheck;

(b) The income is not exempt in WCCC; and

(c) You have enough income history to make an accurate estimate of your future income; or

(d) Evidence of your income in the future is available, such as a letter from your employer.

(3) Lump sum payment means a one-time payment that is not exempt in WCCC, such as back child support, an inheritance, or gambling winnings.

(4) Expected average monthly income means the average monthly income amount used to figure your countable income.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-500, filed 6/28/99, effective 7/1/99.]

WAC 388-290-525 How does the department figure my expected average monthly income? (1) If you have ongoing income, we figure your expected average monthly income by:

(a) Verifying that the income presented to us is an accurate amount;

(b) Dividing the amount in subsection (1)(a) of this section by the number of months it took your family to get the income; or

(c) Using the best available estimate of your family's current and expected nonexempt income, if:

(i) Multiple months of past income are not available; or

(ii) You don't have the income history to make an accurate estimate of your future income.

(2) If you get a lump sum payment during your WCCC authorization period, we:

(a) Verify that the income presented to us is an accurate amount;

(b) Divide the lump sum payment by twelve; and

(c) Count the result of subsection (2)(b) of this section as part of your expected average monthly income.

(4) If you have a combination of ongoing income and one or more lump sum payments, we use the appropriate guideline for each kind of income to figure your expected average monthly income.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-525, filed 6/28/99, effective 7/1/99.]

WAC 388-290-600 How does the department figure my countable income, and what is countable income used for? All countable income received directly by your family is used to determine WCCC eligibility and calculate your WCCC copayment except if you automatically pay the minimum copayment under WAC 388-290-700 or 388-290-750.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-600, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-600, filed 6/28/99, effective 7/1/99.]

WAC 388-290-650 How does the department figure my copayment, once my countable income is known?

If your family's countable income falls within this range...	...Then your copayment is...
(1) At or below eighty-two percent of the Federal Poverty Level (FPL).	Ten dollars.
(2) Above eighty-two percent and up to one hundred thirty-seven and one-half percent FPL.	Twenty dollars.
(3) Over one hundred thirty-seven and one-half percent of the FPL.	The dollar amount equal to subtracting one hundred thirty-seven and one-half of FPL from countable income, multiplying by forty-four percent, then adding twenty.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-650, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-650, filed 6/28/99, effective 7/1/99.]

WAC 388-290-700 Does the department set the minimum copayment if I'm a minor parent? We set the minimum copayment if you are a minor parent, and

(1) Receiving TANF and living independently; or

(2) Part of your parent or relative's TANF grant.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-700, filed 6/28/99, effective 7/1/99.]

WAC 388-290-750 Are there other times when the department sets the minimum copayment? We also set the minimum copayment:

(1) In the first full month following the month you get a job, if you get TANF at the time of application for WCCC;

(2) In all the months you are a WCCC consumer, if your family's only source of income during this time is a TANF grant; or

(3) In the first month you apply for WCCC, if you don't get TANF at the time of application for WCCC.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-750, filed 6/28/99, effective 7/1/99.]

WAC 388-290-800 When does the department calculate copayments? We calculate your copayment:

(1) At the time of the initial eligibility determination;

(2) At least every six months, starting from the first month of eligibility;

(3) When your monthly income decreases, except if your TANF grant goes down due to a sanction;

(4) When your family size changes; or

(5) When you are no longer eligible for:

(i) The three-month TANF grant exemption under WAC 388-290-475; or

(ii) The minimum copayment under WAC 388-290-700 or 750.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-800, filed 6/28/99, effective 7/1/99.]

WAC 388-290-850 What child care providers can the department pay under the WCCC program? To receive payment under the WCCC program, your child care provider must fall into one of the following categories:

(1) Licensed as required by chapter 74.15 RCW and chapters 388-73, 388-155 (Minimum licensing requirements for family child day care homes), or 388-150 WAC (Minimum licensing requirements for child day care centers).

(2) Exempt from licensing but certified by the department, including:

(a) Tribal child care facilities meeting the requirements of tribal law;

(b) Child care facilities on a military installation;

(c) Child care facilities operated on public school property by a school district.

(3) Exempt from licensing and certification, but the in-home/relative provider must:

(a) Be a U.S. citizen or legally residing in the country;

(b) Be one of the following adult relatives providing care in either the child's or relative's home:

(i) An adult sibling living outside the child's home; or

(ii) A grandparent, aunt, uncle, first cousin, or great-grandparent, great-aunt, or great-uncle; and

(iii) Not the child's biological, adoptive, or step-parent; or

(iv) An extended tribal family member under chapter 74.15 RCW.

(c) Be an adult friend or neighbor providing care in the child's own home;

(d) Meet the in-home relative provider requirements in WAC 388-165-235;

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

(f) Not be disqualified based on information in WAC 388-290-854 (3) or (4).

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-850, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-850, filed 6/28/99, effective 7/1/99.]

WAC 388-290-854 When will the department not pay toward the cost of in-home/relative child care? The

department will not pay toward the cost of in-home/relative care if:

(1) Your in-home/relative provider does not meet the requirements in WAC 388-290-850;

(2) You fail to submit a completed criminal background inquiry form;

(3) The department determines your in-home/relative provider is not of sufficient physical, emotional or mental health to meet the needs of the child in care, or the household may be at risk of harm by this provider, as indicated by information other than conviction information; or

(4) Your in-home/relative provider has been convicted of, or has charges pending for crimes listed in WAC 388-390-882 or 388-290-886.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-854, filed 8/1/00, effective 8/2/00.]

WAC 388-290-858 Why do we review your in-home/relative provider's criminal background information? The department reviews the provider's criminal background information because the department:

(1) Wants you to have this information to help you to make informed, safe, and responsible decisions about your child(ren)'s care provider; and

(2) Does not pay toward the cost of child care provided by individuals convicted of crimes listed in WAC 388-290-882 and 388-290-886.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-858, filed 8/1/00, effective 8/2/00.]

WAC 388-290-862 When is a criminal background check required? The department requires the criminal background check for each in-home/relative provider:

(1) When you request payment for services by a new in-home/relative provider;

(2) Every two years for existing in-home/relative providers; or

(3) When the department has reason to do a criminal background check more frequently.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-862, filed 8/1/00, effective 8/2/00.]

WAC 388-290-866 Where does the department get the criminal background information on the in-home/relative provider? The department gets criminal background information from available sources such as:

(1) The Washington state patrol under chapter 10.97 RCW;

(2) Other states and federally recognized Indian tribes; and

(3) Disclosure by the in-home/relative provider.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-866, filed 8/1/00, effective 8/2/00.]

WAC 388-290-870 What does the department do with the criminal background information on the in-home/relative provider? (1) The department compares the criminal background information including pending charges with convictions listed in WAC 388-290-882 and 388-290-886.

(a) A pending charge for a crime is given the same weight as a conviction.

(b) If the conviction has been renamed it is given the same weight as the previous named conviction. For example, larceny is now theft.

(c) Convictions whose titles are preceded with the word "attempted" are given the same weight as those titles without the word "attempted."

(d) Convictions that are considered the same as those listed in WAC 388-290-882 and 388-290-886 are given the same weight as those titles.

(2) The department:

(a) Determines if the in-home/relative provider's criminal background contains information that will not allow the authorization of payment towards the cost of WCCC;

(b) Notifies the parent of the criminal background information;

(c) Denies or stops payment toward the cost of care by this in-home/relative provider, when the criminal background information disqualifies the in-home/relative provider; and

(d) Assists parents in finding other child care arrangements.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-870, filed 8/1/00, effective 8/2/00.]

WAC 388-290-874 Will I be notified of the results of the criminal background information on my in-home/relative provider? You will receive notice telling you whether or not the department is able to authorize payment toward the cost of care.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-874, filed 8/1/00, effective 8/2/00.]

WAC 388-290-878 Can I still use my chosen in-home/relative provider to care for my child(ren) if the provider has been convicted of a disqualifying crime? The department will not pay toward the cost of care if we disqualify an in-home/relative provider. It is your choice whether you use the in-home/relative provider to care your child(ren).

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-878, filed 8/1/00, effective 8/2/00.]

WAC 388-290-882 What convictions permanently disqualify my in-home/relative provider from being authorized by WCCC? The following crimes permanently disqualify your in-home/relative provider from authorization toward the cost of child care:

(1) Aggravated murder;
(2) Arson in the first degree;
(3) Assault in the first, second or third degree;
(4) Assault of a child in the first, second or third degree;
(5) Burglary in the first degree;
(6) Child abandonment;
(7) Child abuse or neglect (RCW 26.44.020);
(8) Child buying or selling;
(9) Child molestation in the first, second or third degree;
(10) Communication with a minor for immoral purposes;

(11) Criminal abandonment;
(12) Criminal mistreatment in the first or second degree;
(13) Custodial assault;
(14) Custodial interference in the first and second degree;
(15) Custodial sexual misconduct in the first and second degree;
(16) Delivery of a controlled substance;
(17) Drive-by shooting;
(18) Extortion in the first or second degree;
(19) Felony indecent exposure;
(20) Incest;
(21) Indecent liberties;
(22) Homicide by watercraft;
(23) Kidnapping in the first and second degree;
(24) Leading organized crime;
(25) Luring;
(26) Malicious explosion first, second and third degree;
(27) Malicious harassment;
(28) Malicious placement of an imitation device first degree;
(29) Manslaughter in the first and second degree;
(30) Manufacture of a controlled substance;
(31) Murder in the first and second degree;
(32) Patronizing a juvenile prostitute;
(33) Possession with the intent to deliver a controlled substance;
(34) Possession with the intent to manufacture a controlled substance;
(35) Promoting a suicide attempt;
(36) Promoting pornography;
(37) Promoting prostitution in the first degree;
(38) Public indecency (if toward a child less than fourteen);
(39) Rape in the first, second and third degree (including the rape of a child);
(40) Reckless Endangerment;
(41) Robbery in the first and second degree;
(42) Selling or distributing erotic materials to a minor;
(43) Sexual exploitation of a minor;
(44) Sexual misconduct with a minor in the first or second degree;
(45) Sexually violating human remains;
(46) Stalking;
(47) Theft in the first degree;
(48) Unlawful imprisonment;
(49) Unlawful use of building for drug purposes;
(50) Vehicular assault;
(51) Vehicular homicide;
(52) Violation of a child abuse restraining order-felony; or
(53) Any person whose name appears on the Washington state registered sex offender and kidnapping offender list.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-882, filed 8/1/00, effective 8/2/00.]

WAC 388-290-886 Are there some crimes that require a set amount of time to pass before my in-home/relative provider may be authorized for WCCC? A set amount of time must pass between the date of conviction and the date of the criminal background information form for specific convictions. The department will only authorize payment toward the cost of care by an in-home/relative provider if the following time periods have passed:

(1) Three years or more for:
(a) Assault in the fourth degree;
(b) Prostitution; or
(c) Theft in the third degree.
(2) Five years or more for:
(a) Forgery;
(b) Prostitution related crimes such as patronizing a prostitute; or
(c) Theft in the second degree.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-886, filed 8/1/00, effective 8/2/00.]

WAC 388-290-888 When can I ask the department to review the decision to deny authorization of my in-home/relative provider? (1) You may request the department review our decision to deny payment toward the cost of care by your in-home/relative provider when:

(a) The conviction is listed in WAC 388-290-886;
(b) The required amount of time has not elapsed between the conviction date and the date of application for child care by this provider; and
(c) We receive your request for review in writing or by contacting DSHS within thirty days of our decision.

(2) The review is separate from a hearing and provided by Administrative staff within the department.

(3) You will be requested to:
(a) Provide additional information; and
(b) Complete the request for review form.

(4) The department will notify you in writing of our decision within thirty days after receiving the information.

(5) If after we complete the review to reconsider your in-home/relative provider we determine care provided by this in-home/relative provider may be authorized, we will allow payment back to the date of disqualification if:

(a) All other eligibility requirements are met; and
(b) Verification of care is provided within thirty days of your request for payment.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-888, filed 8/1/00, effective 8/2/00.]

WAC 388-290-900 When can the department establish a protective payee to pay my in-home/relative provider? We can establish a protective payee to receive WCCC warrants for you when:

(1) You do not pay your in-home/relative child care provider; and
(2) We issued a child care warrant to the correct address and twelve or more working days have passed since the issuance date;
(3) You have not reported the WCCC warrant lost, stolen, or destroyed; or
(4) You have a history of failing to pay your in-home/relative provider(s).

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-900, filed 6/28/99, effective 7/1/99.]

WAC 388-290-905 What responsibilities does the department have under the WCCC program? We will:

(1) Inform you of your rights and responsibilities under the WCCC program;

(2) Inform you of the types of child care providers we can pay;

(3) Permit you to choose your in-home/relative provider as long as that provider meets the requirements in WAC 388-290-850.

(4) Review and act upon information described in WAC 388-290-854 and 388-290-866 regarding your in-home/relative provider;

(5) Inform you of the community resources that can help you select child care, if needed;

(6) Only authorize payment when no adult in your family is able and available to care for your children;

(7) Only authorize payment to child care providers who allow you to see your children whenever they are in care;

(8) Respond to you within ten days if you report a change of circumstance;

(9) Provide prompt child care payments to your licensed or certified provider; and

(10) Notify you whenever we establish or change your WCCC copayment.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-905, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-905, filed 6/28/99, effective 7/1/99.]

WAC 388-290-910 What responsibilities do I have under the WCCC program? Your responsibility is to:

(1) Choose a provider meeting requirements of WAC 388-290-850 and make your own child care arrangements;

(2) Notify the department of any change in providers within five days;

(3) Pay your in-home/relative provider the entire amount the department sends you for in-home/relative care;

(4) Pay, or make arrangements to pay, your WCCC copayment directly to your child care provider;

(5) Supply the department with necessary information to allow us to correctly determine your eligibility and make proper child care payment to your provider;

(6) Notify your provider within ten days when we change your child care authorization;

(7) Provide notice to the department within ten days of any change in:

(a) Family size;

(b) Income level; or

(c) The amount of child care needed.

(8) Assure your in-home/relative provider provides a valid social security number to the department, if you choose an in-home/relative provider; and

(9) Report to your child care authorizing worker, within twenty-four hours, any pending charges or conviction information you learn about your in-home/relative provider.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-910, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-910, filed 6/28/99, effective 7/1/99.]

WAC 388-290-915 When do WCCC payments start? If you are eligible for WCCC, the department authorizes WCCC payments the date you apply for the program, or the date you choose a child care provider we can pay under WAC 388-290-850, whichever is later.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-915, filed 6/28/99, effective 7/1/99.]

WAC 388-290-920 When does the department provide me with advance and adequate notice of WCCC payment changes? (1) We provide you with advance and adequate notice for changes in payment when the change results in a suspension, reduction, termination, or forces a change in child care arrangements, except as noted in WAC 388-290-925, below.

(2) **"Advance notice,"** means a notice of a WCCC reduction, suspension, or termination that is mailed at least ten days before the date of the intended action.

(3) **"Adequate notice"** means a written statement of the action the department intends to take, the facts relating to the decision, the Washington Administrative Code (WAC) supporting the action, and your right to request a fair hearing.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-920, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-920, filed 6/28/99, effective 7/1/99.]

WAC 388-290-925 When don't advance and adequate notice rules apply? Advance and adequate notice requirements don't apply in the following circumstances:

(1) You tell the department you no longer want WCCC;

(2) Your whereabouts are unknown to the department;

(3) You are receiving duplicate child care benefits;

(4) Your normal WCCC authorization period is scheduled to end; or

(5) If the department determines your in-home/relative provider may not be of sufficient physical, emotional or mental health to meet the needs of the child(ren) in care the household may be at risk of harm by this provider as indicated by information other than criminal background.

(6) Your in-home/relative provider has been convicted of, or has charges pending for crimes listed in WAC 388-290-882 or 388-290-886.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-925, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-925, filed 6/28/99, effective 7/1/99.]

WAC 388-290-930 Under what circumstances does my eligibility for WCCC end? Your eligibility for WCCC ends if:

(1) Copayment fees assessed by the department are not paid; and

(2) Mutually acceptable payment arrangements are not made with your child care provider; or

(3) You don't meet other WCCC eligibility requirements.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-930, filed 6/28/99, effective 7/1/99.]

WAC 388-290-935 When might I be eligible for WCCC again? You might be eligible for WCCC again when:

(1) Back copayment fees are paid; or

(2) Mutually acceptable payment arrangements are made with your child care provider(s); and

(3) You meet other WCCC eligibility requirements.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-935, filed 6/28/99, effective 7/1/99.]

WAC 388-290-940 Do I have the right to request a hearing? (1) WCCC consumers can request hearings under chapter 388-02 WAC on any action affecting WCCC benefits except for mass changes resulting from a change in policy or law.

(2) Child care providers can request hearings under chapter 388-02 WAC only for WCCC overpayments.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-940, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-940, filed 6/28/99, effective 7/1/99.]

WAC 388-290-945 Can I receive WCCC pending the outcome of a hearing? (1) If you are a WCCC consumer, you can receive WCCC pending the outcome of a hearing if you request the hearing:

(a) On or before the effective date of an action; or

(b) No more than ten days after the department sends you a notice of adverse action.

"Adverse action" means an action to reduce or terminate your WCCC, or to set up a protective payee to receive your WCCC warrant for you.

(2) If you lose a hearing, any WCCC you use between the date of the adverse action and the date of the hearing or hearing decision is an overpayment to you, the consumer.

(3) If we obtain information that your provider may not be authorized to care for children under WAC 388-290-850 and you request a hearing on this decision, you are not eligible for WCCC payments toward the cost of care by this provider pending the outcome of the hearing. If you are eligible for WCCC, you may receive child care benefits towards another eligible provider, pending the outcome of the hearing.

[Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-945, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-945, filed 6/28/99, effective 7/1/99.]

WAC 388-290-950 When does the department collect overpayments? (1) In areas not covered by this section, WCCC consumers are subject to chapter 388-410 WAC (Benefit errors).

(2) When setting up an overpayment, we reduce the WCCC overpayment by the amount of the WCCC underpayment when applicable.

(3) We recover WCCC overpayments from you, regardless of whether you are a current or past WCCC consumer, if:

(a) The amount we overpay is more than three hundred dollars; and

(b) Your child(ren) attend child care when not authorized by the department to do so;

(c) A member of a different overpaid family later becomes a member of your family;

(d) Cost of recovery does not exceed the overpayment amount;

(e) You:

(i) Do not report a change of circumstance within ten days under WAC 388-290-910; and

(ii) Use WCCC during a period of time when you would otherwise have been ineligible or eligible for a smaller amount of care; or

(f) You knowingly fail to give the department information that affects the amount of WCCC you are eligible for.

(4) Recovery of overpayments cannot force a change in your child care arrangements.

(5) We recover WCCC overpayments from child care providers, if:

(a) The amount we overpay is more than three hundred dollars;

(b) The provider receives payment for WCCC services not provided; or

(c) We pay the provider more than the cost of providing WCCC under WAC 388-165-180 and 388-165-185; and

(d) The cost of recovery does not exceed the overpayment amount.

(6) We set up overpayments starting the date that:

(a) You use WCCC when not authorized by the department to do so; or

(b) The child care provider provides care when not authorized by the department to do so.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-950, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-950, filed 6/28/99, effective 7/1/99.]

Chapter 388-310 WAC
WORKFIRST

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-310-1850 Re-employ Washington Workers (RWW). [Statutory Authority: RCW 74.08.090 and 74.04.050. 00-08-021, § 388-310-1850, filed 3/24/00, effective 4/24/00; 99-14-044, § 388-310-1850, filed 6/30/99, effective 7/31/99.] Repealed by 00-24-040, filed 11/29/00, effective 12/30/00. Statutory Authority: RCW 74.08.090 and 74.04.050.

WAC 388-310-0100 WorkFirst—Purpose. (1) **What is the WorkFirst program?**

The WorkFirst program offers services and activities to help people in low-income families find jobs, keep their jobs, find better jobs and become self-sufficient. The program links families to a variety of state, federal and community resources to meet this goal. When you enter the WorkFirst program, you will be asked to work, look for work and/or prepare for work.

(2) **Who does the WorkFirst program serve?**

The WorkFirst program serves three groups:

(a) Parents and children age sixteen or older who receive cash assistance under the temporary assistance for needy families (TANF), general assistance for pregnant women (GA-S) or state family assistance (SFA) programs; and

(b) Parents who no longer receive cash assistance and need some continuing support to remain self-sufficient; and

(c) Low income parents who support their family without applying for or relying on cash assistance.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-08-051, § 388-310-0100, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0200 WorkFirst—Activities. (1) **Who is required to participate in WorkFirst activities?**

(a) You are required to participate in WorkFirst activities, and become what is called a "mandatory participant," if you:

(i) Receive TANF or SFA cash assistance; and

(ii) Are a custodial parent or age sixteen or older; and

(iii) Are not exempt. (You can only get this exemption if you are caring for your child under three months of age. See WAC 388-310-0300 for more details.)

(b) Participation is voluntary for all other WorkFirst participants (those who no longer receive or have never received TANF or SFA cash assistance).

(2) **What activities do I participate in when I enter the WorkFirst program?**

When you enter the WorkFirst program, you will participate in one or more of the following activities (which are described in more detail in other sections of this chapter):

(a) Paid employment (see WAC 388-310-0400 (2)(a) and 388-310-1500);

(b) Self employment (see WAC 388-310-1700);

(c) Job search (see WAC 388-310-0600);

(d) Community jobs (see WAC 388-310-1300)

(e) Work experience (see WAC 388-310-1100);

(f) On-the-job training (see WAC 388-310-1200);

(g) Vocational educational training (see WAC 388-310-1000);

(h) Basic education activities (see WAC 388-310-0900);

(i) Job skills training (see WAC 388-310-1050);

(j) Community service (see WAC 388-310-1400); and/or

(k) Activities provided by tribal governments for tribal members and other American Indians (see WAC 388-310-1400(1) and 388-310-1900).

(3) **If I am a mandatory participant, how much time must I spend doing WorkFirst activities?**

If you are a mandatory participant, you will be required to spend up to forty hours a week working, looking for work or preparing for work. You will have an individual responsibility plan (described in WAC 388-310-0500) that includes the number of hours a week that you are required to participate.

(4) **What activities do I participate in after I get a job?**

You may participate in other activities, which are called "post employment services" (described in WAC 388-310-1800) once you are working twenty hours or more a week. Work can include a paid, unsubsidized job, self-employment, college work study or a subsidized job like a community jobs placement. Post employment services include:

(a) Activities that help you keep a job (called an "employment retention" service); and/or

(b) Activities that help you get a better job or better wages (called a "wage and skill progression" service).

[Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-0200, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0200, filed 3/1/00, effective 3/1/00; 99-08-051, § 388-310-0200, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0300 WorkFirst—Infant care exemptions for mandatory participants. (1) **If I am a mandatory participant, when can I be exempted from participating in WorkFirst activities?**

You can claim an exemption from participating in WorkFirst activities during months that you are needed in the home to personally provide care for your child under three months of age.

(2) **Can I participate in WorkFirst while I am exempt?**

You may choose to participate in WorkFirst while you are exempt. If you decide later to stop participating, and you still qualify for an exemption, you will be put back into exempt status with no financial penalty.

(3) **Does an exemption from participation affect my sixty-month time limit for receiving TANF or SFA benefits?**

An exemption from participation does not affect your sixty-month time limit for receiving TANF or SFA benefits (described in WAC 388-484-0005). Even if exempt from participation, each month you receive a TANF/SFA grant counts toward your sixty-month limit.

[Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0300, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0300, filed

4/28/99, effective 5/29/99; 97-20-129, § 388-310-0300, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0400 WorkFirst—Entering the WorkFirst program as a mandatory participant. (1) **What happens when I enter the WorkFirst program as a mandatory participant?**

If you are a mandatory participant, WorkFirst requires you to look for a job as your first activity unless you are temporarily deferred from job search. You must follow instructions as written in your individual responsibility plan (see WAC 388-310-0500) while you are in job search.

(2) **Are there any reasons why I might be temporarily deferred from looking for a job?**

If you are a mandatory participant, your case manager will ask if you have any reasons why you cannot go to job search. You may be temporarily deferred from looking for a job for any of the following reasons:

(a) You work twenty or more hours a week. **"Work"** means to engage in any legal, income generating activity which is taxable under the United States Tax Code or which would be taxable with or without a treaty between an Indian Nation and the United States; or

(b) You work sixteen or more hours a week in the federal or state work study program and you attend a Washington state community or technical college at least half-time; or

(c) You are under the age of eighteen, have not completed high school, GED or its equivalent and are in school full-time; or

(d) You are eighteen or nineteen years of age and are attending high school or an equivalent full-time; or

(e) You are pregnant or have a child under the age of twelve months, and are participating in other pregnancy to employment activities. See WAC 388-310-1450; or

(f) You are fifty-five years old or older and caring for a child you are related to (and you are not the child's parent), you may go into community service (described in WAC 388-310-1400 (2)(b)); or

(g) Your situation prevents you from looking for a job. (For example, you may be unable to look for a job while you have health problems, are homeless and/or dealing with family violence.)

(3) **What are my requirements if I am temporarily deferred from job search?**

(a) If and when your job search is temporarily deferred, you may be required to take part in an employability evaluation as part of your individual responsibility plan. Your individual responsibility plan will describe what you need to do to be able to enter job search and then find a job (see WAC 388-310-0500 and 0700).

(b) If you enter the pregnancy to employment pathway (described in WAC 388-310-1450(2)), you must take part in an assessment.

(4) **What happens if I do not follow my WorkFirst requirements?**

If you do not participate in job search, or in the activities listed in your individual responsibility plan, and you do not have a good reason, the department will impose a financial penalty (sanction, see WAC 388-310-1600).

[Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0400, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0400, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0400, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0500 WorkFirst—Individual responsibility plan. (1) **What is the purpose of my individual responsibility plan?**

The purpose of your individual responsibility plan is to give you a written statement that describes:

(a) What your responsibilities are; and

(b) Which WorkFirst activities you are required to participate in; and

(c) What services you will receive so you are able to participate.

(2) **What is included in my individual responsibility plan?**

Your individual responsibility plan includes the following:

(a) What WorkFirst activities you must be engaged in, a start and end date for each activity and how many hours a week you must spend in each activity.

(b) Any other specific requirements that are tied to the WorkFirst work activity. For example, you might be required to learn English as part of your work experience activity.

(c) What services you need to participate in the activity. For example, you may require support services (such as help with paying for transportation) or help with paying childcare.

(d) Your statement that you recognize the need to become and remain employed as quickly as possible.

(3) **How is my individual responsibility plan developed?**

You and your case manager will work together to develop your individual responsibility plan and decide what activities will be included in it. Then, your case manager will assign you to specific WorkFirst activities that will help you find employment as quickly as possible.

(4) **What happens after my individual responsibility plan is completed?**

Once your individual responsibility plan is completed:

(a) You will sign and get a copy of your individual responsibility plan.

(b) You and your case manager will review your plan as necessary over the coming months to make sure your plan continues to meet your employment needs. You will sign and get a copy of your individual responsibility plan every time it is reviewed and changed.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0500, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0500, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0600 WorkFirst—Job search. (1) **What is job search?**

Job search is an opportunity to learn and use skills you need to find and keep a job. Job search may include:

(a) Classroom instruction; and/or

(b) Structured job search that helps you find job openings, complete applications, practice interviews and apply other skills and abilities with a job search specialist or a group of fellow job-seekers; and/or

(c) Pre-employment training.

(2) **What is pre-employment training?**

Pre-employment training helps you learn skills you need for an identified entry level job that pays more than average entry level wages.

(a) Pre-employment training is an acceptable job search activity when an employer or industry commits to hiring or giving hiring preference to WorkFirst participants who successfully complete pre-employment training.

(b) You can find out about current pre-employment training opportunities by asking your job service specialist, your case manager or staff at your local community and technical college.

(3) **Who provides me with job search?**

You get job search from the employment security department or another organization under contract with WorkFirst to provide these services.

(4) **How long do I stay in job search?**

Periods of job search may last up to twelve continuous weeks. Job search specialists will monitor your progress. By the end of the first four weeks, a job search specialist will determine whether you should continue in job search. Job search will end when:

(a) You find a job; or

(b) You become exempt from WorkFirst requirements (see WAC 388-310-0300); or

(c) Your situation changes and you are temporarily deferred from continuing with job search (see WAC 388-310-0400); or

(d) Job search specialists have determined that you need additional skills and/or experience to find a job; or

(e) You have not found a job at the end of the job search period.

(5) **What happens at the end of job search if I have not found a job?**

At the end of each job search period, you will be referred back to your case manager for an employability evaluation if you have not found a job. You and your case manager will also modify your individual responsibility plan.

[Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-0600, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0600, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0700 WorkFirst—Employability evaluation. (1) **Why do I receive an employability evaluation?**

You receive an employability evaluation from your case manager to determine:

(a) Why you are unable to look for work (if you are temporarily deferred from job search) or why you have been unable to find work in your local labor market; and

(b) Which WorkFirst activities you need to become employed in the shortest time possible.

(2) **What is the employability evaluation and when will it be used?**

(a) The employability evaluation is a series of questions and answers used to determine your ability to find and keep a job in your local labor market.

(b) You and your case manager and/or social worker use the information from this evaluation to create or modify your individual responsibility plan, adding activities that help you become employable.

(c) Your case manager evaluates your ability to find employment when you are a mandatory WorkFirst participant and have:

(i) Gone through a period of job search without finding a job;

(ii) Been referred back early from job search; or

(iii) Been temporarily deferred from job search.

(d) After your employability evaluation, you may receive more assessments to find out if you need additional services.

[Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0700, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0700, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0800 WorkFirst—Support services. (1) **Who can get support services?**

(a) WorkFirst participants;

(b) Sanctioned WorkFirst participants during the two-week participation before the sanction is lifted;

(c) Unmarried or pregnant minors who are income eligible to receive TANF and are:

(i) Living in a department approved living arrangement (WAC 388-486-0005) and are meeting the school requirements (WAC 388-486-0010); or

(ii) Actively working with a social worker to remove the barriers that are preventing the minor from living in a department approved living arrangement and/or meeting the school requirements.

(d) Former WorkFirst recipients who are looking for work, preparing for work, or working.

(2) **Why do I receive support services?**

(a) Support services help you participate in work and WorkFirst activities that lead to independence. You can also get help in paying your child care expenses through the working connections child care assistance program. (Chapter 388-290 WAC describes the rules for this child care assistance program.)

(b) Support services help you to keep working, accept a job, participate in job search, advance in your job and/or increase your wages.

(3) **What support services may I receive?**

You may receive support services, including but not limited to any of the following:

(a) Employment related needs such as work clothing or uniforms, tools, equipment, relocation expenses, or fees;

(b) Transportation costs such as mileage reimbursement, public transportation vouchers, and car repair;

(c) Professional services;

(d) Personal needs such as clothing appropriate for job search or other work activities;

(e) Special needs such as accommodations for employment;

(f) Identified specific needs due to location or employment if you are an American Indian;

(g) Job skills training, vocational education and/or basic education if:

(i) It is an approved activity in your individual responsibility plan; and

(ii) You do not qualify for sufficient student financial aid to meet the cost.

(h) Transitional work expense of one thousand dollars if:

(i) You are in unsubsidized employment; or

(ii) You are in subsidized employment that does not use TANF funds or does not end with your grant; and

(iii) You are in the assistance unit and receiving a TANF/SFA grant of one hundred dollars or less a month; and

(iv) You or anyone in your assistance unit is not in sanction status; and

(v) You voluntarily stop receiving your TANF/SFA grant; and

(vi) You are an adult and have never received a transitional work expense.

(4) **What are the requirements to get support services?**

The department or its agents will decide what support services you will receive, as follows:

(a) You need the support services to do the activities in your individual responsibility plan, do job search, accept employment, do paid work, continue to work, to advance in your job and/or increase your wages; or

(b) You are a pregnant or parenting minor who is income eligible to receive TANF and you need support services to remove barriers that prevent you from living in a department approved living arrangement and/or meet the school requirements; or

(c) Your request is within twenty-four months after your TANF/SFA case closed; and

(d) It is within available funds; and

(e) It does not assist, promote, or deter religious activity.

(5) **How much support services can I get?**

The chart below shows the guidelines for the amount and type of support services you can get. There is a suggested limit of three thousand dollars per person per program year (July 1st to June 30th) for support services you can receive from the department and/or employment security.

Type of Support Service	Suggested Limit
Accommodation (reasonable)	$1,000 for each request
Car repair	$750 per program year
Clothing–General	Participant–$250 for each request Each child–$100 for each request
Clothing/uniforms–Employment	Participant–$200 per program year
Counseling	No limit
Diapers	$50 per child per month
Educational expenses	$300 for each request
Employer reimbursement	No limit
Haircut	$40 for each request
License/fees/liability insurance	$600 per each license, fee or liability insurance request per program year
Lunch	Same rate as established by OFM for state employees
Medical exams (not covered by Medicaid)	$150 per exam
Mileage	Same rate as established by OFM for state employees
Personal hygiene	$50 for each request (up to three times per program year)
Professional, trade, association, union and bonds	$300 for each fee
Public transportation	$150 per month
Relocation	$1,000 per program year
Rent, housing, deposits	$500 per program year
Short-term lodging and meals	Same rate as established by OFM for state employees
Testing–Diagnostic	$200 each
Tools/equipment	$500 for each request

(6) **What if I request more support services than the suggested maximum amounts, or ask for services not specifically covered in the guidelines?**

If you request support services from your case manager, you can:

(a) Ask to see a copy of these guidelines;

(b) Ask for additional services, if you are requesting more than the guidelines allow or asking for services or goods not mentioned in the guidelines; and/or

(c) Request a fair hearing, if your request for support services is denied.

(7) **What happens to my support services if I do not participate as required?**

The department will give you ten days notice, following the rules in WAC 388-310-1600, then discontinue your support services until you participate as required.

[Statutory Authority: RCW 74.08.090, 74.04.050, and 78.08A.340. 00-13-106, § 388-310-0800, filed 6/21/00, effective 7/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-14-043, § 388-310-0800, filed 6/30/99, effective 7/31/99; 97-20-129, § 388-310-0800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0900 WorkFirst—Basic education. (1) **What is basic education?**

Basic education is high school completion, classes to prepare for GED and testing to acquire GED certification. It may include families that work, workplace basics, adult basic education (ABE) or English as a second language (ESL) training if:

(a) It is determined you need this education to become employed or get a better job; and

(b) This activity is combined with paid or unpaid employment or job search.

(2) **When do I participate in basic education as part of WorkFirst?**

Your [you] may participate in basic education as part of WorkFirst under any of the following circumstances:

(a) You may choose to participate, if you are twenty years of age or older and are working in paid or unpaid employment or in job search for a minimum of twenty hours a week (in addition to the basic education).

(b) You may be required to participate if you are a mandatory participant, a parent eighteen or nineteen years of age, you do not have a high school diploma or GED certificate and you need this education in order to find employment.

(c) You will be required to be in high school or a GED certification program if you are a mandatory participant, six-

teen or seventeen years old and you do not have a high school diploma or GED certificate.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0900, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0900, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1000 WorkFirst—Vocational education. (1) **What is vocational education?**

Vocational education is training that leads to a degree or certificate in a specific occupation and is offered by an accredited:

(a) Public and private technical college or school;

(b) Community college; or

(c) Tribal college.

(2) **When can vocational education be included in my individual responsibility plan?**

We may add vocational education to your individual responsibility plan if:

(a) You are working twenty or more hours a week; or

(b) You lack job skills that are in demand for entry level jobs in your area; and

(c) The vocational education program is the only way that you can acquire the job skills you need to qualify for entry level jobs in your area (because there is no available work experience, pre-employment training or on-the-job training that can teach you these skills).

(3) **Can I get help with paying the costs of vocational education?**

WorkFirst will pay for the costs of your vocational education, such as tuition or books, if vocational education is in your individual responsibility plan and there is no other way to pay them. You can also get help with paying your child care costs through the working connections child care program. (See chapter 388-290 WAC for the working connections child care program rules.)

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1000, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1000, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1000, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1050 WorkFirst—Job skills training. (1) **What is job skills training?**

Job skills training is training in specific skills directly related to employment, but not tied to a specific occupation. Job skills training programs differ in how long the course lasts, what skills are taught and who provides the training. The training may be offered by:

(a) Community based organizations;

(b) Businesses;

(c) Tribal governments; or

(d) Public and private community and technical colleges.

(2) **When can job skills training be included in my individual responsibility plan?**

We may add job skills training in your individual responsibility plan for the same reasons we would add vocational education. That is if:

(a) You are working twenty or more hours a week; or

(b) You lack job skills that are in demand for entry level jobs in your area; and

(c) The job skills training program is the only way you can acquire the job skills you need to qualify for entry level jobs in your area (because there is no available work experience, pre-employment training, or on-the-job training that can teach you these skills).

(3) **Can I get help with paying the costs of job skills training?**

WorkFirst will pay your costs, such as tuition or books, if job skills training is in your individual responsibility plan and there is no other way to pay them. You can also get help with paying your child care costs through the working connections child care program. (See chapter 388-290 WAC for the working connections child care program rules.)

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1050, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1050, filed 11/10/98, effective 12/11/98.]

WAC 388-310-1100 WorkFirst—Work experience. (1) **What is work experience?**

Work experience (sometimes called WEX) is an activity for mandatory participants that will teach you the basics of holding down a job and give you a chance to practice or expand your work skills. Work experience teaches you these skills by assigning you to unpaid work with:

(a) A private, nonprofit organization;

(b) A community or technical college; or

(c) A federal, state, local or tribal government or district.

(2) **What happens when I am enrolled in a work experience activity?**

When you are enrolled in a work experience activity:

(a) The organization, government or district that is supervising your work experience position must comply with all applicable state and federal health and safety standards while you are working there.

(b) You may be required to look for work on your own and must accept any paid employment you find that meets the criteria in WAC 388-310-1500.

(3) **How long does a work experience assignment last?**

Your case manager must review your work experience assignment if it lasts longer than six months. This review will determine whether you need more time to learn the skills and abilities that the work experience assignment was set up to teach you.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1100, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1200 WorkFirst—On-the-job training. (1) **What is on-the-job training?**

On-the-job training (sometimes called OJT) is skills training provided by an employer at the their place of business. You are paid to both work and spend some time learning new skills to help you do your job better. You may receive the training at your job site or be sent to a classroom (using "release time" from your job) to get some of this training.

(2) **When do I qualify for on-the-job training?**

You may qualify for on-the-job employment if:

(a) You lack skills which are in demand in the local labor market; and

(b) There are employers in your area who can and will provide the training.

(3) **Is my employer reimbursed for giving me on-the-job training?**

Your employer may be reimbursed for giving you on-the-job training for up to fifty percent of your total gross wages for regular hours of work and pre-approved release time for training.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1200, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1300 Community jobs program. (1) **What is the community jobs program?**

The community jobs program helps you gain work skills and experience by enrolling you in a temporary, subsidized job. You will also receive other services and support to help you move into unsubsidized employment as quickly as possible.

(a) The state department of community, trade and economic development (DCTED) administers the community jobs program.

(b) DCTED selects community jobs contractors (CJC) by using a competitive "requests for proposal" process. DCTED, based upon the successful proposals, develops contracts specific to each selected community jobs contractor.

(c) The CJCs develop and manage the community jobs positions, pay the wages, provide support services and act as the "employer of record" while you are enrolled in a subsidized community job.

(d) Employers at the community jobs work sites must take actions to help participants move into unsubsidized employment. If they do not meet this requirement, they will not be considered for additional community jobs employees.

(e) The department of social and health services funds the community jobs program and reimburses your wages to the CJCs.

(2) **How will I be affected if I am enrolled in the community jobs program?**

If you are enrolled in the community jobs program:

(a) Your case manager will assign you to a community job position for no more than nine months.

(b) You may be assigned to a community job position when:

(i) You have gone through job search without finding a job; and/or

(ii) You and your case manager decide you need a supportive work environment to help you become more employable.

(c) You may not be enrolled in any community jobs position that requires you to do work related to religious, electoral or partisan political activities.

(d) You, your case manager and the CJC will review the appropriateness of your community jobs position every ninety days during your nine-month placement, looking at:

(i) Your continued TANF/SFA eligibility;

(ii) Any earned or unearned income received by you or another member of your assistance unit (that is, you and other people in your household who are included on your cash grant): and

(iii) Whether the community jobs position is actually helping you become more employable.

(e) You may work twenty or more hours per week in the community jobs position and will be paid the federal or state minimum wage, whichever is higher.

(f) You will earn sick leave and annual leave at the rate agreed upon by DCTED and the CJC for community jobs participants.

(g) The amount of your TANF/SFA monthly grant will be determined by following the rules in WAC 388-450-0050 and 388-450-0215 (1), (3), (4), (5) and (6). WAC 388-450-0215 (2), does not apply to your community jobs wages.

(3) **What kind of employers provide community jobs work sites?**

The CJC may ask the following categories of employers to provide you with a community job work site:

(a) Federal, state or local governmental agencies and tribal governments; and

(b) Private and tribal nonprofit businesses, organizations and educational institutions.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-08-051, § 388-310-1300, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.08.090, 74.04.050 and 74.08A.320. 98-10-054, § 388-310-1300, filed 4/30/98, effective 5/31/98.]

WAC 388-310-1400 WorkFirst—Community service. (1) **What is community service?**

Community service includes two types of activities for mandatory participants:

(a) Unpaid work (such as the work performed by volunteer workers) that you perform for a charitable nonprofit organization, federal, state, local or tribal government or district; or

(b) An activity approved by your case manager which benefits you, your family, your community or your tribe. These activities may include traditional activities that perpetuate tribal culture and customs.

(2) **What type of community service[s] activities benefit me, my family, my community or my tribe and might be included in my individual responsibility plan?**

The following types of community service activities benefit you, your family, your community or your tribe and might be included in your individual responsibility plan:

(a) Caring for a disabled family member;

(b) Caring for a child, if you are fifty-five years old or older and receiving TANF or SFA assistance for the child as a relative (instead of as the child's parent);

(c) Providing childcare for another WorkFirst participant who is doing community service;

(d) Actively participating in a drug or alcohol assessment or treatment program which is certified or contracted by the state under chapter 70.96A RCW;

(e) Participating in family violence counseling or drug or alcohol treatment that will help you become employable or keep your job (this is called "specialized services" in state law); and/or

(f) Participating in the pregnancy to employment pathway.

[Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-1400, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-1400, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1400, filed 10/1/97, effective 11/1/97.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-310-1450 Pregnancy to employment. (1) **How do I know if I am eligible to participate in the pregnancy to employment pathway?**

If you are pregnant or have a child under the age of twelve months, you are a participant in the pregnancy to employment pathway.

(2) **What am I required to do while I am in the pregnancy to employment pathway?**

Based on the results of the assessment you receive as a pregnancy to employment participant, you and your case manager will decide if you will be required to:

(a) Work; or

(b) Look for work; and/or

(c) Participate in a combination of pregnancy to employment services.

(3) **What services are provided in the pregnancy to employment pathway?**

This pathway provides you with services, as available within your community, to help you learn how to work while still meeting your child's needs. You and your case manager will decide which of the variety of services you need, such as help finding:

(a) Parenting classes;

(b) Safe and appropriate child care;

(c) Good health care for yourself and your child; and/or

(d) Employment services.

(e) If you are currently employed you will receive the assessment at your next individual responsibility plan review.

(4) **What determines which services I will receive and what my participation will be?**

As a participant in the pregnancy to employment pathway you may receive:

(a) An assessment (see WAC 388-310-0700);

(b) Services (as available within your community) based on the results of the assessment;

(c) An individual responsibility plan will be developed jointly that reflects participation and services designed to meet your needs and the needs of your child; and

(d) Follow up contact every three months to jointly reassess your needs and the services and activities you are participating in, until your child reaches age twelve months.

(5) **How much do I have to participate?**

(a) Unless a determination of non-participation has been made as described in WAC 388-310-1600, you will be required to participate up to forty hours per week during the first two trimesters of pregnancy. Your participation activity will be determined by the results of your assessment.

(b) During the third trimester of pregnancy your participation is voluntary and may include meeting your medical needs.

(c) From the birth of your child, until your child reaches three months, you are exempt from participation. You may volunteer to participate.

(d) From the third month forward, you will be required to participate part-time, twenty hours per week or more, and transition into full time participation, up to forty hours per week, in work, looking for work or preparing for work by the time your child reaches age twelve months. Your participation activity will be determined by the results of your assessment.

(6) **Will I be sanctioned if I refuse to participate in pregnancy to employment pathway?**

(a) If you are a pregnant woman in your third trimester of pregnancy or if you have an infant less than three months old you will not be sanctioned for not participating.

(b) If you are in the first two trimesters of your pregnancy or have a child three months of age or older, you are required to participate and are subject to the WorkFirst sanction rules (see WAC 388-310-1600).

[Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-1450, filed 3/1/00, effective 3/1/00.]

WAC 388-310-1500 WorkFirst—Employment conditions. (1) **If I am a mandatory participant, are there any limitations on the type of paid or unpaid employment I must accept?**

If you are a mandatory participant, you must accept paid or unpaid employment (including any activity in which an employer-employee relationship exists) unless the employment:

(a) Is not covered by industrial insurance (described in state law under Title 51 RCW) unless you are employed by a tribal government or a tribal private for-profit business;

(b) Is available because of a labor dispute;

(c) Has working hours or conditions that interfere with your religious beliefs or practices (and a reasonable accommodation cannot be made);

(d) Does not meet federal, state or tribal health and safety standards; or

(e) Has unreasonable work demands or conditions, such as working for an employer who does not pay you on schedule.

(2) **Are there any additional limitations on when I can be required to accept paid employment?**

You must accept paid employment unless the job or the employer:

(a) Pays less than the federal, state, or tribe minimum wage, whichever is higher;

(b) Does not provide unemployment compensation coverage (described in state law under Title 50 RCW) unless you:

(i) Work for a tribal government or tribal for-profit business; or

(ii) Are a treaty fishing rights related worker (and exempt under section 7873 of the internal revenue code);

(c) Requires you to resign or refrain from joining a legitimate labor organization; or

(d) Does not provide you benefits that are equal to those provided to other workers employed in similar jobs.

(3) **How many hours of unpaid employment can I be required to perform?**

You can be required to work a set number of hours of unpaid employment each month. The number of hours required will not be more than your TANF, SFA or GA-S cash grant divided by the state or federal minimum wage, whichever is higher.

(4) **What safeguards are in place to make sure I am not used to displace currently employed workers?**

The following safeguards are in place to make sure you are not used to displace currently employed workers:

(a) You cannot be required to accept paid or unpaid employment which:

(i) Results in another employee's job loss, reduced wages, reduced hours of employment or overtime or lost employment benefits;

(ii) Impairs existing contracts for services or collective bargaining agreements;

(iii) Puts you in a job or assignment, or uses you to fill a vacancy, when:

(A) Any other person is on lay off from the same (or very similar) job within the same organizational unit; or

(B) An employer ends the job of a regular employee (or otherwise reduces its workforce) so you can be hired.

(iv) Reduces current employees' opportunities for promotions.

(b) If a regular employee believes your subsidized or unpaid work activity (such as a community jobs or work experience position) violates any of the rules described above, this employee (or his or her representative) has the right to:

(i) A grievance procedure (described in WAC 388-200-1100); and

(ii) A fair hearing (described in chapter 388-08 WAC).

(5) **What other rules apply specifically to subsidized or on-the-job training positions?**

If you are in a subsidized or on-the-job training position:

(a) WorkFirst state agencies must stop paying your wage or on-the-job training subsidy to your employer if your employer's worksite or operation becomes involved in a strike, lockout or bona fide labor dispute.

(b) If your wage subsidy or on-the-job training agreement is ended (and we stop paying any subsidies to your employer) because you were used to displace another employee, it will be up to you and the employer to decide whether you can (or want to) keep working there.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1500, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1600 WorkFirst—Sanctions. (1) **What is a sanction and when is it used?**

A sanction is a penalty that alters your grant when you refuse to:

(a) Give the department the information we need to develop your individual responsibility plan;

(b) Come to scheduled appointments with people who provide WorkFirst services or activities;

(c) Do all of the activities listed on your individual responsibility plan; or

(d) Accept paid employment that meets the criteria in WAC 388-310-1500.

(2) **What happens once I do not provide information, go to an appointment, follow my individual responsibility plan or accept a job?**

If you do not provide information, go to an appointment, follow up on your individual responsibility plan or accept a job, your case manager or social worker will send you a notice to set up an appointment so they can talk to you about the situation. If they are unable to contact you, they will use the information already on hand to find out why you did not follow through with the required activity. Then, your case manager will decide whether:

(a) You were unable to do what was required; or

(b) You were able, but refused, to do what was required.

(3) **What is considered a good reason for not being able to do what WorkFirst requires?**

You have a good reason if it was not possible to follow through on a required activity due to an event outside of your control. Some examples of good reasons may include:

(a) You, your children or other family members were ill;

(b) Your transportation or child care arrangements broke down and you could not make new arrangements in time to comply;

(c) You could not locate child care, for your children under thirteen years, that was:

(i) Affordable (did not cost you more than your co-payment would under the working connections child care program in WAC 388-290);

(ii) Appropriate (licensed, certified or approved under federal, state or tribal law and regulations for the type of care you use and you were able to choose, within locally available options, who would provide it); and

(iii) Within a reasonable distance (within reach without traveling farther than is normally expected in your community).

(d) You could not locate other care services for an incapacitated person who lives with you and your children;

(e) You had a physical, mental or emotional condition, confirmed by a licensed health care professional, that interfered with your ability to participate;

(f) A significant person in your life died;

(g) You were threatened with or subjected to family violence;

(h) You had an immediate legal problem, such as an eviction notice; or

(i) You did not get notice telling you about our information request, an appointment or a requirement on your individual responsibility plan.

(4) **What if my case manager decides that I refused to meet WorkFirst requirements without good reason?**

If your case manager decides you refused to meet WorkFirst requirements without good reason, they will send you a notice that tells you:

(a) What you refused to do;

(b) You will be sanctioned (a penalty will be applied to your grant);

(c) When the sanction starts;

(d) How to request a fair hearing if you disagree with this decision; and

(e) How to end the sanction.

(5) **What are the penalties to my grant?**

The following penalties are applied to your grant for anyone who is sanctioned in your household:

(a) In the first month, we calculate your family's grant and then remove the noncompliant person(s) share of the grant.

(b) In the second month, your reduced grant will be sent to a protective payee every month until the sanction is lifted. (WAC 388-460-0001 describes the protective payee rules.)

(c) In the third and following months, your grant is reduced by the person(s) share or forty percent, whichever is more.

(6) **How do I stop (or end) the sanction?**

To end your sanction:

(a) You must provide the information we requested to develop your individual responsibility plan; and/or

(b) Start and continue to do your required WorkFirst activities.

(c) Your grant will be restored after two weeks of participation, beginning with the day you began doing your required activities.

(7) **What happens if I get sanctioned again after my sanction has been stopped?**

If you are sanctioned again, the sanction process will start again.

(8) **What if I reapply for TANF, SFA or GA-S and I was in sanction when my case closed?**

You are still sanctioned at the level which was in effect when your case closed until you cure your sanction.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1600, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1600, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1700 WorkFirst—Self-employment. (1) **What is self-employment?**

When you work for yourself and do not have an employer, you are self-employed.

(2) **When can I be deferred from job search to pursue self-employment?**

(a) To be deferred from job search for self-employment, you must meet all the conditions below:

(i) You must be working at least twenty hours a week at your business;

(ii) Your business must generate income for you that is equal to the minimum wage (state or federal, whichever is higher) times twenty hours per week after your business expenses are subtracted.

(iii) Your case manager will refer you to a local business resource center, and they must approve your self-employment plan;

(b) If you do not meet all these conditions, you can still be self-employed, but you will also need to participate in job search or other WorkFirst activities.

(3) **What self-employment services can I get?**

If you are a mandatory participant and have an approved self-employment plan in your individual responsibility plan, you may get the following self-employment services:

(a) A referral to community resources for technical assistance with your business plan.

(b) Small business training courses through local community organizations or technical and community colleges.

(c) Information on affordable credit, business training and ongoing technical support.

(4) **What support services may I receive?**

If you have an approved self-employment plan in your individual responsibility plan all support services are available.

(5) **Can I get childcare?**

Childcare is available if you have an approved self-employment plan in your individual responsibility plan. (See chapter 388-290 WAC for working connections child care rules.)

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1700, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1800 WorkFirst—Post employment services. (1)**What is the purpose of post employment services?**

Post employment services help low-income parents who are working twenty hours or more a week keep and cope with their current jobs, look for better jobs, gain work skills for a career and become self sufficient.

(2) **How do I obtain post employment services?**

(a) You can obtain post employment services by:

(i) Asking for a referral from the local community service office;

(ii) Contacting community or technical colleges; or

(iii) Contacting the employment security department. Employment security department staff may also telephone you if you got a job while you were on TANF or SFA to see if you are interested in receiving these services.

(b) You may qualify for different services (from various state or federal programs) depending on whether you:

(i) Are a mandatory participant (that is, you currently receive TANF, SFA or GA-S benefits);

(ii) Used to receive TANF or SFA benefits; or

(iii) Have never been on TANF or SFA.

(3) **Who provides post employment services and what kind of services do they provide?**

(a) You may be assigned to a job success coach, or similar services. Job success services must be delivered in accordance with the equitable access to Indians requirements in state law (in RCW 74.08A.040). The job success coach is a person who will work with you to increase your success in the workplace. The purpose of the job success coach, or similar post employment services, is to:

(i) Help you resolve problems with your employer;

(ii) Help you adjust to your workplace;

(iii) Provide job coaching;

(iv) Provide mentoring;

(v) Increase your job skills;

(vi) Help you develop the skills you need to keep your job;

(vii) Create steps to help you increase your wages; and/or

(viii) Develop educational activities to promote wage progression.

(b) The employment security department can help you increase your wages, increase your job skills or find a better job by providing you with:

(i) Employment and career counseling;

(ii) Labor market information;

(iii) Job leads for a better job (sometimes called job development);

(iv) On the job training;

(v) Help with finding a job that matches your interests, abilities and skills (sometimes called job matching); and

(vi) Help with finding a new job after job loss (sometimes called reemployment).

(c) Any Washington state technical and community college can approve a skill-training program for you that will help you advance up the career ladder. Their staff will talk to you, help you decide what training would work best for you and then help you get enrolled in these programs. The college may approve the following types of training for you at any certified institution:

(i) High school/GED,

(ii) Vocational education training,

(iii) Job skills training,

(iv) Adult basic education,

(v) English-as-a-Second language training, or

(vi) Pre-employment training.

(4) **What other services are available while you receive post employment services?**

While you receive post employment services, you may qualify for:

(a) Working connections childcare if you meet the criteria for this program (described in chapter 388-290 WAC). To qualify, you must also be in an approved post-employment service and your family's income cannot exceed one hundred seventy-five percent of the federal poverty level.

(b) Other support services, such as help in paying for transportation or work expenses.

(c) Other types of assistance for low-income families such as food stamps, medical assistance or help with getting child support that is due to you and your children.

(5) **Who is eligible for post employment service, support services and childcare?**

You may qualify for post-employment services, support services and child care if you are working twenty hours or more a week, and:

(a) You are current TANF or SFA recipient. You qualify for:

(i) All types of post employment services, unless you are in sanction status;

(ii) Tuition assistance from the community and technical college system;

(iii) WorkFirst support services; and

(iv) Working connections childcare.

(b) You are a former TANF or SFA recipient. You qualify for:

(i) Employment retention services (help with keeping a job) for up to twenty-four months after exiting TANF or SFA.

(ii) Wage and skill progression services (help with finding a better job and/or obtaining better wages) for up to twenty four months after exiting TANF or SFA.

(iii) Tuition assistance or pre-employment training from the community and technical college system;

(iv) Working connections childcare assistance; and/or

(v) WorkFirst support services for up to twelve months after exiting TANF or SFA.

(c) You are a low wage earner (that is, your family income does not exceed one hundred seventy-five percent of the federal poverty level) who has never received TANF or SFA benefits, and are in a community or technical college-approved skill training program. You may qualify for:

(i) Tuition assistance or pre-employment training from the community and technical college system; or

(ii) Working connections child care while you are in training or school for up to a total of thirty six months.

(6) **What if I lose my job while I am receiving post employment services?**

If you now receive or used to receive TANF or SFA, help is available to you for up to four weeks so that you can find another job and continue in your approved post employment.

(a) The employment security department will provide you with re-employment services.

(b) At the same time, your case manager can approve up to four weeks of support services and childcare for you.

[Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-1800, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1800, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1900 WorkFirst—Services for American Indian tribal members and other American Indians. (1) **When might I be referred to a tribal government?**

Your case manager may refer you to a tribal government when you are an American Indian who applies for or receives TANF assistance, and:

(a) You are in the population and service area identified in a tribal government's federally-approved tribal TANF program; or

(b) The tribal government does not operate its own TANF program, but it works with the local community service office to provide WorkFirst services and activities to meet your needs.

(2) **What if I am an American Indian and am not referred to a tribal TANF program or tribal government to receive services?**

WorkFirst state agencies and their community partners must give you equitable access to all WorkFirst activities and services.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1900, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1900, filed 10/1/97, effective 11/1/97.]

Chapter 388-330 WAC
BACKGROUND INQUIRIES

WAC

WAC 388-330-010 Purpose and authority. This chapter establishes policy within the department of social and health services for conducting background inquiries and checks of Washington state child abuse information files on those licensed or authorized by the department to care for children or developmentally disabled persons and those employed by or associated with a licensed agency. Such inquiries are required under RCW 74.15.030.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-330-010, filed 4/26/96, effective 5/27/96; 93-15-040 (Order 3534), § 388-330-010, filed 7/13/93, effective 8/13/93; 89-07-096 (Order 2777), § 388-330-010, filed 3/22/89.]

WAC 388-330-020 Scope. (1) Background inquiries. The department's background inquiries:

(a) Shall include, but not be limited to review of:

(i) Records of criminal convictions and pending criminal charges as listed by the Washington state patrol (WSP) per chapters 10.97 and 43.43 RCW;

(ii) Washington state patrol file of a person found to be a child abuser in a civil adjudication or a disciplinary board final decision; and

(iii) Child protective service and case file information in the case and management information system and division of children and family services (DCFS) records.

(b) May include a review of law enforcement records of convictions and pending charges in other states or locations when the need for further information is indicated by:

(i) A person's prior residences;

(ii) Reports from credible community sources; or

(iii) An identification number indicating the subject has a record on file with the Federal Bureau of Investigation.

(2) Affected persons. Persons subject to background inquiries include:

(a) All persons licensed to care for children or disabled persons under:

(i) Chapter 74.15 RCW; or

(ii) Contract with the department to provide that care.

(b) All staff, employed by licensed or authorized providers, involved in the direct care or supervision of children and developmentally disabled persons;

(c) Any volunteer or other person having regular, unsupervised access to children or developmentally disabled persons in facilities, homes, or operations licensed or authorized by the department to provide care under chapter 74.15 RCW.

(3) Persons not affected. This chapter does not apply to schools, hospitals, or other facilities where the primary focus is not custodial and where the provider is not acting in place of the parent.

(4) This chapter does not apply to persons being considered for employment or volunteer activities with the department of social and health services. Background check requirements applicable to department employees and volunteers are set forth in MSR 326-26-140 and 2SSB 5063, chapter 486, Laws of 1987, respectively.

[Statutory Authority: RCW 74.15.030. 93-15-040 (Order 3534), § 388-330-020, filed 7/13/93, effective 8/13/93; 89-07-096 (Order 2777), § 388-330-020, filed 3/22/89.]

WAC 388-330-030 Application of inquiry findings. (1) For the purposes of conducting criminal history portions of background inquiries under RCW 74.15.030, the department shall only consider a person's convictions and pending charges. The department shall not solicit or use as the sole basis for disqualification information about:

(a) Arrests not resulting in charges; and

(b) Dismissed charges.

(2) The department shall maintain a listing of offenses which, because of their seriousness, shall disqualify prospective care providers from being licensed or otherwise authorized to provide care to children or developmentally disabled persons. The following offenses or their equivalents in jurisdictions outside of the state of Washington shall constitute that list:

(a) Aggravated murder;

(b) Murder in the first degree;

(c) Murder in the second degree;

(d) Manslaughter in the first degree;

(e) Manslaughter in the second degree;

(f) Simple assault, if the assault involves physical harm to another person;

(g) Assault in the first degree;

(h) Assault in the second degree;

(i) Assault in the third degree;

(j) Custodial assault;

(k) Vehicular homicide;

(l) Criminal mistreatment in the first degree;

(m) Criminal mistreatment in the second degree;

(n) Reckless endangerment;

(o) Kidnapping in the first degree;

(p) Kidnapping in the second degree;

(q) Unlawful imprisonment;

(r) Rape in the first degree;

(s) Rape in the second degree;

(t) Rape in the third degree;

(u) First degree rape of a child;

(v) Second degree rape of a child;

(w) Third degree rape of a child;

(x) Child molestation in the first degree;

(y) Child molestation in the second degree;

(z) Child molestation in the third degree;

(aa) Sexual misconduct with a minor in the first degree;

(bb) Sexual misconduct with a minor in the second degree;

(cc) Indecent liberties;

(dd) Felony indecent exposure;

(ee) Arson in the first degree;

(ff) Arson in the second degree;

(gg) Burglary in the first degree;

(hh) Extortion in the first degree;

(ii) Extortion in the second degree;

(jj) Robbery in the first degree;
(kk) Robbery in the second degree;
(ll) Incest in the first degree;
(mm) Incest in the second degree;
(nn) Promoting prostitution in the first degree;
(oo) Promoting prostitution in the second degree;
(pp) Sexual exploitation of a minor;
(qq) Communication with a minor for immoral purposes;
(rr) Child selling - child buying;
(ss) Public indecency, if toward a person under fourteen years of age;
(tt) Prostitution;
(uu) Dealing in depictions of a minor engaged in sexually explicit conduct;
(vv) Sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;
(ww) Possession of depictions of a minor engaged in sexually explicit conduct;
(xx) Patronizing a juvenile prostitute;
(yy) Family abandonment;
(zz) Child abandonment;
(aaa) Unlawfully manufacturing, delivering, or possessing, with intent to deliver, a controlled substance;
(bbb) Promoting a suicide attempt;
(ccc) Malicious harassment;
(ddd) Promoting pornography;
(eee) Coercion;
(fff) Child abuse or neglect as defined under RCW 26.44.020;
(ggg) Violation of child abuse restraining order; and
(hhh) First or second degree custodial interference.

(3) Whenever a criminal history inquiry reveals a prospective care provider has been charged with or convicted of an offense or is in the WSP file as a person found to be a child abuser in a civil adjudication or disciplinary board final decision, the department shall take action as follows:

(a) If it is confirmed the subject's name appears on the aforementioned WSP file of child abusers, that person shall not be licensed, employed by licensees or contractors, serve in a volunteer capacity for licensees or contractors, or otherwise be authorized by the department to provide care;

(b) If the inquiry reveals charges are pending against the subject for any of the offenses listed in subsection (2) of this section, or their equivalents in other jurisdictions, the department shall withhold licensure or authorization to provide care until dismissal or acquittal occurs. Pending charges for other offenses may be grounds for withholding licensure or authorization to provide care. If the inquiry reveals pending charges are more than one year old, the department shall contact the charging law enforcement agency to determine the disposition or status of the charge;

(c) If the inquiry reveals the subject has been convicted of any of the offenses listed in subsection (2) of this section or their equivalents in other jurisdictions, the department shall deny licensure or authorization to provide care. The department at its discretion may license a person or authorize a person to provide care despite a conviction under subsection (2) of this section if the person presents to the department a certificate of rehabilitation issued by a superior court under RCW 43.43.830(4). A certificate of rehabilitation shall address the fitness of the person to provide the specific type of care considering the following factors:

(i) The seriousness and circumstances of the illegal act;
(ii) The number of crimes for which the person was convicted;
(iii) The amount of time passed since the illegal act was committed;
(iv) The age of the person at the time of conviction;
(v) Whether the person has entered and successfully completed all appropriate rehabilitative services, including those ordered by a court;
(vi) The behavior of the person since the illegal act was committed;
(vii) Recommendations of persons closely associated with the person;
(viii) The duties the person would perform at the agency, and the vulnerability of the persons under care; and
(ix) Other evidence of rehabilitation.

If the department licenses or approves a person under this subsection, it may place limitations or conditions on the person in the performance of the person's duties at the agency.

(d) If the inquiry reveals the subject has been convicted of an offense not listed in subsection (2) of this section, the department shall consider such information in determining the character, suitability, and competence of the prospective caretaker as required by chapter 74.15 RCW. However, the department shall not use conviction as the sole basis for denial of licensure or authorization to provide care unless the conviction is directly related to the employment, licensure, or authorization being sought. The department shall consider the recency, seriousness, kind, and number of previous offenses, as well as the vulnerability of the clients to be cared for.

[Statutory Authority: RCW 74.15.030. 93-15-040 (Order 3534), § 388-330-030, filed 7/13/93, effective 8/13/93. Statutory Authority: RCW 74.15.030, chapters 74.15 and 43.43 RCW. 92-08-038, § 388-330-030, filed 3/24/92, effective 4/24/92. Statutory Authority: RCW 74.15.030. 89-07-096 (Order 2777), § 388-330-030, filed 3/22/89.]

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.]

WAC 388-330-040 Inquiry form to be submitted—Time requirements. (1) Applicants for licensure under chapter 74.15 RCW shall complete the background inquiry form at the time of application.

(2) Employees and volunteers of those licensed or otherwise authorized to provide care under chapter 74.15 RCW shall complete and submit the DSHS background inquiry form to the person licensed or authorized to provide care. This shall be done prior to or as soon as possible after being on the premises and having regular unsupervised contact with children or developmentally disabled persons. The employer, licensee, or authorized person shall submit the properly completed form to the appropriate DSHS licensor or authorizing person within seven calendar days of the time the employee or volunteer had regular unsupervised contact.

(3) The department shall not issue a license or otherwise authorize persons to provide care until they have properly completed and submitted the inquiry form and the results are known to the department; except, such care may be authorized if the inquiry form has been submitted. If a child is placed with a relative under RCW 13.34.060 or 13.34.130, and if such relative appears otherwise suitable and competent to provide care and treatment, the criminal history background check required by this section need not be completed before placement, but shall be completed as soon as possible after placement.

[Statutory Authority: RCW 74.15.030. 89-07-096 (Order 2777), § 388-330-040, filed 3/22/89.]

WAC 388-330-050 Release of information. (1) Release of criminal history information.

(a) Unless there is a signed release of information, the department may only share with a provider:

(i) The criminal inquiry information used to disqualify an employee or volunteer of that provider; or

(ii) The fact the subject is listed on the Washington state patrol's child abuse information file if that is the basis for a disqualification.

(b) The department shall not share any other inquiry information with the provider or provider's employees unless the department withheld licensure or care authorization based on that information.

(2) Release of abuse information from department files.

(a) The department shall not share with care providers or prospective providers any abuse information in department files.

(b) Unless there is a release of information signed by the employee, the department may only tell a provider or prospective provider that the results of the department's background inquiry disqualify the employee. Even if the employee has signed a release of information, the department shall not discuss identifying information about the victim of the abuse.

(3) Release of inquiry findings to the subject of inquiry. The department shall provide disqualified care providers with inquiry findings about themselves if the providers:

(a) Make the requests in writing; and

(b) Offer proof of identity.

[Statutory Authority: RCW 74.15.030. 93-15-040 (Order 3534), § 388-330-050, filed 7/13/93, effective 8/13/93; 89-07-096 (Order 2777), § 388-330-050, filed 3/22/89.]

WAC 388-330-060 Sanctions for noncompliance. Any licensee, employer, contractor, or other care provider within the scope of this chapter may be subject to sanctions by the department pursuant to applicable licensing requirements or statutes or contractual agreements for failure to comply with the requirements of this chapter.

[Statutory Authority: RCW 74.15.030. 89-07-096 (Order 2777), § 388-330-060, filed 3/22/89.]

Chapter 388-400 WAC
PROGRAM SUMMARY

WAC

WAC 388-400-0005 Who is eligible for temporary assistance for needy families? (1) You can get temporary assistance for needy families (TANF), if you:

(a) Can be included in a TANF/SFA assistance unit as defined in WAC 388-408-0015 through 388-408-0030;

(b) Meet the citizenship/alien status requirements of WAC 388-424-0005;

(c) Reside in the state of Washington, or, if you are a child, live with a caretaker relative who meets the state residency requirements of WAC 388-468-0005;

(d) Are in financial need as specified under chapters 388-450, 388-470 and 388-488 WAC;

(e) Assign your rights to child support and cooperate in establishing paternity and collecting child support as required under WAC 388-422-0005 through 388-422-0030;

(f) Provide your Social Security number as required under WAC 388-476-0005;

(g) Cooperate in a review of your eligibility as required under WAC 388-434-0005;

(h) Cooperate in a quality assurance review as required under WAC 388-464-0001;

(i) Participate in the WorkFirst program as required under chapter 388-310 WAC;

(j) Report changes of circumstances as required under WAC 388-418-0005;

(k) Meet the requirements of WAC 388-462-0010, if you are pregnant; and

(l) Meet the living arrangement and school attendance requirements of WAC 388-486-0005 and 388-486-0010, if you are an unmarried pregnant and parenting teen.

(2) In addition to rules listed in subsection (1) of this section, a child must meet the following rules to get TANF:

(a) Meet the age requirements under WAC 388-404-0005; and

(b) Live in the home of a relative as required under WAC 388-454-0005; or

(c) If living with a parent, that parent cannot have exhausted their sixty-month lifetime limit of TANF or SFA cash benefits as defined in WAC 388-484-0005.

(3) You cannot get TANF if you have been:

(a) Convicted of certain felonies and other crimes as specified in WAC 388-442-0010; and

(b) Convicted of unlawful practices in obtaining public assistance as specified in WAC 388-446-0005 and 388-446-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-400-0005, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0010 Who is eligible for state family assistance? (1) To be eligible for state family assistance (SFA), certain aliens must meet Washington state residency requirements as listed in WAC 388-424-0015.

(2) You are eligible for SFA if you are not eligible for temporary assistance for needy families for the following reasons:

(a) You are a qualified alien and have been in the United States for less than five years as described in WAC 388-424-0010;

(b) You are a alien who is permanently residing in the United States under color ow law (PRUCOL) as defined in WAC 388-424-0005;

(c) You are a nineteen or twenty-year-old student that meets the education requirements of WAC 388-404-0005;

(d) You are a caretaker relative of a nineteen or twenty-year-old student that meets the education requirements of WAC 388-404-0005; or

(e) You are a pregnant woman who has been convicted of:

(i) Misrepresenting their residence in order to receive benefits from two or more states at the same time; or

(ii) A drug-related felony as described in WAC 388-442-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-400-0010, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0015 General assistance for children—Summary of eligibility requirements. (1) To be eligible for general assistance for children (GA-H), a child must:

(a) Live with a court-appointed legal guardian or court appointed permanent custodian as required under chapter 388-454 WAC;

(b) Meet the general assistance citizenship/alien status requirements under WAC 388-424-0005(3);

(c) Be in financial need according to temporary assistance for needy families (TANF) income and resource rules in chapters 388-450, 388-470 and 388-488 WAC, except that child support received is considered the child's unearned income; and

(d) Meet all other requirements of a child eligible for TANF except citizenship/alien status and requirements to:

(i) Live with a relative of specified degree; and

(ii) Participate in WorkFirst activities if not in school.

(2) A child is not eligible for GA-H if:

(a) The child is eligible for or receives TANF or Supplemental Security Income (SSI); or

(b) The child or the child's caretaker has refused or failed to cooperate in obtaining TANF or SSI on behalf of the child.

(3) A GA-H assistance unit is established as specified in WAC 388-408-0010.

(4) The child's custodian or payee is the GA-H grant payee.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0020 General assistance for pregnant women—General eligibility requirements. (1) To be eligible for general assistance for pregnant women (GA-S), a woman must:

(a) Meet the requirements of WAC 388-462-0005; and

(b) Meet the general assistance citizenship/alien status requirements under WAC 388-424-0005(3); and

(c) Be in financial need according to temporary assistance for needy families (TANF) income and resource rules in chapters 388-450, 388-470 and 388-488 WAC; and

(d) Provide a Social Security number as required under WAC 388-476-0005; and

(e) Reside in the state of Washington as required under WAC 388-468-0005.

(2) A woman is not eligible for GA-S if she:

(a) Is eligible for or her needs are being met by the Supplemental Security Income (SSI) program TANF or state family assistance (SFA);

(b) Is under sanction for failing to comply with SSI requirements;

(c) Fails or refuses to cooperate without good cause in obtaining SSI; or

(d) Fails or refuses to cooperate in obtaining TANF or SFA. This includes disqualifications for:

(i) Convictions for misrepresenting residence to obtain assistance in two or more states as specified under chapter 388-446 WAC;

(ii) Convictions for drug-related felonies and failing to complete drug treatment as specified under chapter 388-442 WAC;

(iii) Failing to report a child's absence within five days of becoming reasonably certain the absence will exceed ninety days as specified in chapter 388-418 WAC; or

(iv) Failing to meet school attendance requirements for unmarried teen parents as specified under chapter 388-486 WAC.

(3) The assistance unit for a woman applying for or receiving GA-S will be established according to WAC 388-408-0010.

(4) Unmarried pregnant or parenting minors who are not emancipated under a court decree must meet the living arrangement requirements of WAC 388-486-0005.

(5) A pregnant woman in an institution may be eligible for GA-S as specified under WAC 388-230-0080.

(6) Effective May 1, 1999, GA-S cash benefits will count toward the sixty-month time limit as specified under WAC 388-484-0005.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-08-050, § 388-400-0020, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0025 General assistance unemployable—General eligibility requirements. (1) You can get general assistance unemployable (GAU) benefits if:

(a) You are incapacitated as required under WAC 388-448-0010 through 388-448-0120;

(b) You are at least eighteen years old or, if under eighteen, a member of a married couple;

(c) You are in financial need according to GAU income and resource rules in chapters 388-450, 388-470 and 388-488 WAC;

(d) You meet the general assistance citizenship/alien status requirements under WAC 388-424-0005(3);

(e) You provide a Social Security number as required under WAC 388-476-0005;

(f) You reside in the state of Washington as required under WAC 388-468-0005;

(g) You undergo a treatment and referral assessment as provided under WAC 388-448-0130 through 388-448-0150;

(h) You assign interim assistance as provided under WAC 388-448-0210.

(2) You cannot get GAU benefits if:

(a) You are eligible for temporary assistance for needy families (TANF) benefits;

(b) You are eligible for state family assistance (SFA) benefits unless you are not eligible under WAC 388-400-0010;

(c) You have the ability to, but refuse to meet a TANF or SFA eligibility rule;

(d) You are eligible for supplemental security income (SSI) benefits;

(e) You are an ineligible spouse of an SSI recipient; or

(f) You were denied benefits or your benefits were terminated by the Social Security Administration (SSA) for failing to follow a SSI program rule or application requirement.

(3) The assistance unit will be established according to WAC 388-408-0010.

(4) You may be eligible for GAU if you reside in a public institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.

Your eligibility will depend upon the type of institution you are in.

(a) If you reside in a public institution and are otherwise eligible for GAU, you may be eligible for general assistance if you are:

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

(ii) A patient in a public mental institution and are:

(A) Sixty-five years of age or older; or

(B) Twenty years of age or younger.

(b) You are not eligible for GAU when you are in the custody of or confined in a public institution such as a state penitentiary or county jail including placement:

(i) In a work release program; or

(ii) Outside of the institution.

[Statutory Authority: RCW 74.04.057, 74.08.090. 00-15-017, § 388-400-0025, filed 7/10/00, effective 9/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0030 Refugee cash assistance—Summary of eligibility requirements. (1) To be eligible for refugee cash assistance (RCA), persons must:

(a) Provide the name of the voluntary agency (VOLAG) which resettled them; and

(b) Meet the:

(i) Immigration status requirements of WAC 388-466-0005;

(ii) Work and training requirements of WAC 388-466-0015;

(iii) Income and resource requirements under chapters 388-450 and 388-470 WAC with exceptions as provided under WAC 388-466-0010; and

(iv) Monthly reporting requirements of chapter 388-456 WAC.

(2) Persons are not eligible to receive RCA if they:

(a) Are eligible for temporary assistance for needy families (TANF) or Supplemental Security Income;

(b) Have been denied TANF or have been terminated from TANF due to intentional noncompliance with TANF eligibility requirements; or

(c) Are full-time students in institutions of higher education unless the educational activity is part of a department-approved employability plan.

(3) Refugee families, including families with children who are United States citizens, will be treated as single assistance units according to chapter 388-408 WAC.

(4) Eligibility and benefit levels for RCA assistance units are determined using the TANF payment standards in WAC 388-478-0020.

(5) Persons eligible for RCA are eligible for additional requirements for emergent situations as provided in chapter 388-436 WAC.

(6) A person meeting the requirements of this section is eligible for refugee cash assistance only during the eight-month period beginning in the first month the person entered the United States.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0035 Refugee medical assistance—Summary of eligibility requirements. (1) To be eligible for refugee medical assistance (RMA), persons must:

(a) Provide the name of the voluntary agency (VOLAG) which resettled them; and

(b) Meet the immigration status requirements of WAC 388-466-0005.

(2) Except for a person who is not eligible under subsection (3) of this section, a person is eligible for RMA if the person:

(a) Receives refugee cash assistance (RCA); or

(b) Is eligible for but chooses not to apply for or receive RCA.

(3) Persons are not eligible to receive RMA if they are:

(a) Eligible for Medicaid;

(b) Are not eligible for RCA because they have not met the employment and training requirements of WAC 388-466-0015; or

(c) Are full-time students in institutions of higher education unless the educational activity is part of a department-approved employability plan.

(4) Refugee families, including families with children who are United States citizens, will be treated as single assistance units according to chapter 388-408 WAC.

(5) A person meeting the requirements of this section is eligible for RMA only during the eight-month period beginning in the first month the person entered the United States.

(6) A recipient of RCA and RMA who becomes ineligible for RCA due to an increase in income remains eligible for extended RMA benefits until the end of the eighth month period following entry into the United States.

(7) A person will have his or her eligibility for RMA determined based on the rules for the medically needy program if the person is:

(a) Not eligible for Medicaid; or

(b) Not eligible for RCA because of excess income, unless the person is eligible for extended RMA under subsection (6) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0040 General eligibility requirements for the federal food assistance program. (1) Persons applying for benefits for the federal food assistance program must meet certain eligibility criteria established under the Food Stamp Act of 1977 as amended.

(2) When a person applies for benefits, a decision is made about who must be included in the assistance unit as specified under WAC 388-408-0035.

(3) After the assistance unit is determined, all members must:

(a) Be U.S. citizens or nationals as specified under WAC 388-424-0005(1); or

(b) Be qualified aliens as specified under WAC 388-424-0020;

(c) Be residents of the state of Washington as specified under chapter 388-468 WAC; and

(d) Provide Social Security numbers as specified under chapter 388-476 WAC.

(4) To be eligible, an assistance unit must:

(a) Have income at or below gross and net income standards unless excluded from these standards as specified under WAC 388-478-0060;

(b) Own resources at or below the applicable resource limits as specified in WAC 388-470-0005;

(c) Provide identity as specified under WAC 388-406-0015;

(d) Participate in the food stamp employment and training program (FSE&T) as specified under chapter 388-444 WAC;

(e) Meet the eligibility criteria for strikers as specified in chapter 388-480 WAC;

(f) Return a completed monthly report as required under chapter 388-456 WAC.

(5) Assistance units are allowed deductions from their income as specified under WAC 388-450-0200.

(6) Persons with disabilities may be allowed special consideration as explained in subsection (7) of this section, when the person:

(a) Receives SSI;

(b) Receives disability payments:

(i) Under Titles I, II, XIV, or XVI of the Social Security Act;

(ii) From a local, state or federal government agency that considers the disability as permanent under section 221(i) of the Social Security Act;

(iii) From the Railroad Retirement Act under sections 2 (a)(1)(iv) and (v) and meets Title XIX disability elements or is eligible for Medicare.

(c) Receives disability-related medical assistance under Title XIX of the Social Security Act;

(d) Is a veteran and receives disability payments rated at one hundred percent;

(e) Is a spouse of a veteran and:

(i) Is in need of an attendant or permanently housebound; or

(ii) Has a disability as described under section 221(i) of the Social Security Act and entitled to death or pension payments under Title 38 of the USC.

(7) A person with disabilities described in subsection (6) of this section:

(a) Does not have to have income at or below the gross income standard, only the net income standard;

(b) May be entitled to a medical deduction as described under chapter 388-450 WAC; or

(c) Is not required to count the value of a vehicle when the vehicle is needed to transport them as specified under WAC 388-470-0070 and 388-470-0075.

(8) The following persons applying for food assistance are denied benefits:

(a) Students attending an institution of higher education when the student does not meet the eligibility factors as specified under WAC 388-482-0005;

(b) Able-bodied adults without dependents who are no longer eligible under WAC 388-444-0030; and

(c) Assistance units who participate in the food distribution program. This program is available to assistance units living on or near an Indian reservation. The program is administered by tribal organizations approved by the federal Food and Nutrition Service (FNS).

(9) The following persons applying for food assistance are denied benefits but some of their income and all of their resources are considered available to the eligible assistance unit members:

(a) Fugitive felons including probation and parole violators and felons convicted of drug-related felonies as specified under chapter 388-442 WAC;

(b) Persons failing to attest to citizenship or alien status under WAC 388-408-0035(9);

(c) Persons disqualified for:

(i) An intentional program violation as specified under WAC 388-446-0015;

(ii) Failure to provide a Social Security number under chapter 388-476 WAC; or

(iii) Not participating with work requirements as specified under chapter 388-444 WAC; or

(d) Persons who are ineligible aliens under WAC 388-424-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0045 Food assistance program for legal immigrants (FAP)—General eligibility requirements. (1) A legal immigrant meets alien status eligibility for the state-funded food assistance program if the immigrant:

(a) Meets those alien status requirements of the Food Stamp Act of 1977 in effect prior to August 22, 1996;

(b) Is not eligible for federal food stamps solely due to the immigrant provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193, as amended. The immigrant must meet alien status rules under WAC 388-424-0025.

(2) FAP provides the same amount of benefits as the federal food stamp program. Some assistance units may receive a combined benefit of both state and federal food stamps. Food assistance benefit levels are found in WAC 388-478-0060.

(3) FAP follows the same eligibility rules, except for alien status, as the federal food stamp program. The federal food stamp program summary is found in WAC 388-400-0040.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0045, filed 7/31/98, effective 9/1/98.]

Chapter 388-404 WAC
AGE REQUIREMENTS

WAC

WAC 388-404-0005 How does a child's age affect their eligibility for TANF, SFA or GA-H? (1) To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA) or general assistance for children (GA-H), a child must be:

(a) Under age eighteen; or

(b) Under age nineteen, and participating full-time in a secondary education program or the equivalent level of vocational or technical training.

(i) "Participating" means the educational or training institution has determined:

(A) The child's school attendance is satisfactory; and

(B) The child is making acceptable progress toward completing the program.

(ii) "Full-time" attendance and course load requirements are defined by the educational or training institution.

(2) A child who does not qualify for assistance under subsection (1) of this section may qualify for SFA if the child is under age twenty-one, and:

(a) Receiving a special education due to their disability as specified in RCW 28A.155.020; or

(b) Participating full-time in a secondary education program or the equivalent level of vocational training as defined in (1)(b) above.

(3) Children who receive SFA under WAC 388-404-0005 and who are nineteen years of age or older are not eligible for family medical or SFA related medical.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-404-0005, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-404-0010 Age requirement for GA-U and ADATSA. To be eligible for general assistance - unemployable (GA-U) or the ADATSA program a person must be:

(1) At least eighteen years of age or older; or

(2) For GA-U only, if under eighteen years of age, a member of a married couple:

(a) Residing together, or

(b) Residing apart solely because a spouse is:

(i) On a visit of ninety days or less;

(ii) In a public or private institution;

(iii) Receiving care in a hospital, long-term care facility, or chemical dependency treatment facility; or

(iv) On active duty in the uniformed military services of the United States.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-404-0015 Definition of elderly person for food and cash assistance programs. For food and cash assistance, **"elderly person"** means a person sixty years of age or older.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-406 WAC
APPLICATIONS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-406-0020 Destitute household definition. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0020, filed 7/31/98, effective 9/1/98.] Repealed by 99-24-008, filed 11/19/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-406-0005 Who may apply. Any person may file an application for cash, medical or food assistance.

(1) For food assistance, applications may be made by a responsible household member or an authorized representative.

(2) For medical and cash assistance, an application may be made by:

(a) Persons applying on their own behalf or on behalf of their dependents;

(b) A legal guardian or caretaker applying on behalf of a minor or incompetent person; or

(c) Any other person acting on behalf of the applicant when application cannot be made under one of the preceding methods. For cash assistance the person must indicate the reason the applicant is not able to apply on his or her own behalf.

(3) For GA-U and medical programs, a Washington state resident who is temporarily living out of the state may apply through a person or agency acting on the client's behalf.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0405 and 388-504-0410.]

WAC 388-406-0010 Filing an application. (1) A person may file an application by submitting a written request for benefits using a form designated by the department, to the applicant's local community service office (CSO) in person or by mail.

(a) A person may file an application on the same day that benefits are requested when the request is made in the applicant's local CSO during regular business hours.

(b) A household applying for food, medical and/or cash assistance may do so by submitting a single request for benefits.

(c) For food assistance, a household consisting only of clients applying for or receiving Supplemental Security Income (SSI) may file an application at the local Social Security Administration District Office (SSADO).

(d) Clients who receive SSI or who are otherwise determined eligible for Medicaid by the Social Security Administration will be authorized medical assistance without being required to file a separate application with the department.

(2) The request for benefits form must be as brief as administratively possible and seek information ordinarily known to the applicant, including:

(a) The name and address of the applicant;

(b) The type of assistance requested (i.e., food, medical and/or cash assistance);

(c) For medical and cash assistance:

(i) The applicant's telephone number, if known; and

(ii) The names, birthdates and social security numbers, if known, of all persons for whom assistance is requested; and

(d) For TANF and SFA, the names, birthdates and social security numbers, if known, of:

(i) All children under the age of nineteen who are living in the home and who are siblings of any child for whom assistance is being requested; and

(ii) All parents, if living in the home, of any child for whom assistance is requested.

(e) An application is required for a medically needy program client who requests eligibility beyond the certification period.

(3) To initiate an application, the filed request for benefits form must include:

(a) The name and address of the applicant; and

(b) The signature of the applicant or the applicant's representative.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0405.]

WAC 388-406-0015 Expedited service for food assistance. (1) When you give us your food assistance application, the department will look at your situation to see if you can get benefits within five calendar days. This fast service is called "expedited service." "Day one" of the five-day period is, most often, the day after you give us your application. See subsection (7) below for situations for applicants when "day one" is a different day.

(2) To get expedited service, you must provide proof of your identity and meet one of these three conditions:

(a) You have available cash of one hundred dollars or less and have monthly income before taxes under one hundred fifty dollars; or

(b) Your monthly income before taxes plus available cash is less than the total of your rent and utility allowance; or

(c) You have a destitute migrant or seasonal farm worker household member, as defined in WAC 388-406-0021, whose available cash does not exceed one hundred dollars.

(3) If you get expedited service, you have up to thirty days from the time you apply to provide other information we need before we can give you more benefits.

(4) If you have received expedited service in the past, you can get this service again if you meet the requirements listed in subsection (2) above and you:

(a) Provided all the information we needed to prove eligibility for your last expedited service benefit period; or

(b) Had another benefit period under regular nonexpedited processing after your last expedited service benefit period.

(5) If you are eligible for expedited service and are not required to have an office interview, you can:

(a) Have a telephone interview or home visit; and

(b) Still get benefits within the five-day expedited time period.

(6) If you are denied expedited service, you can ask for a department review of your case. The review will take place within two working days from the date you were denied expedited service.

(7) If you are an applicant, your five-day expedited service period starts on the:

(a) Date of the rescheduled interview when you are screened as expedited service eligible but do not show up for your initial interview;

(b) Date you prove your identity if you do not provide proof at the initial interview;

(c) Date of your interview when you:

(i) Waive your expedited interview and are found eligible for expedited service during your rescheduled interview;

(ii) Are screened as ineligible for expedited service and later found eligible for the service during your interview; or

(iii) Do not request expedited service on the application and are found eligible for the service during your interview.

(d) Date you are released from a public institution if you are a SSI recipient.

(8) If you request expedited service on a recertification form, your five-day period:

(a) Starts the first day of your new certification period when you reapply before the end of your current certification period;

(b) Is the same as a new application when you reapply after the current certification period ends; or

(c) Starts the day of your interview if you cause a delay in the recertification.

[Statutory Authority: RCW 74.04.510 and Section 11 (e)(9) of the Food Stamp Act. 00-06-015, § 388-406-0015, filed 2/22/00, effective 4/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0015, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0021 How the department decides if you are a migrant or seasonal farmworker and if you are destitute. The rules in this section apply to food assistance.

(1) A migrant is a person who travels away from home on a regular basis, usually with a group of other workers, to seek employment in an agriculturally-related activity. A migrant assistance unit is an assistance unit that travels for this purpose.

(2) A seasonal farmworker is a person who:

(a) Does agricultural work on a farm for edible crops; and

(b) Is not required to be away from their permanent place of residence overnight in order to perform this work.

(3) For seasonal farmworkers, agricultural work is field work in which the person:

(a) Plants;

(b) Cultivates; or

(c) Harvests the crop.

(4) An assistance unit is considered a seasonal farmworker assistance unit if it receives its only countable income from:

(a) Seasonal farmwork;

(b) Unemployment compensation between seasons; or

(c) Interest earned on a checking or savings account.

(5) A migrant or seasonal farmworker is considered destitute when:

(a) The assistance unit's income for the month of application was received before the date of application and was from a source no longer providing income; or

(b) The assistance unit's income of the month of application is from a new source and the assistance unit will not receive more than twenty-five dollars during the ten calendar days from the date of application.

(6) A household member changing jobs but continuing to work for the same employer is considered to be receiving income from the same source.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-406-0021, filed 11/19/99, effective 1/1/00.]

WAC 388-406-0025 Applicant to provide information needed to determine eligibility. The applicant or applicant's representative must cooperate with the department by providing information needed to determine eligibility. Cooperation includes:

(1) Completing an application form and any supplemental forms required by the department to determine eligibility.

(a) The applicant will be assisted by department staff in the completion of all required application forms when needed. All applicants will be screened to determine the need for necessary supplemental accommodation (NSA) services and provided with such services as required under WAC 388-200-1300.

(b) Completed application forms must be signed:

(i) For food assistance, by an adult household member or minor applicant when there is no adult member;

(ii) For TANF, SFA and RCA, by all adult applicants and minor parents, if living in the home, of children for whom assistance is requested;

(iii) For GA-S and GA-U, by the applicant and spouse, if living in the home, whether or not assistance is being requested on behalf of the spouse;

(iv) For medical programs, by the applicant's relative or representative when the applicant dies or is otherwise unable to complete the application;

(v) An applicant's signature by mark requires two witnesses. The signatures of witnesses must appear on the form and be identified by the department as witnesses.

(2) Completing an interview if required under chapter 388-452 WAC;

(3) Providing additional information needed to determine eligibility as required under WAC 388-406-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0030 Requests for additional information. An applicant is allowed at least ten calendar days to provide additional information required by the department to determine eligibility. This information will be requested in writing and may include supplemental forms and documents or statements verifying the applicant's circumstances as specified in chapter 388-490 WAC. The applicant is allowed additional time to provide requested information when:

(1) The applicant has requested, orally or in writing, additional time to provide the information; or

(2) The department determines the need for different or additional information following the initial interview or after having requested specific information. In these situations, the applicant will be:

(a) Provided with a written request for the additional information; and

(b) Allowed at least ten calendar days to provide the information.

(3) When the applicant for medical and cash assistance has not provided all of the requested information, the applicant will be:

(a) Provided with a written request for information still needed to determine eligibility; and

(b) Allowed at least ten calendar days to provide the information.

(4) All applicants who are assessed as needing NSA services will be assisted in complying with the requirements of this section as required under WAC 388-200-1300.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0035 Time limits for processing applications. (1) The application process as defined in WAC 388-406-0050(1) must be completed as quickly as possible. The time limits specified in this section cannot be used as a waiting period for determining eligibility.

(2) When applying the time limits specified in this section, day one is the date following the date:

(a) A request for benefits form is received by the department as specified under WAC 388-406-0010;

(b) A household consisting solely of persons eligible for SSI files a food assistance application at the SSADO; or

(c) An SSI recipient applying for food assistance is released from a public institution when the person filed an application with the SSADO before release.

(3) Time limits are in calendar days unless otherwise specified. Time limits for application process completion are no more than:

(a) Thirty days for TANF, SFA, RCA, consolidated emergency assistance program (CEAP), diversion cash assistance (DCA), and food assistance;

(b) Forty-five days for general assistance and alcohol and drug abuse treatment and shelter assistance (ADATSA); and

(c) Medical program benefits must be processed no more than:

(i) Sixty days when a disability decision is required;

(ii) Fifteen working days for pregnant women; and

(iii) Forty-five days for all other categories.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0470.]

WAC 388-406-0040 Delays in application processing. (1) When the department discovers that a food assistance application has not been processed within the initial thirty day time limit, and:

(a) The department has sufficient information to determine eligibility, the application will be processed without further delay; or

(b) If additional information is needed to determine eligibility, the household will be:

(i) Mailed or given a written request for the additional information needed to determine eligibility; and

(ii) Allowed an additional thirty day period to provide the information.

(2) When a household files a joint application requesting food assistance and medical or cash assistance:

(a) Approval of the food assistance application cannot be delayed pending the processing of the application for medical or cash assistance;

(b) A new application for food assistance cannot be required if the application for medical or cash assistance is denied;

(c) Approval for a medical program is not delayed pending the processing of the application for cash or food assistance.

(3) For medical and cash assistance, application processing may be delayed only when good cause exists as specified in WAC 388-406-0045.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0040, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

WAC 388-406-0045 Good cause for delay in processing medical and cash assistance applications. (1) Good cause reasons for delay in processing a medical or cash assistance application include:

(a) The applicant does not provide requested information or take another required action;

(b) The eligibility decision depends on medical reports and there is a delay in obtaining the reports or in securing medical information;

(c) An eligibility determination depends on correspondence with out-of-state or intercity contacts and no other verification is available for the eligibility factor;

(d) An administrative or other emergency occurs which is beyond the department's control; or

(e) For cash assistance, an eligibility determination depends on extensive property appraisals.

(2) For medical assistance, good cause exists only when the department otherwise acted promptly at all stages of the application process.

(3) For TANF and SFA, good cause exists only when the department:

(a) Notifies the applicant in writing of specific information needed to determine eligibility within twenty days of the date of application;

(b) Notifies the applicant in writing of the need for additional information or action within five calendar days;

(c) Determines eligibility and disposes of the application within five working days of receiving all information necessary to determine eligibility; and

(d) Determines good cause exists and documents the decision in the case record on or before the time limit for processing the application expires.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0045, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

WAC 388-406-0050 Completing the application process. (1) Application processing is completed when the department makes an eligibility decision and:

(a) Authorizes benefits and, for food assistance, mails or gives a written approval notice to the applicant; or

(b) Mails or gives a written withdrawal or denial notice to the applicant.

(2) The applicant will be notified of the department's eligibility decision in writing. A notice of denial or withdrawal must meet the adequate notice requirements in WAC 388-458-0005.

(3) For cash, medical, and food assistance, an applicant may voluntarily withdraw an application orally or in writing.

(4) For cash assistance, an application is considered withdrawn when the applicant:

(a) Fails to appear for a scheduled interview required for eligibility determination; and

(b) Does not contact the department to reschedule the interview within thirty days from the date of application.

(5) For approved applications, the date the applicant becomes eligible for assistance is established according to WAC 388-406-0055.

(6) A decision to deny an application must be made according to the requirements of WAC 388-406-0060.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0050, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2505.]

WAC 388-406-0055 Date of eligibility for approved applications. The effective date of eligibility for approved applications is:

(1) For cash assistance, the earlier of:

(a) The date the department has sufficient information to make an eligibility decision; or

(b) The last day of the time limit period specified in WAC 388-406-0035.

(2) For medical programs, as specified in chapter 388-416 WAC.

(3) For food assistance, except as described in subsections (4) and (5) of this section:

(a) The first day of the month following the end of the previous certification period for:

(i) All households that reapply before their previous certification period ends; and

(ii) Migrant and seasonal farmworker households that reapply within one month after their previous certification period ends; or

(b) The date of application for all other households.

(4) For food assistance applications approved after reconsideration as required by WAC 388-406-0065:

(a) The date the household provides required verification when:

(i) The application is denied because the applicant fails to respond to a written request for the verification, and

(ii) The household provides the requested verification after the end of the initial thirty-day time limit; or

(b) The date the household becomes eligible for TANF or SFA when:

(i) The household is denied nonassistance food assistance; and

(ii) Is later found to be categorically eligible for food assistance because TANF or SFA is approved.

(5) For food assistance applications not processed within the thirty-day time limit, the first day of the month following the month of application when:

(a) Required verification is not provided by the household by the end of the initial thirty-day time limit;

(b) The household provides the required verification by the end of the second thirty-day period; and

(c) The delay in providing the required verification is the fault of the household.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0060 What happens when my application is denied? (1) The department will deny your application when we cannot decide your eligibility based on the information we have.

(2) If we ask you to provide information and you do not provide it by the due date, we will not deny your application unless this information is needed to decide your eligibility.

(3) We will deny your application for everyone in the assistance unit when:

(a) You do not provide information that is required to decide eligibility for everyone in your assistance unit; or

(b) Your situation causes everyone in your assistance unit to be not eligible.

(4) We will tell you about our decision to deny your application by following notice requirements in WAC 388-458-0005.

(5) If we deny your application, you may request a fair hearing. If we deny your application because we do not have enough information to decide that you are eligible, the hearing issue is whether you can provide the needed information.

(6) For medical and cash assistance applications:

(a) If getting medical information is slowed down beyond your and our control, we will not deny your application;

(b) If you have good cause under WAC 388-406-0045, we will wait to deny your application; and

(c) If you do not meet a medical spenddown obligation, we will not deny your medical application before thirty days after the end of the base period as defined in WAC 388-519-0110.

(7) For food assistance applications:

(a) If you do not keep your first scheduled appointment:

(i) We will send you a letter telling you to get in touch with us to schedule another appointment; and

(ii) We will deny your application on the thirtieth day after you applied if you do not schedule a new appointment.

(b) If you do not provide the requested information within ten days:

(i) We will deny your application right after the ten days if you do not have a pending application for TANF, SFA, or SSI; or

(ii) We may wait to deny your application up to thirty days from the date you applied if you have a pending application for TANF, SFA or SSI.

(c) If we do not deny your application within the first thirty-days from the date you applied, we will deny your application at the end of the second thirty-day period when:

(i) We could not make an eligibility decision based on the information provided to us; and

(ii) You did not provide the requested information that was necessary to decide eligibility.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.057 and C.F.R. 273.2(h1d), waiver October 10, 1984. 00-13-076, § 388-406-0060, filed 6/19/00, effective 7/20/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0060, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0485.]

WAC 388-406-0065 Reconsideration of denied applications. (1) For medical and cash assistance, an applicant is allowed thirty days from the date of a denial notice to provide information needed to determine eligibility as specified in the notice.

(a) A redetermination of eligibility will be made and eligibility will be determined based on the information provided unless the applicant's circumstances have changed to the extent that additional information is needed to determine eligibility.

(b) If eligibility is approved based on the information provided, the eligibility date is based on the application date of the denied application.

(2) A denial of an application for medical benefits will be rescinded if the applicant, following the thirty-day period specified in subsection (1) of this section:

(a) Timely requests a fair hearing to appeal the denial; and

(b) Provides additional information needed to establish eligibility, including medical expenses sufficient to meet spenddown if the applicant shows reasonable cause for the delay in verifying the medical expenses.

(3) For food assistance, an applicant is allowed thirty days from the end of the initial thirty-day period to provide information needed to determine eligibility as specified in a denial notice. If the information is provided, the eligibility date is determined as specified under WAC 388-406-0055.

(4) A denied food assistance application will be re-evaluated within sixty days of the application date when the household was:

(a) Applying for both food assistance and TANF, SFA or SSI; and

(b) Denied food assistance before TANF, SFA or SSI was approved.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0065, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0485.]

Chapter 388-408 WAC
ASSISTANCE UNITS

WAC

WAC 388-408-0005 Definition of assistance unit for cash assistance programs. A cash assistance unit is a person or group of persons who live together and whose income, resources, and needs are considered as a unit for the purpose of determining eligibility and the amount of the cash assistance payment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0010 Assistance units for general assistance programs. (1) A GA-U assistance unit includes:

(a) An incapacitated adult; or

(b) A married couple if both persons are incapacitated and living together.

(2) A GA-H assistance unit includes only the child or children eligible for GA-H (see WAC 388-400-0015).

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-408-0010, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0015 Assistance units for temporary assistance for needy families (TANF) or state family assistance (SFA). The department must include in a TANF or SFA assistance unit certain persons who are living together, unless those person(s) must be excluded under WAC 388-408-0020 or are excluded at the option of the family under WAC 388-408-0025. An assistance unit for TANF or SFA benefits or combination of TANF and SFA benefits must include the following:

(1) The child for whom assistance is requested and:

(a) That child's full, half or adoptive sibling(s);

(b) The natural or adoptive parent(s) or stepparent(s); and

(c) The parent(s) of a pregnant or parenting minor who claims to be in need and is providing the primary care for the:

(i) Pregnant minor;

(ii) Minor parent;

(iii) Minor parent's child; or

(iv) Full, half or adoptive sibling(s) of a pregnant or parenting minor.

(2) A pregnant woman if there is no TANF or SFA eligible child in the home.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-408-0015, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0020 Who is excluded from TANF and SFA assistance units? (1) For the purpose of this section, "excluded" means that you will not be included when the department counts the number of people in the assistance unit to determine the payment standard for that assistance unit.

(2) This section describes the reasons why the department may exclude you from the TANF or SFA assistance unit.

(a) The department cannot exclude you from TANF or SFA assistance unit if the only reason you want to be excluded is that your income or resources make the assistance unit ineligible or reduces the amount of assistance it can receive.

(b) If the department excludes you from the TANF or SFA assistance unit, we will not count your income unless you are financially responsible for a member of the assistance unit. The rules for determining who is financially responsible and how the department counts their income and resources are WAC 388-450-0095 through 388-450-0130.

(3) The department will exclude you from an assistance unit if you are:

(a) An adopted child who:

(i) Receives federal, state or local adoption assistance; and

(ii) Including you in the assistance unit would reduce the assistance unit's grant due to budgeting the adoption assistance income.

(b) A minor parent or child who has been placed in Title IV-E, state, or locally funded foster care except for temporary absences allowed for under WAC 388-454-0015;

(c) An adult parent in a two-parent household when:

(i) The other parent is unmarried and under the age of eighteen; and

(ii) The department determines the living arrangement is not appropriate under WAC 388-486-0005.

(d) A recipient of SSI benefits.

(e) Not included in the assistance unit at the option of your family as allowed under WAC 388-450-0025; or

(f) Ineligible for TANF or SFA because you do not meet an eligibility requirement that is not related to your ownership of income or resources:

(i) Eligibility requirements for TANF are listed in WAC 388-400-0005.

(ii) Eligibility requirements for SFA are listed in WAC 388-400-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-408-0020, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0025 Optional TANF and SFA assistance unit members. Unless excluded under WAC 388-408-0020, the following persons, if otherwise eligible, may be included in a TANF or SFA assistance unit at the option of the caretaker relative:

(1) One nonparental caretaker relative as defined in WAC 388-454-0010 if a parent of a child in the assistance unit does not reside in the home;

(2) The step siblings of a child included in the assistance unit;

(3) Children who are not siblings of a child included in the assistance unit;

(4) The siblings of a child receiving SSI;

(5) Any parent of a child receiving SSI;

(6) One nonparental relative of specified degree of a child receiving SSI if the child's parent or parents are not living in the home;

(7) One nonparental relative of specified degree of a child in the home receiving foster care; and

(8) For recipient assistance units, the child of unmarried parents when the child is living with both parents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0030 Consolidation of TANF and SFA assistance units. (1) All children included as mandatory or optional members and who live with the same caretaker relative or relative married couple must be 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 assistance, assistance is continued for all assistance unit members who remain eligible.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0035 Assistance units for food assistance. (1) For food assistance, a household is:

(a) A person living alone;

(b) A group of people living together who purchase or prepare meals together;

(c) A group of people living together who are required to be one household because of the relationship to each other as described in subsection (2) of this section; or

(d) An elderly person with permanent disabilities who is unable to prepare meals. The combined income of all others living in the residence (excluding the spouse) cannot exceed the one hundred sixty-five percent standard under WAC 388-478-0060. The person's spouse must be included in the food assistance household.

(2) The following people living together must be one household even if they purchase and prepare meals separately:

(a) Spouses which means persons who are legally married or who present themselves as husband and wife to the community, friends and relatives;

(b) Parents and their children under twenty-two years of age regardless of the child's marital status; and

(c) Children under eighteen years of age and the adult who the child is living with when the adult is not the child's parent. When a minor child lives with an adult who is not the child's parent, the child is considered to be under parental control unless the child receives in their own name:

(i) A TANF grant; or

(ii) Gross income equal to or exceeding the TANF grant standard in WAC 388-478-0020(2).

(3) A household member who is absent from the household a full issuance month, is not eligible for benefits with that household.

(4) The following persons living in the residence are not household members and if eligible may be a separate food assistance household:

(a) Roomers who are persons that pay for lodging but not meals;

(b) Others who purchase and prepare meals separately from the household; or

(c) Live-in attendants regardless of purchase and prepare arrangements.

(5) The following persons living in the residence are not household members and are not eligible for food assistance as a separate household:

(a) Ineligible students; and

(b) Persons eighteen to fifty years old without dependents who are no longer eligible for benefits as specified in chapter 388-444 WAC.

(6) A person who is living in the residence and is not a household member as described in subsection (4) and (5), is not included when household size, income eligibility, and benefit level are determined for the food assistance unit.

(7) A boarder is a person who:

(a) Is paying a reasonable amount for lodging and meals as determined by the department; or

(b) Is in foster care.

(8) A client can exclude a boarder at the client's request. If excluded, the boarder cannot be a separate food assistance household. Residents of licensed for-profit boarding homes are not eligible for benefits.

(9) The following household members are ineligible for food assistance and are considered ineligible members:

(a) Those disqualified for:

(i) Intentional program violation (IPV) as specified in WAC 388-446-0015;

(ii) Noncompliance with work requirements as specified in WAC 388-444-0055; or

(iii) Failure to provide SSN as specified in WAC 388-476-0005;

(b) Those who fail to sign the application attesting to citizenship or alien status or immigrants not eligible because of alien status;

(c) Fleeing felons as specified in WAC 388-442-0010(1); or

(d) Those convicted of drug felonies as described under WAC 388-442-0010(2).

(10) A person who is living in the residence and is an ineligible household member is not included when household size and benefit level is determined.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0040 Residents of institutions. (1) Most residents of institutions are not eligible for food assistance benefits. Residents of the following institutions may be eligible:

(a) Federally subsidized housing for the elderly;

(b) Qualified drug and alcohol treatment centers when an employee of the treatment center is the authorized representative;

(c) Qualified group homes for persons with disabilities;

(d) A shelter for battered women and children when the resident left the home that included the abuser; or

(e) Nonprofit shelters for the homeless. Homeless clients may use food stamps to purchase prepared meals from meal providers for the homeless.

(2) A qualified group home is a nonprofit residential facility that:

(a) Houses sixteen or fewer persons with disabilities as defined under WAC 388-400-0040(6); and

(b) Is certified by the division of developmental disabilities (DDD).

(3) Elderly or disabled household members and spouses may use food stamps to purchase meals from the following when approved by FNS:

(a) Communal dining facility; or

(b) Nonprofit meal delivery service.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0045 Shelters for battered women and children. (1) Persons living in a shelter for battered women and children may receive food assistance.

(2) A shelter resident who left a food assistance household that included the abuser:

(a) Is certified as a separate household; .

(b) May receive an additional allotment even when the resident already received benefits with the abuser; and

(c) Are certified on the basis of:

(i) Income and resources to which they have access; and

(ii) Expenses for which they are responsible.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0050 Homeless status for food assistance. A client is considered homeless when they do not have a regular nighttime residence or when they stay primarily in a:

(1) Supervised shelter that provides temporary living or sleeping quarters;

(2) Halfway house providing temporary residence for persons going into or coming out of an institution;

(3) Residence of another person that is temporary and the client has lived there for ninety days or less; or

(4) A place not usually used as sleeping quarters for humans.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0055 Medical assistance units. (1) A medical assistance unit (MAU) is determined on the basis of relationship and financial responsibility.

(a) Married persons, living together are financially responsible for each other;

(b) Parents are financially responsible for their unmarried, minor children living in the same household;

(c) A parent's financial responsibility is limited when their minor child is receiving inpatient chemical dependency or mental health treatment. Only the income a parent chooses to contribute to the child is considered available when:

(i) The treatment is expected to last ninety days or more;

(ii) The child is in court-ordered out-of-home care in accordance with chapter 13.34 RCW; or

(iii) The department determines the parents are not exercising responsibility for the care and control of the child.

(d) Minor children are not financially responsible for their parents or for their siblings.

(2) Certain situations require the establishment of separate MAUs for some family members living in the same household. Separate MAUs are established for:

(a) A pregnant minor, regardless of whether she lives with her parent(s);

(b) A child with income;

(c) A child with resources which makes another family member ineligible for medical assistance;

(d) A child of unmarried parents when both parents reside with the child;

(e) Each unmarried parent of a child in common, plus any of their children who are not in separate MAUs;

(f) A nonresponsible caretaker relative;

(g) SSI recipients or persons related to SSI from the non-SSI related family members;

(h) The purpose of applying medical income standards for an:

(i) SSI-related applicant whose spouse is not relatable to SSI or is not applying for SSI-related medical; and

(ii) Ineligible spouse of an SSI-recipient.

(3) Only the parent's income actually contributed to a pregnant minor is considered income to the minor.

(4) A parent's income up to one hundred percent of the Federal Poverty Level (FPL) is allocated to the parent and other members of the parent's MAU. The excess is allocated among their children in separate MAUs.

(5) A parent's resources are allocated equally among the parent and all persons in the parent's household for whom the parent is financially responsible. This includes family members in separate MAUs.

(6) Countable income for medical programs is described in WAC 388-450-0150 and 388-450-0210.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610, 388-506-0630 and 388-507-0730.]

Chapter 388-410 WAC
BENEFIT ERROR

WAC

WAC 388-410-0001 What is a cash/medical assistance overpayment? (1) An overpayment is any cash or

medical assistance paid that is more than the assistance unit was eligible to receive.

(2) There are two types of cash/medical overpayments:

(a) Intentional overpayments, presumed to exist when the client willfully or knowingly:

(i) Fails to report within twenty days a change in circumstances that affects eligibility; or

(ii) Misstates or fails to reveal a fact affecting eligibility as specified in WAC 388-446-0001.

(b) Unintentional overpayments, which includes all other client-caused and all department-caused overpayments.

(3) If you request a fair hearing and the fair hearing decision is in favor of the department, then:

(a) Some or all of the continued assistance you get before the fair hearing decision must be paid back to the department (see WAC 388-418-0030); and

(b) The amount of assistance you must pay back will be limited to sixty days of assistance, starting with the day after the department receives your hearing request.

(4) If you receive child support payments directly from the noncustodial parent, you must turn these payments over to the division of child support (DCS). These payments are not cash assistance overpayments.

[Statutory Authority: RCW 74.04.510 and 7 C.F.R. 273.9 (d)(6). 99-24-131, § 388-410-0001, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0005 Cash and medical assistance overpayment amount and liability. (1) The amount of overpayment for cash and medical assistance households is determined by the amount of assistance received to which the assistance unit was not entitled.

(2) Cash and medical assistance overpayments are recovered from:

(a) Any individual member of an overpaid assistance unit, whether or not the member is currently a recipient; or

(b) Any assistance unit of which a member of the overpaid assistance unit has subsequently become a member.

(3) A cash or medical assistance overpayment is not recovered from:

(a) A nonneedy caretaker relative or guardian who received no financial benefit from the payment of assistance; or

(b) A person not receiving assistance when an unintentional overpayment of less than thirty-five dollars is discovered and/or computed.

(4) Overpayments resulting from incorrectly received cash assistance are reduced by:

(a) Cash assistance a household would have been eligible to receive from any other category of cash assistance during the period of ineligibility; and

(b) Child support the department collected for the month of overpayment in excess of the amount specified in (a) of this subsection; or

(c) Any existing grant underpayments.

(5) A cash assistance overpayment cannot be reduced by a medical or food assistance underpayment.

(6) A medical assistance overpayment cannot be reduced by a cash or food assistance underpayment.

(7) An underpayment from one assistance unit cannot be credited to another assistance unit to offset an overpayment.

(8) All overpayments occurring after January 1, 1982 are required to be repaid by mandatory grant deduction except where recovery is inequitable as specified in WAC 388-410-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0010 Repayment of grant overpayment occurring prior to April 3, 1982, and resulting department error. (1) An assistance unit will not be held liable for an overpayment occurring prior to April 3, 1982, which was caused by departmental error, until the department determines recovery would not be inequitable. Recovery is considered inequitable if:

(a) The department informed the recipient or the recipient's authorized representative that the recipient was entitled to part or all of the financial assistance or services overpaid; or

(b) The department acted in a manner which would reasonably lead the recipient to believe he/she was eligible to receive the assistance or services overpaid; and

(c) The recipient retained or accepted the assistance with the understanding that he/she had the right to rely upon the information received from the department; and

(d) The recipient would suffer an injury if the department were allowed to refuse to recognize the department's admission, statement, act or omission; and

(e) Injury as used in this section includes liability for repayment of a debt due the state.

(2) If the department determines recovery would be inequitable:

(a) The recipient is not liable for repayment;

(b) The overpayment is not a debt due the state; and

(c) The recipient is so informed.

(3) If recovery would not be inequitable, the recipient will be notified:

(a) Of the specific reason why recovery is not inequitable;

(b) That the recipient is liable for repayment of the debt;

(c) Whether the overpayment is subject to a mandatory deduction from the current grant; and

(d) Of the right to contest the decision.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0015 Recovery of cash assistance overpayments by mandatory grant deduction. (1) All overpayments of cash assistance are recovered by means of a mandatory deduction from future continuing assistance grants except as specified by WAC 388-410-0010.

(2) All members of an overpaid assistance unit are responsible for repayment of an overpayment. Repayment may be from:

(a) Resources and/or income; or

(b) Deductions from subsequent grants; and

(c) An assistance unit member's estate.

(3) The mandatory grant deduction of an intentional overpayment is ten percent of the monthly grant payment standard.

(4) A monthly grant deduction of up to one hundred percent of the grant can be established when:

(a) The overpayment is intentional;

(b) The client has liquid resources available but refuses to use these resources in full or partial satisfaction of the overpayment; and

(c) The amount of income and resources remaining available to the assistance unit is not less than ninety percent of the grant payment standard.

(5) An unintentional overpayment is recovered by grant deduction of five percent of the monthly grant payment standard unless the client voluntarily requests a larger deduction in writing.

(6) A monthly deduction for overpayment recovery can be established against the clothing and incidental grant of a recipient in a nursing facility, intermediate care facility, or hospital. A monthly deduction cannot be established against the vendor payment to the nursing facility, intermediate care facility or hospital.

(7) When the monthly grant deduction is equal to or more than the current grant for which the client is eligible had no overpayment occurred, the grant is suspended.

(8) No more than the total amount of an overpayment may be collected by mandatory deduction from a client's public assistance grant. The client will receive compensation for an underpayment resulting from any erroneous monthly deduction.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0020 Food assistance overpayments. There are three different types of overpayments in the food assistance program. These types are:

(1) An administrative error overpayment defined as an overpayment caused solely by:

(a) The department's action or failure to act causing an incorrect determination of categorical eligibility (CE); and

(b) A resulting claim which can be computed based on a change in net income or assistance unit size.

(2) An inadvertent household error overpayment defined as any overpayment caused by either misunderstanding or unintended error by a household that is:

(a) The result of Social Security Administration (SSA) action or failure to act causing an incorrect determination of CE; and

(b) A resulting claim which can be computed based on a change in net income or assistance unit size.

(3) An intentional program violation overpayment defined as any overpayment resulting from an intentional program violation as specified under chapter 388-446 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0025 Food assistance overpayment liability. (1) Food assistance overpayment claims are established against any assistance unit:

(a) Receiving more food assistance benefits than it was entitled to receive; or

(b) Containing an adult member who was an adult member of another assistance unit receiving more benefits than it was entitled to receive.

(2) All persons who were adult members of a food stamp assistance unit at the time of a food stamp overpayment are jointly and separately liable and are subject to collection action.

(3) A food assistance administrative error claim or inadvertent household error claim cannot be established unless the assistance unit:

(a) Signed the application form; and

(b) Was certified by the community service office (CSO) in the correct catchment area; or

(c) Cashed an expired food coupon authorization card that was altered by the assistance unit.

(4) An administrative error overpayment is established when:

(a) Discovered within twelve months of its occurrence; and

(b) The household is mailed a recovery demand letter and the overpayment is calculated within twenty-four months of discovery.

(5) An inadvertent household error overpayment is established when:

(a) Discovered within twenty-four months of its occurrence; and

(b) The household is mailed a recovery demand letter and the overpayment is calculated within twenty-four months of discovery.

(6) An intentional program violation overpayment is established when:

(a) Discovered within seventy-two months of its occurrence; and

(b) The household is mailed a recovery demand letter and the overpayment is calculated within twenty-four months of discovery.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0030 Food assistance overpayment amount and recovery. (1) The amount of a food assistance overpayment is determined by counting the difference between:

(a) The allotment actually authorized; and

(b) The allotment that should have been authorized.

(2) The monthly allotment the assistance unit should have been authorized is determined counting the actual income received by the assistance unit.

(3) A food assistance overpayment can be reduced by a food assistance underpayment if the underpayment was:

(a) Not previously restored; or

(b) Already used to reduce an overpayment.

(4) All inadvertent household or administrative error claims are subject to collection unless:

(a) The entire overpayment claim is cancelled by an underpayment;

(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) An attempt to collect will prejudice an inadvertent household error case referred for possible prosecution or administrative disqualification.

(5) An intentional program violation is subject to collection action against the liable assistance unit unless:

(a) The assistance unit has repaid the overpayment;

(b) The assistance unit cannot be located; or

(c) The department determines collection action will prejudice the case against an assistance unit member referred for prosecution.

(6) An assistance unit or assistance unit member may repay an overpayment by:

(a) A lump sum;

(b) Regular installments under a payment schedule as specified in subsection (7) of this section; or

(c) Allotment reduction.

(7) Currently participating food assistance units liable for an inadvertent household error or intentional program violation overpayment may repay by a negotiated monthly installment amount. The repayment amount must not be less than the amount that could be recovered through allotment reduction. The payment schedule may be renegotiated by either the department or the assistance unit member.

(8) Food assistance units repaying overpayments by allotment reduction will repay:

(a) An administrative error overpayment by an amount agreed to by the assistance unit;

(b) An inadvertent household error overpayment by the greater of:

(i) Ten percent of the assistance unit's monthly allotment; or

(ii) Ten dollars per month.

(c) An intentional program violation overpayment by the greater of:

(i) Twenty percent of the household's monthly allotment; or

(ii) Ten dollars per month.

(9) Involuntary reduction of the allotment an assistance unit is currently receiving is authorized when the household is liable for an inadvertent household error; and

(a) Fails to notify the department of their chosen repayment agreement; or

(b) Fails to request a fair hearing and continued benefits within twenty days of receipt of notice from the department of collection action.

(10) An assistance unit that is liable for an intentional program violation claim must chose a repayment agreement within ten days of receipt of notice of collection action. Failing to do so will subject the assistance unit to involuntary reduction of their current food assistance allotment.

(11) A household that fails to meet the terms of an agreed repayment schedule is subject to involuntary reduction of their current food assistance allotment unless:

(a) Overdue payments are caught up; or

(b) The household requests renegotiation of the payment schedule.

(12) Collection action is suspended when:

(a) A liable household member cannot be located; or

(b) Cost of further collection action is likely to exceed the amount that can be recovered.

(13) The amount of an overpayment can be negotiated if the amount offered approximates the net amount expected to be collected prior to the expiration of the collection period by statute.

(14) Prior to the expiration of the collection period, unpaid overpayments are written off and any applicable liens are released when:

(a) There is no further possibility of collection;

(b) There was an accepted offer of compromise leaving an unpaid balance after payment; or

(c) There is an unpaid balance remaining after a case has been in suspense for three consecutive years.

(15) Food assistance overpayments occurring in another state may be collected in this state if the originating state does not intend to pursue collection and provides the following:

(a) Documentation of the overpayment computation and overpayment notice prepared for the client; and

(b) Proof of service showing the client received the overpayment notice.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0035 Alien and alien sponsor cash, and food assistance overpayments. (1) An alien and their sponsor are jointly and individually liable for any overpayment of cash or food assistance made to the alien during the three years after the alien's entry into the United States.

(2) When an overpayment to a sponsored alien results from incorrect information provided by the alien's sponsor, both the alien and the sponsor are liable for repayment.

(3) When the alien's sponsor had good cause for reporting the incorrect information, the sponsored alien is solely liable for an inadvertent household error overpayment.

(4) When good cause does not exist, collection action is initiated against:

(a) The alien's sponsor; or

(b) The sponsored alien's assistance unit; or

(c) Of the two, the one considered most likely to repay first.

(5) Collection action is initiated against an alien's sponsor for an inadvertent household error when:

(a) A department representative contacts the sponsor in person or by phone; and

(b) The sponsor is informed in writing there will be no responsibility for repayment if good cause for reporting incorrect information causing the overpayment can be demonstrated.

(6) Collection action is initiated against the sponsored alien's assistance unit for an inadvertent household error when:

(a) Collection action is taken first against the alien's sponsor; and

(b) The alien's sponsor does not respond within thirty days; or

(c) The sponsored alien provides incorrect information concerning the sponsor or sponsor's spouse through misunderstanding or unintended error.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0040 Cash and food assistance underpayments. (1) All cash assistance underpayments not credited against an overpayment are repaid upon discovery to any current or former recipient.

(2) All food assistance benefits underpaid are restored when:

(a) An underpayment was caused by department error;

(b) An administrative disqualification for intentional program violation was reversed;

(c) A rule or instruction specifies restoration of unpaid benefits; or

(d) A court action finds benefits were wrongfully withheld.

(3) A client is eligible for restoration of underpaid benefits for any of the twelve months prior to:

(a) The month the client requests restoration;

(b) The month the department discovers an underpayment;

(c) The date the household makes a fair hearing request when a request for restoration of benefits was not received; or

(d) The date court action was started when the client has taken no other action to obtain restoration of benefits.

(4) The client may request a fair hearing if they disagree with the amount of benefits the department determines were underpaid.

(5) If household composition changes prior to the department's restoration of an underpayment, the underpayment is paid to:

(a) First, the household containing a majority of the persons who were household members at the time of the underpayment; or

(b) Second, the household containing the head of the household at the time of the underpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0040, filed 7/31/98, effective 9/1/98.]

Chapter 388-412 WAC
BENEFIT ISSUANCES

WAC

WAC 388-412-0005 General information about cash assistance payments. (1) Eligible clients may receive cash assistance by electronic benefit transfer (EBT) or warrant. Each separate assistance unit receives a separate cash benefit grant, even if there are multiple assistance units in the same residence.

(2) A married couple who both receive any general assistance benefit must be considered one assistance unit. However, cash payments are made individually and will not exceed one half of the two-person GA-U standard.

(3) Grants are rounded down to the next whole dollar amount with the following exceptions:

(a) Clothing and personal incidental (CPI) allowance; and

(b) Grants with a deduction for repayment of an overpayment.

(4) Grant payments are not issued for under ten dollars except:

(a) Grants with a deduction for repayment of an overpayment;

(b) CPI allowances with income deducted; or

(c) Supplemental Social Security (SSI) interim assistance payments.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-412-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0005, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0010 Endorsing the warrant. (1) Clients must endorse their warrants unless they have executed a power of attorney. If a client has given someone else a power of attorney, the client must give the department a copy.

(2) If a client is unable to sign the warrant, it must be endorsed by the client's mark or thumb print witnessed by two people. The witnesses must give their names and addresses to the person that cashes the warrant.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0015 Food assistance allotments. (1) A client's food assistance benefit amount is called an allotment. An allotment is the total dollar value of coupons an eligible assistance unit receives for a calendar month.

(2) Assistance units with no income receive the maximum allotment as described under the thrifty food plan (TFP) in WAC 388-478-0060. Assistance units with net income receive smaller amounts.

(3) When an assistance unit has income, the allotment is determined by:

(a) Multiplying the assistance unit's net monthly income by thirty percent and rounding up to the next whole dollar; and

(b) Subtracting the results from the thrifty food plan for the appropriate assistance unit size as specified in WAC 388-478-0060.

(4) Except for those described in WAC 388-406-0055 eligible assistance units receive benefits from the effective date of eligibility to the end of the first month. This is called proration and is based on a thirty-day month.

(5) In the first month of eligibility, assistance units do not receive an allotment when the amount is less than ten dollars.

(6) Eligible one and two person assistance units receive a minimum ten dollar allotment:

(a) After the first month of eligibility; or

(b) In the first month of eligibility when the CSO receives the assistance unit's application on the first day of the month.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-412-0015, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0020 How cash assistance benefits are delivered. Depending on the circumstances of the assistance unit, the department decides when cash assistance benefits are:

(1) Mailed by warrant to the address where clients live except when:

(a) The department redirects the benefit issuance to the local office;

(b) The department has established there are problems with receiving mail at the client's address;

(c) A client requests in writing that the benefit issuance be mailed to the local office, such as a homeless client without an address; or

(d) A client requests that the benefit issuance be sent to a temporary address for less than ninety days.

(2) Deposited directly into an electronic benefit transfer account.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0020, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0025 Issuing food assistance benefits. (1) An eligible assistance unit is issued benefits by means of:

(a) A food coupon authorization (FCA) card that must be redeemed for food coupons;

(b) Food coupons mailed directly to the client; or

(c) Electronic benefit transfers (EBT).

(2) Clients are issued food assistance benefits during the first ten days of the month.

(3) A client must redeem an FCA for coupons during the period that is specified on the FCA card.

(4) Eligible clients applying on or after the 16th of the month are issued one allotment called a combined issuance that includes benefits for:

(a) The month of application; and

(b) The following month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0030 Returning a warrant. (1) A person who has possession of a warrant payable to a deceased payee must return the warrant to the department for cancellation.

(2) A person who has possession of a warrant payable to an assistance unit payee who has left the home and is not likely to return during the month to endorse the warrant, must return the warrant to the CSO. The warrant may be reissued to another eligible payee for the assistance unit.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0030, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0035 Loss, theft, destruction or nonreceipt of a warrant issued to clients and vendors. The following applies to replacements of warrants issued to clients and to vendors.

(1) The department does not replace a warrant or the cash proceeds from a warrant which was endorsed by a client or vendor.

(2) Clients or vendors asking for a replacement of a warrant which was not endorsed by them must:

(a) Complete a notarized affidavit;

(b) Provide all facts surrounding the loss, theft, destruction or nonreceipt of the warrant; and

(c) File a report with the police or the post office, as appropriate.

(3) If a client is eligible to receive a replacement, the warrant is issued:

(a) On or before the tenth of the month in which the warrant was due; or

(b) Within five working days of the date the decision is made to replace the warrant, whichever is later.

(4) A client or vendor is issued the full amount of the original warrant if the warrant is replaced.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0035, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0040 Replacing lost, stolen, or destroyed food assistance allotments. (1) A client may receive a replacement for a one month food assistance allotment when:

(a) An FCA or food coupons are lost or stolen from the mail;

(b) An FCA is stolen after receipt; or

(c) An FCA card, coupons or food purchased with coupons are destroyed in a disaster.

(2) To get a replacement, a client must:

(a) Report the theft or destruction within ten days of the incident; or

(b) Report nonreceipt of the benefits within the period that benefits are intended to be used; and

(c) Sign a department affidavit within ten days of the report attesting to the loss.

(3) A client's request for a replacement is denied when:

(a) Certified mail coupons are signed for by any person residing or visiting at the address provided by the client;

(b) Coupons or an FCA card are lost or misplaced after receipt;

(c) Coupons are stolen after receipt;

(d) A client already received two replacements described in subsection (1) above within the previous five months; or

(e) The request is determined to be fraudulent.

(4) A client cannot receive a disaster food stamp program allotment and a replacement allotment for the same period.

(5) A replacement as specified in subsection (1) will not count against an assistance unit when:

(a) An allotment is returned to the department;

(b) The original or replacement FCA is not cashed;

(c) The replacement is issued because of a department error;

(d) A partial coupon delivery is caused by a department error; or

(e) The coupons delivered are improperly made or are mutilated. There must be at least three-fifths of the each coupon to turn in for an exchange.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0045 General information about cash and food assistance issued by electronic benefits transfer. (1) The department may decide which assistance unit gets cash assistance payment by warrant or EBT.

(2) All food assistance benefits are issued by EBT.

(3) The department establishes an EBT account for each assistance unit and provides information about how to use the account.

(4) EBT benefits reported lost or stolen are replaced for the amount of the loss only when:

(a) The department makes an error that causes a loss of benefits; or

(b) Both the EBT card and personal identification number (PIN) are stolen from the mail; and

(c) The client never had the ability to access the benefits; and

(d) The loss is reported within ten days from the date the client became aware of the loss.

(5) The department does not replace benefits which have been deposited into an electronic benefit account and are available to the client. The benefits are considered to be cash or coupons.

(6) The EBT account becomes inactive when it is not used for ninety days. After ninety days, the client must ask the department to reactivate the account to use the benefits.

(7) Food assistance benefits are canceled and will not be replaced when the EBT account is not used for two hundred seventy days.

(8) If a client moves to an area where EBT benefits cannot be used, the client may ask the department to convert EBT food assistance benefits to food coupons. Because food coupon books are certain values, there may be a small amount left in the EBT account after converting the benefits. If the remaining benefits are not used within seven days from the date of conversion, the remaining benefits will be canceled.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0045, filed 12/31/98, effective 1/31/99.]

Chapter 388-414 WAC
CATEGORICAL ELIGIBILITY FOR FOOD ASSISTANCE

WAC

WAC 388-414-0001 Some food assistance households do not have to meet all eligibility requirements. (1) **What is "categorical eligibility"?**

Some food assistance households do not have to meet all of the eligibility requirements for food assistance. The department calls this categorical eligibility. Categorically eligible households have already met these requirements for another program:

(a) Resources;

(b) Gross and net income standards; and

(c) Residency.

(2) **Who is categorically eligible for food assistance?**

Your household is categorically eligible when

(a) **All members** of your household are getting general assistance (GA) cash benefits;

(b) All members of your household are getting Supplemental Security Income (SSI) on their own behalf;

(c) All members of your household are getting either GA or SSI on their own behalf; or

(d) **Some members** of your household are authorized to receive payments or services from the following programs and you all benefit from the assistance:

(i) Temporary assistance for needy families (TANF) cash assistance;

(ii) State family assistance (SFA);

(iii) Diversion cash assistance (DCA) for the month you receive assistance and the three following months; or

(iv) TANF post-employment services (as defined in WAC 388-310-1800) as long as your assistance unit meets TANF resource requirements.

[Statutory Authority: RCW 74.08.090, 74.04.510. 00-11-035, § 388-414-0001, filed 5/10/00, effective 8/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-414-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-416 WAC
CERTIFICATION PERIODS

WAC

WAC 388-416-0005 Certification periods for food assistance. A certification period is the specified amount of

time the assistance unit is determined eligible. Assistance units are certified for the following periods:

(1) Not more than twenty-four months for assistance units without earned income or cash assistance when all members are elderly;

(2) Not more than twelve months for assistance units with no earned income and all household members are disabled or elderly.

(3) Not more than six months for assistance units:

(a) Receiving cash assistance;

(b) With earned income and required to report monthly;

(c) With recent work history and required to report monthly; or

(d) Not likely to have any changes.

(4) Not more than three months for assistance units:

(a) Consisting of migrant seasonal farmworkers;

(b) Containing an able-bodied adult without dependents (ABAWD);

(c) Without any income and not receiving cash assistance;

(d) With expenses that exceed income received;

(e) That are homeless or staying in an emergency or battered spouse shelter:

(f) That are staying in a non-ADATSA drug and alcohol treatment center; or

(g) Not identified in this section.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-416-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-416-0010 Medical certification periods for recipients of cash assistance programs. (1) The certification period for medical services begins on the first day of the month of application when the client is determined eligible for cash assistance for one of the following programs:

(a) Temporary assistance for needy families (TANF) or state family assistance (SFA); or

(b) Supplemental Security Income (SSI); or

(c) General assistance for pregnant women (GA-S); or

(d) General assistance for children (GA-H); or

(e) Refugee assistance.

(2) The certification period for the medical programs associated with the cash programs in subsection (1) of this section continues as long as eligibility for these programs lasts. When a client's cash assistance is terminated, eligibility for medical assistance is continued until eligibility is redetermined as described in WAC 388-418-WAC.

(3) The certification period for medical can begin up to three months prior to the month of application for clients described in subsection (1) of this section if the conditions in WAC 388-416-0015(6) apply.

(4) The certification period for medical care services begins on the date eligibility begins for the following cash assistance programs:

(a) General assistance for unemployable persons (GA-U); or

(b) Alcohol and drug abuse treatment and support act (ADATSA) programs, when the client is either receiving a grant or waiting for treatment to begin.

(5) The certification period for medical care services for clients in subsection (4) of this section runs concurrently with the period of eligibility for the client's cash assistance program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2110, 388-521-2120, 388-522-2210 and 388-524-2420.]

WAC 388-416-0015 Certification periods for categorically needy (CN) medical and children's health insurance program (CHIP). (1) A certification period is the period of time a person is determined eligible for a categorically needy (CN) medical program. Unless otherwise stated in this section, the certification period begins on the first day of the month of application and continues to the last day of the last month of the certification period.

(2) For a child eligible for the newborn medical program, the certification period begins on the child's date of birth and continues through the end of the month of the child's first birthday.

(3) For a woman eligible for a medical program based on pregnancy, the certification period ends the last day of the month that includes the sixtieth day from the day the pregnancy ends.

(4) For families, children, and SSI-related persons, the certification period is twelve months. When the medical assistance unit is also receiving benefits under a cash or food assistance program, the medical certification period is updated to begin anew at each:

(a) Approved application for cash or food assistance; or

(b) Completed eligibility review.

(5) When the child turns nineteen the certification period ends even if the twelve-month period is not over. The certification period may be extended past the end of the month the child turns nineteen when:

(a) The child is receiving inpatient services on the last day of the month the child turns nineteen;

(b) The inpatient stay continues into the following month or months; and

(c) The child remains eligible except for exceeding age nineteen.

(6) A retroactive certification period can begin up to three months immediately before the month of application when:

(a) The client would have been eligible for medical assistance if the client had applied; and

(b) The client received covered medical services as described in WAC 388-529-0100.

(7) If the client is eligible only during the three-month retroactive period, that period is the only period of certification.

(8) Any months of a retroactive certification period are added to the designated certification periods described in this section.

(9) For a child determined eligible for CHIP medical benefits as described in chapter 388-542 WAC:

(a) The certification periods are described in subsections (1), (4), and (5) of this section;

(b) There is not a retroactive eligibility period as described in subsections (6), (7), and (8); and

(c) For a child who has creditable coverage at the time of application, the certification period begins on the first of the month after the child's creditable coverage is no longer in effect, if:

(i) All other CHIP eligibility factors are met; and

(ii) An eligibility decision is made per WAC 388-406-0035.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.09.450. 00-08-002, § 388-416-0015, filed 3/22/00, effective 5/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0015, filed 7/31/98, effective 9/1/98. Formerly 388-509-0970, 388-521-2105, 388-522-2210 and 388-522-2230.]

WAC 388-416-0020 Certification periods for noninstitutionalized medically needy (MN) program. (1) The certification period for the noninstitutionalized medically needy (MN) program begins:

(a) On the first day of the month in which hospital expenses equal the spenddown amount; or

(b) On the day that spenddown is met, when hospital expenses are less then the spenddown amount or no hospital expenses are involved.

(2) The certification period continues through the last day of the final month of the base period as described in chapter 388-519 WAC.

(3) The certification period can begin up to three months immediately prior to the month of application as described in chapter 388-519 WAC.

(4) The certification period for MN clients with income below the medically needy income level (MNIL) is twelve months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2105 and 388-521-2130.]

WAC 388-416-0025 Certification period for children's health program. (1) The certification period for the children's health program begins on the first day of the month of application.

(2) The certification period continues for twelve months or through the end of the month the child turns eighteen, whichever is earlier. This period can be extended as described in WAC 388-416-0015(4).

(3) The certification period can begin up to three months immediately prior to the month of application, as described in WAC 388-416-0015 (6) and (7).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0970, 388-519-1905, 388-521-2106 and 388-522-2210.]

WAC 388-416-0030 Certification periods for the medically indigent (MI) program. (1) A client must meet the emergency medical expense requirement (EMER), before eligibility can be determined for the medically indigent (MI) program.

(2) If the client is not required to spenddown excess income or resources, the certification period for MI begins on the date that the EMER was met.

(3) When an MI applicant must satisfy a spenddown amount, the certification period begins:

(a) On the first day of the month in which hospital expenses (excluding the EMER) equal the spenddown amount; or

(b) On the day that spenddown is met, when hospital expenses are less than the spenddown amount.

(4) The certification period cannot exceed three calendar months in a twelve month period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2140.]

WAC 388-416-0035 Certification periods for Medicare cost sharing programs. (1) The certification period for the qualified Medicare beneficiary (QMB) program:

(a) Is for twelve months; and

(b) Begins the first day of the month following the month of QMB eligibility determination; and

(2) The certification period for the qualified disabled working individual (QDWI) program:

(a) Is twelve months; and

(b) May begin up to three months prior to the month of application if on the first day of the first month of the certification period the person:

(i) Is or had been enrolled in Medicare Part A; and

(ii) Meets or has met the department's eligibility requirements for QDWI.

(3) The certification period for the:

(a) Special low income medicare beneficiary (SLMB) program is twelve months in duration;

(b) Expanded special low income medicare beneficiary (ESLMB) program extends to the end of the calendar year.

(4) The certification periods for SLMB and ESLMB may begin up to three months prior to the month of application if on the first day of the first month of the certification period the person:

(a) Is or has been enrolled in Medicare Part B; and

(b) Meets or has met the department's eligibility requirements for SLMB or ESLMB.

(5) The certification period for SLMB coverage is twelve months in duration.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2150, 388-521-2155 and 388-521-2160.]

Chapter 388-418 WAC
CHANGE OF CIRCUMSTANCE

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-418-0010 Requesting information or action needed. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0010, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-418-0012 Prospective eligibility for food assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-418-0012, filed 7/26/99, effective 9/1/99.] Repealed by 00-07-077, filed 3/14/00, effective 5/1/00. Statutory Authority: RCW 74.08.090.

388-418-0015 Recipient fails to provide requested information or take requested action. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0015, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-418-0030 Notifying a recipient of intent to reduce, suspend or terminate assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-418-0030, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2205 and 388-525-2570.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-418-0005 Clients must report certain changes to the department within specified time limits. (1) Clients who receive cash or food assistance must report the following changes about everyone in the assistance unit. The client must report these changes within ten days of when they learn about the change. Clients must report:

(a) The gross monthly amount of unearned income they receive when:

(i) They start receiving money from any new source.

(ii) The amount received from a previously reported source changes by more than twenty-five dollars.

(b) When someone, including a newborn child, moves in or out, even if the change is temporary.

(c) The marriage or divorce of any assistance unit member.

(d) A new residence, including any change in shelter expenses because of the move.

(e) Obtaining a vehicle.

(f) The end of a temporary disability when the temporary disability is the reason for excluding a vehicle.

(g) When the assistance unit's countable resources exceed the resource limits described in chapter 388-470 WAC.

(h) Any of the following changes related to employment:

(i) A new job or different employer.

(ii) A change in wage rate or pay scale.

(iii) An employment status change from part-time to full time. The employer determines when an employee has full-time employment status.

(2) Clients who receive only children or pregnant women's medical assistance must report the following changes. The client must report these changes within twenty days of when they learn about the change. Clients must report:

(a) When someone, including a newborn child, moves in or out, even if the change is temporary.

(b) When a pregnancy begins or ends.

(c) A new residence.

(3) Clients who receive any other medical assistance must report the following changes. Clients must report these changes about themselves, their spouses or any dependents. The client must report these changes within twenty days of when they learn about the change. Clients must report:

(a) When someone, including a newborn child, moves in or out, even if the change is temporary.

(b) When an assistance unit member gets married, divorced or separated.

(c) When a pregnancy begins or ends.

(d) A new residence or address.

(e) Any change in the amount of income received from any new or previously reported source.

(f) Any change in the amount of expenses paid for shelter.

(g) Any change in the amount of expenses paid for medical care.

(h) Changes in resources.

(4) For TANF/SFA, a caretaker relative must report within five days when they learn that the temporary absence of a child will exceed ninety days. When the relative fails to report timely, the relative:

(a) Is not eligible for one month; and

(b) The relative's countable income is considered available to the remaining members of the assistance unit.

(5) When a change is reported late, the client may receive the wrong amount or the wrong type of assistance. When benefits are overpaid, the client must repay the assistance as described in chapter 388-410 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-418-0005, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0020 How the department determines the date a change affects the benefit amount. (1) Unless otherwise specified, the rules in this chapter refer to cash, food and medical assistance benefits.

(2) When a change causes an increase in benefits, the client must provide proof of the change before we adjust the benefit amount.

(a) The change affects the next month after the change is reported if the client provides verification within ten days from the date we request verification.

(b) The change affects the next month after the verification is received if the client provides verification after ten days from the date we request verification.

(c) When the client is entitled to receive additional benefits, the department must send the additional amount within ten days of the day the client provides requested verification.

(3) When a change causes a decrease in benefits:

(a) If the client reports the change within the time limits in WAC 388-418-0005, the change affects the first month following the advance notice period. The advance notice period:

(i) Begins on the day we send the client a notice about the change, and

(ii) Is determined according to the rules in WAC 388-458-0010.

(b) If the client fails to report the change within the time limits in WAC 388-418-0005:

(i) The change affects the first month following the day the advance notice period would end if the client reported the change on time, allowing:

(A) Ten days for the client to report the change, and

(B) Ten days for the advance notice period to begin.

(ii) We continue assistance unchanged through the advance notice period when the advance notice period ends later than the effective date.

(iii) We establish an overpayment claim according to the rules in chapter 388-410 WAC when benefits continue beyond the effective date.

(4) Within ten days of the day we learn about a change, the department:

(a) Sends advance notice according to the rules in chapter 388-458 WAC; and

(b) Takes necessary action to correct the benefit. Action on a change is delayed when the client requests a hearing about a proposed decrease in benefits before the effective date or within the advance notice period.

(5) When the client requests a hearing and continued benefits:

(a) The department continues the same benefits received prior to the advance notice of reduction until the earliest of the following events occur:

(i) For food assistance only, the client's certification period expires;

(ii) The end of the month the fair hearing decision is mailed;

(iii) The client states in writing that the assistance unit does not want continued benefits;

(iv) The client withdraws the fair hearing request in writing; or

(v) The client abandons the fair hearing request; or

(vi) An administrative law judge issues a written order that ends continued benefits prior to the fair hearing.

(b) The department establishes an overpayment claim according to the rules in chapter 388-410 WAC when the hearing decision agrees with the department's action.

(6) Some changes have a specific effective date as follows:

(a) When cash assistance benefits increase because a person is added to the assistance unit, we use the effective date rules for applications in WAC 388-406-0055.

(b) When cash assistance benefits increase because the household becomes eligible for a higher payment standard, we use the date the change occurred.

(c) When a change in law or regulation changes the benefit amount, we use the date specified by the law or regulation.

(d) When institutional medical assistance participation changes, we calculate the new participation amount beginning with the month the income or allowable expense changes.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-418-0020, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0025 Effect of changes on medical program eligibility. (1) A client continues to be eligible for Medicaid until the department determines the client's ineligibility or eligibility for another medical program. This applies to a client who, during a certification period, becomes ineligible for, is terminated from, or requests termination from:

(a) A CN Medicaid program or SFA-related medical program; or

(b) Any of the following cash grants:

(i) TANF or SFA;

(ii) SSI;

(iii) GA-H; or

(iv) GA-X. See WAC 388-434-0005 for changes reported during eligibility review.

(2) A child remains continuously eligible for medical benefits for a period of twelve months from the date of certification for medical benefits or last review, whichever is later. This applies unless the child:

(a) Moves out of state;

(b) Loses contact with the department or the department does not know the child's whereabouts;

(c) Turns eighteen years of age if receiving children's health program benefits;

(d) Turns nineteen years of age if receiving children's CN or CN scope of care program benefits;

(e) Dies; or

(f) Receives benefits under the children's health insurance program (CHIP) and:

(i) Does not pay health insurance premiums for four consecutive months; or

(ii) Is determined to have had creditable coverage at the time of application. Refer to chapter 388-542 WAC.

(3) When a client becomes ineligible for refugee cash assistance, refugee medical assistance can be continued only through the eight-month limit, as described in WAC 388-400-0035(6).

(4) A client receiving benefits under a TANF or SFA cash grant or related medical program is eligible for a medical extension, as described under WAC 388-523-0100, when the client's cash grant or related medical program is terminated as a result of:

(a) Earned income; or

(b) Collection of child or spousal support.

(5) A change in income during a certification period does not affect eligibility for:

(a) Pregnant women's medical programs; or

(b) The first six months of the TANF/SFA-related medical extension.

(6) For a child receiving benefits under CHIP as described in chapter 388-542 WAC, the department must redetermine eligibility for a Medicaid program when the family reports:

(a) Family income has decreased to less than two hundred percent FPL;

(b) The child becomes pregnant;

(c) A change in family size; or

(d) The child receives SSI.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.09.450. 00-08-002, § 388-418-0025, filed 3/22/00, effective 5/1/00. Statutory Authority: RCW 74.04.050, 74.04.057 and Section 4731 of the BBA (Public Law 105-33). 99-10-064, § 388-418-0025, filed 5/3/99, effective 6/3/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0840, 388-509-0920, 388-509-0960, 388-522-2205 and 388-522-2210.]

Chapter 388-420 WAC
CHEMICAL DEPENDENCY FOOD ASSISTANCE

WAC

WAC 388-420-010 Alcohol and drug treatment centers. (1) Food assistance is only available to a resident of a drug or alcohol treatment center when the treatment center is:

(a) Administered by a public or private nonprofit agency; and

(b) Certified by the division of alcohol and substance abuse (DASA).

(2) A resident is considered a one person assistance unit. However if the resident's spouse or child is also living in the treatment center, the spouse or child is included in the resident's assistance unit.

(3) The resident must have a designated employee of the treatment center act as an authorized representative as specified in chapter 388-460 WAC.

(4) The authorized representative receives and uses the food assistance benefits for meals the resident is served in the treatment center.

(5) The authorized representative also has responsibilities as specified in chapter 388-460 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-420-010, filed 7/31/98, effective 9/1/98.]

Chapter 388-422 WAC
CHILD SUPPORT

WAC

WAC 388-422-0005 Assignment of support rights. (1) To receive cash assistance under TANF, SFA, or GA-H, each client must assign to the state of Washington all rights to support for each person for whom the client is applying. This includes the rights to any support which has accrued before assignment is made. If a client fails to assign support rights for each person for whom assistance is requested, then cash assistance will be denied to the entire assistance unit.

(2) To receive medical assistance, each client must assign to the state of Washington all rights to medical support for each person for whom the client is applying. This includes the rights to any medical support which has accrued before assignment is made.

(3) Assignment is made when a client signs the application or accepts the cash or medical assistance.

(4) After assignment is made, a client must send any direct support they receive to the division of child support (DCS).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-422-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0560.]

WAC 388-422-0010 Cooperation with division of child support. (1) When applying for or receiving TANF, SFA, GA-H, or Medicaid, the following individuals must cooperate with the DCS in establishing paternity and collecting support as specified in WAC 388-14-201:

(a) All persons for whom benefits are applied for or received; and

(b) The caretaker relative or court-appointed guardian of a child for whom benefits are applied for or received.

(2) For TANF and SFA, if a caretaker relative fails to cooperate with DCS without good cause according to WAC 388-422-0020, the cash grant paid to the assistance unit will be reduced by twenty-five percent of what they would otherwise have received.

(3) For Medicaid, if a caretaker relative fails to cooperate with DCS without good cause according to WAC 388-422-0020, that individual will be denied medical assistance unless they are pregnant.

(4) Cooperation is determined by DCS.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-422-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0560.]

WAC 388-422-0020 Good cause for not cooperating with the division of child support. (1) An individual described under WAC 388-422-0010 is not required to cooperate with DCS if the department finds that cooperation is against the best interest of the child for whom child support is sought. A client has the right to claim good cause for refusing to cooperate and the department must determine if the claim is valid.

(2) Cooperation is against the best interest of the child and cash assistance can be continued when:

(a) The individual's cooperation can reasonably be anticipated to result in serious physical or emotional harm to:

(i) The child; or

(ii) The caretaker relative, if it reduces the caretaker relative's capacity to adequately care for the child; or

(b) Establishing paternity or securing support would be harmful to the child who:

(i) Was conceived as a result of incest or forcible rape; or

(ii) Is the subject of legal adoption proceedings pending before a superior court; or

(iii) Is the subject of ongoing discussions between the parent and a public or licensed child placement agency to decide whether the parent will keep the child or put the child up for adoption. The discussions cannot have gone on for more than three months.

(3) When cash assistance cannot be continued because a client's claim of good cause does not meet the standard in subsection (2) of this section, medical assistance may be able to be continued. The standard for good cause for medical assistance is broader in that good cause can be based solely on the best interests of the:

(a) Child as in subsection (2) of this section; or

(b) Person who is being asked to cooperate.

(4) A client has twenty days from the date good cause is claimed to provide information and evidence to support the claim, unless it cannot be obtained within such time.

(5) A client has the right to:

(a) Be informed of their right to claim good cause for refusing to cooperate;

(b) Receive a determination of their good cause claim within thirty days of the date the claim is made, as long as the necessary information and evidence was provided to the department within twenty days;

(c) Receive assistance without delay while their good cause claim is pending a determination, if they have provided supportive evidence and information;

(d) Receive information on their right to ask for a fair hearing if the department denies the claim of good cause; and

(6) Approved good cause claims will be reviewed at least every six months to determine if good cause continues to exist.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-422-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0570 and 388-505-0560.]

WAC 388-422-0030 Child support in excess of the TANF grant payment. A TANF recipient is ineligible when current child support collected by the division of child support exceeds the TANF grant payment for two-consecutive months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-422-0030, filed 7/31/98, effective 9/1/98.]

Chapter 388-424 WAC
CITIZENSHIP/ALIEN STATUS

WAC

WAC 388-424-0005 The effect of citizenship and alien status on eligibility for benefits. (1) To receive benefits under the temporary assistance for needy families (TANF), Medicaid, children's health insurance program (CHIP) or federal food stamp program, a person must be a:

(a) U.S. citizen;

(b) U.S. national; or

(c) Qualified alien who meets the eligibility requirements described in:

(i) WAC 388-424-0010 for TANF, Medicaid, and CHIP; or

(ii) WAC 388-424-0020 for federal food stamps.

(2) To receive benefits under the general assistance and ADATSA programs, a person must be a:

(a) U.S. citizen;

(b) U.S. national;

(c) Qualified alien; or

(d) A PRUCOL alien as defined in subsection (4) of this section.

(3) Qualified aliens are any of the following:

(a) Lawful permanent residents under the Immigration and Nationality Act (INA);

(b) Those granted asylum under section 208 of the INA;

(c) Those paroled under section 212 (d)(5) of the INA for at least one year;

(d) Those admitted as refugees under section 207 of the INA;

(e) Aliens whose deportation (removal) is being withheld under section 241 (b)(3) or 243(h) of the INA;

(f) Those granted conditional entry under section 203 (a)(7) of the INA as in effect prior to April 1, 1980;

(g) Cuban and Haitian entrants as defined in section (501)(e) of the Refugee Education Assistance Act of 1980; or

(h) Amerasians admitted under section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as amended); or

(i) Aliens who are victims of domestic violence, or whose children are victims of domestic violence, when:

(i) The domestic violence was committed in the U.S. by the alien's spouse, parent, or a member of the spouse or parent's family residing in the same household as the alien;

(ii) The alien did not actively participate in the violence against his or her own children when the children are the victims of domestic violence;

(iii) The alien no longer resides with the person who committed the domestic violence;

(iv) There is a substantial connection between the domestic violence and the need for public assistance benefits; and

(v) The alien has an application with the Immigration and Naturalization Service (INS) either approved or pending for:

(A) Legal immigration status under section 204 (a)(1)(A) or section 204 (a)(1)(B) of the INA; or

(B) Cancellation of removal under section 244 (a)(3) of the INA as in effect prior to April 1, 1997 or section 240A (b)(2) of the INA.

(4) A PRUCOL alien must meet all of the following conditions:

(a) They are permanently residing in the U.S.;

(b) They do not meet a definition of a qualified alien as defined in subsection (3) of this section;

(c) The INS knows they are residing in the U.S.; and

(d) The INS is not likely to enforce their departure.

(5) During the application process, one of the following persons must indicate on the application for benefits whether each household member is a U.S. citizen or qualified alien:

(a) An adult applicant in the household; or

(b) The person applying for benefits when there are no adults in the household.

[Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-424-0005, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520, 388-518-1805 and 388-510-1020.]

WAC 388-424-0010 Alien status—Eligibility requirements for the temporary assistance for needy families program and medical benefits. (1) Qualified aliens as described in WAC 388-424-0005(3) who were residing in the U.S. before August 22, 1996 may receive temporary assis-

tance for needy families (TANF), Medicaid, and CHIP benefits.

(2) Qualified aliens who first physically entered the U.S. after August 21, 1996 cannot receive TANF, Medicaid, or CHIP for five years after their date of entry, unless they are any of the following:

(a) An alien as described under WAC 388-424-0005 (3)(b), (d), (e), (g), or (h); or

(b) A lawful permanent resident who is:

(i) On active duty in the U.S. military, other than active duty for training;

(ii) An honorably discharged U.S. veteran;

(iii) A veteran of the military forces of the Philippines who served prior to July 1, 1946, as described in Title 38, section 107 of the U.S. code;

(iv) A Hmong or Highland Lao veteran who served in the military on behalf of the U.S. Government during the Vietnam conflict; or

(v) The spouse or unmarried dependent child(ren) of a person described in subsection (2)(f)(i) through (iv) of this section.

(3) Aliens who qualify for Medicaid benefits, but are determined ineligible because of alien status or requirements for a Social Security Number, may receive medical coverage as follows:

(a) State-funded categorically needy (CN) scope of care for:

(i) Pregnant women, as specified in WAC 388-462-0015;

(ii) Children as specified in WAC 388-505-0210;

(iii) Persons eligible for or receiving cash assistance under the state family assistance program (SFA); or

(iv) Aliens who were lawfully residing in the U.S. before August 22, 1996, including PRUCOL aliens as defined in WAC 388-424-0005(4).

(b) Alien emergency medical services as specified in WAC 388-438-0110.

(4) Alien status does not effect eligibility for the medically indigent program described in WAC 388-438-0100.

[Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-424-0010, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520 and 388-518-1805.]

WAC 388-424-0015 Citizenship and alien status—Eligibility requirements for the state family assistance program (SFA). To receive SFA benefits, you must be:

(1) A qualified alien who is not eligible for TANF benefits because of the five-year period of ineligibility described in WAC 388-424-0010(2); or

(2) An alien who is permanently residing in the U.S. under color of law (PRUCOL) as defined in WAC 388-424-0005(4).

[Statutory Authority: RCW 74.04.050, 74.08.090. 00-08-060, § 388-424-0015, filed 3/31/00, effective 4/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

WAC 388-424-0020 Alien status and eligibility requirements for the federal food stamp program. (1) For federal food stamps, an alien must meet one of the conditions in column 1 and one of the conditions in column 2.

Column 1

Refugee
Asylee
Deportation withheld
Cuban or Haitian entrant
Aliens lawfully admitted for permanent residence (immigrants)
Parolee for at least one year
Conditional Entrant
Battered spouse, battered child, or parent or child of a battered person as defined in WAC 388-424-0005

Column 2

The following noncitizens are only eligible for seven years after admitted or granted status:

Refugee/Amerasian/Asylee
Deportation withheld/Cuban or Haitian entrant
(The above noncitizens may be eligible even if they become immigrants within the seven-year period.)

There is no time limit for the following noncitizens:

1. Permanent resident aliens with forty Social Security Administration (SSA) work quarters.
2. Honorably discharged veterans, active duty military (other than training), spouse, and unmarried dependent children.
3. Lawfully in U.S. on August 22, 1996 and:
   a. Now under eighteen, or
   b. Disabled or blind, or
   c. Sixty-five or older on August 22, 1996.

(2) In addition to the above noncitizens, the following, legally residing in the U.S., are eligible for federal food stamps.

(a) Hmong or Highland Laotian tribe members (and spouse and dependent children) when tribe rendered assistance to the U.S. during the Vietnam era.

(b) Canadian born American Indians who are fifty percent American Indian blood.

(c) American Indians who are noncitizens and members of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act.

(3) Lawful permanent residents can receive credit for SSA work quarters by:

(a) Earning enough money to qualify for work quarters; or

(b) Getting credit for quarters earned by a parent or stepparent while the alien is under eighteen; or

(c) Getting credit for quarters earned by a spouse during their marriage if the alien remains married to the spouse or the spouse is deceased.

(4) Lawful permanent residents cannot receive credit for a SSA work quarter after January 1, 1997 if receiving TANF, nonemergency Medicaid, or food stamp benefits during that quarter.

[Statutory Authority: RCW 74.04.510, S. 1150, the Agricultural Research, Extension, and Education Reform Act of 1998. 99-01-058, § 388-424-0020, filed 12/11/98, effective 1/11/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

WAC 388-424-0025 Citizenship and alien status—Eligibility requirements for the food assistance program for legal immigrants. To receive benefits under the food assistance program (FAP) for legal immigrants, you must be one of the following:

(1) A qualified alien, as defined in WAC 388-424-0005, who cannot receive federal food stamps because of the eligibility restrictions described in WAC 388-424-0020; or

(2) An alien who does not meet the definition of a qualified alien as defined in WAC 388-424-0005 but who is:

(a) Allowed to enter the U.S. for permanent residence by permission of the U.S. Attorney General under section 249 of the Immigration and Nationality Act (INA);

(b) Admitted for temporary residence under section 245A of the INA and is aged, blind, or disabled as described in Title XVI of the Social Security Act;

(c) Granted temporary resident status by the Immigration and Naturalization Service (INS) as a special agricultural worker under section 210 of the INA;

(d) Granted family unity status by the INS and the alien's spouse or parent is eligible to participate in FAP or the federal food stamp program; or

(e) Permanently residing under color of law (PRUCOL) in the United States as defined in WAC 388-424-0005(4).

[Statutory Authority: RCW 74.08A.120. 00-13-036, § 388-424-0025, filed 6/13/00, effective 7/14/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

Chapter 388-426 WAC
CLIENT COMPLAINTS

WAC

388-426-0005 Client complaints.

WAC 388-426-0005 Client complaints. (1) Clients who believe they have been discriminated against by the department for reason of race, color, creed, political affiliation, national origin, religion, age, gender, disability, or birthplace have the right to file a complaint. Clients can file discrimination complaints with the:

(a) DSHS, Division of Access and Equal Opportunity, PO Box 45012, Olympia, WA, 98504;

(b) Administrator, Food and Nutrition Services, 3101 Park Center Drive, Alexandria, VA, 22302; or

(c) Secretary of Agriculture, U.S. Department of Agriculture, Washington D.C., 20250.

(2) Clients with a complaint about a department decision or action have the right to present their complaint, in writing, to a supervisor.

(a) Within ten days of the receipt of the complaint:

(i) A decision will be made on the client's complaint; and

(ii) The client will be sent written notice of the decision, including information about the right to further review by the local office administrator.

(b) Clients not satisfied with the decision of a supervisor have the right to present a written complaint to the local office administrator. Within ten days of the receipt of the complaint:

(i) A decision will be made on the complaint, and

(ii) The client will be sent written notice of the decision.

(c) Written notice of the administrator's decision concludes the complaint procedure.

(d) The filing of a written complaint does not prevent a client from requesting a fair hearing under WAC 388-08-413.

(e) Clients have the right to speak to a worker's supervisor or have a decision or action reviewed by the supervisor, whether or not a formal complaint has been filed.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-426-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-426-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-428 WAC
CONFIDENTIALITY

WAC

388-428-0010 Request for address disclosure by a parent when a child is living with a nonparental caretaker.

WAC 388-428-0010 Request for address disclosure by a parent when a child is living with a nonparental caretaker. (1) When TANF or SFA has been approved for a child who is living with a nonparental caretaker, the address and location of the child may be released to the child's parent when:

(a) The parent has legal custody of the child or is allowed visitation rights or residential time with the child under a court order; and

(b) No court order restricts or limits the parent's right to contact or visit the child or the child's caretaker by imposing conditions to protect the child or the caretaker from harm;

(c) The department has not found that the caretaker has good cause for refusing to cooperate in child support enforcement activities related to the parent's support obligation; and

(d) There is no substantiated claim or pending investigation involving abuse or neglect of any child by the parent;

(e) There are no pending proceedings as listed in subsections (1)(b) through (d).

(2) A parent may request the child's address and location:

(a) In person, with satisfactory evidence of identity, at the community services office where the child's record is being maintained;

(b) Through an attorney; or

(c) If residing outside the state of Washington, by submitting a notarized request.

(3) If the request for the child's address and location is based on a court order granting the parent legal custody, visitation rights or residential time, the parent must also submit:

(a) A copy of the court order; and

(b) A sworn statement that the order has not been modified.

(4) Prior to release of the child's address and location, the child's caretaker will be notified that:

(a) The child's parent has requested the information; and

(b) The information will be released within thirty days from the date of the notice unless the caretaker:

(i) Provides proof of a current investigation or pending court case involving the abuse or neglect of any child by the parent;

(ii) Provides a copy of a court order which prevents disclosure of the address or restricts the parent's right to contact or visit the caretaker or the child by imposing conditions to protect the caretaker or child from harm;

(iii) Requests a fair hearing which results in a decision that disclosure must be denied because of the existence of one or more of the conditions in subsection (1) of this section.

(5) A parent's request for disclosure of a child's address and location will be responded to within thirty-five days. The response will notify the parent:

(a) Of the child's address and location if the information may be disclosed;

(b) The reasons for denying the request if the information may not be disclosed; or

(c) That a decision has not been made because the child's caretaker:

(i) Has requested a hearing and a final hearing decision has not been entered; or

(ii) Is claiming good cause for refusing to cooperate in child support enforcement activities related to the parent's support obligation and a final decision has not been made on the caretaker's claim.

(d) When the decision has not been made because of a pending fair hearing decision or good cause claim determination, the parent will be notified of the decision within ten days of the hearing decision or good cause determination.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-428-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-434 WAC
ELIGIBILITY REVIEWS AND RECERTIFICATIONS

WAC

WAC 388-434-0005 The department reviews each client's eligibility for benefits on a regular basis. (1) If you receive cash assistance, the department reviews your eligibility for assistance at least once every six months.

(2) When it is time for your eligibility review, the department requires you to complete a review form. We use the information you provide to determine your eligibility for all assistance programs.

(3) If you complete an interview for assistance with a department representative and sign the printed application for benefits (AFB) form, you do not have to complete a separate review form.

(4) For cash assistance, the eligibility review form or the AFB must be dated and signed by both husband and wife, or both parents of a child in common when the parents live together.

(5) If you receive medical assistance only, the eligibility review form or the AFB must be signed by at least one parent when the parents live together.

(6) We may move the date of your eligibility review if we decide your circumstances need to be reviewed sooner.

(7) At your review, we look at:

(a) All eligibility requirements under WAC 388-400-0005 through 388-400-0035, 388-503-0505 through 388-503-0515, and 388-505-0210 through 388-505-0220;

(b) Changes that happened since we last determined your eligibility; and

(c) Changes that are anticipated to happen during the next review period.

(8) If you receive medical assistance only, we set your eligibility review date in advance under WAC 388-416-0005 through 388-416-0035. We will start the review process before your benefits end.

(9) Clients are responsible for attending an interview if one is required under WAC 388-452-0005.

(10) If you do not complete the eligibility review for cash assistance, you are considered to be withdrawing your request for continuing assistance.

(a) Your cash assistance benefits will end.

(b) Your medical assistance will continue for twelve consecutive months from the last:

(i) Application;

(ii) Eligibility review; or

(iii) Food assistance application or recertification.

(11) We must send you written notice under WAC 388-458-0005, 388-458-0010, and 388-450-0015 before assistance can be suspended, terminated, or a benefit error is established as a result of your eligibility review.

(12) If you are currently receiving cash or medical assistance, and you are found to no longer be eligible for benefits, we will determine if you are eligible for other medical programs. Until we decide if you are eligible for other programs, your medical assistance will continue under WAC 388-418-0025 even if you request that your benefits end.

(13) When a client is determined to need necessary supplemental accommodation (NSA) under WAC 388-200-1300, we will help the client meet the requirements of this section.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-434-0005, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-434-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2230.]

WAC 388-434-0010 Recertification for food assistance. (1) A household reapplies timely when the department receives the application by:

(a) The fifteenth day of the last month of certification; or

(b) The fifteenth day after the household receives a notice of certification when the household's certification period is two months or less.

(2) A household completes the reapplication process when it:

(a) Submits a timely reapplication;

(b) Completes an interview; and

(c) Submits requested verification.

(3) A household receives uninterrupted benefits when the household completes the reapplication process timely. Uninterrupted benefits mean the household's benefits will continue to be mailed on the same mailing day of the month.

(4) A household that reapplies timely and completes the application process will receive a notice of approval or denial:

(a) By the end of the current certification period; or

(b) By the thirtieth day after the last allotment when the household was certified for one month.

(5) When a household that reapplies late, the reapplication is treated like an initial application and will be approved or denied under WAC 388-406-0035.

(6) See chapter 388-458 WAC for adequate notice and translation requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-434-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-436 WAC
EMERGENCY CASH ASSISTANCE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-436-0001	Additional requirement for emergent needs (AREN). [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0001, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-046, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055 and 74.08.090.
388-436-0005	AREN good cause. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-046, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055 and 74.08.090.
388-436-0010	Winterization. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0010, filed 7/31/98, effective 9/1/98.] Repealed by 00-10-036, filed 4/24/00, effective 6/1/00. Statutory Authority: RCW 74.08.090.

WAC 388-436-0002 If my family has an emergency, can I get help from DSHS to get or keep our housing or utilities? DSHS has a program called additional requirements for emergent needs (AREN). If your family has an emergency and you need a one-time cash payment to get or keep safe housing or utilities, you may be eligible. The special AREN payment is in addition to the regular monthly cash grant your family may already get.

(1) To get AREN, you must:

(a) Be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or refugee cash assistance (RCA);

(b) Have an emergency housing or utility need; and

(c) Have a good reason that you do not have enough money to pay your housing or utility costs.

(2) To get AREN, you must be eligible for TANF, SFA, or RCA. This means you must:

(a) Get benefits through TANF, SFA, or RCA. For RCA you must also be pregnant or have an eligible child; or

(b) Apply for TANF, SFA, and RCA, and meet all eligibility criteria including:

(i) The maximum earned income limit under WAC 388-478-0035;

(ii) The requirement that your unearned income not exceed the grant payment standard;

(iii) The requirement that your countable income as defined under WAC 388-450-0162 must be below the payment standard in WAC 388-478-0020 when you have both earned income and unearned income;

(iv) The resource limits under chapter 388-470 WAC;

(v) The program summary rules for either TANF (WAC 388-400-0005); SFA (WAC 388-400-0010); or RCA (WAC 388-400-0030); and

(vi) The requirement that you must be pregnant or have an eligible child.

(3) If you do not get or do not want to get TANF, SFA or RCA, you cannot get AREN to help with one-time housing or utility costs. We will look to see if you are eligible for diversion cash assistance (DCA) under WAC 388-432-0005.

(4) To get AREN, you must have an emergency housing or utility need. You may get AREN to help pay to:

(a) Prevent eviction or foreclosure;

(b) Get housing if you are homeless or need to leave your home because of domestic violence;

(c) Hook up or prevent a shut off of utilities related to your health and safety. We consider the following utilities to be needed for health and safety:

(i) Electricity or fuel for heating, lighting, or cooking;

(ii) Water;

(iii) Sewer; and

(iv) Basic local telephone service if it is necessary for your basic health and safety.

(d) Repair damage or defect to your home when it causes a risk to your health or safety:

(i) If you own the home, we may approve AREN for the least expensive method of ending the risk to your health or safety;

(ii) If you do not own the home, you must ask the landlord in writing to fix the damage according to the Residential Landlord-Tenant Act at chapter 59.18 RCW. If the landlord refuses to fix the damage or defect, we may pay for the repair or pay to move you to a different place whichever cost is lower.

(e) If you receive TANF or SFA, WorkFirst support services under WAC 388-310-0800 may be used to help you relocate to new housing to get a job, keep a job, or participate in WorkFirst activities. Nonhousing expenses, that are not covered under AREN, may be paid under WorkFirst support services. This includes expenses such as car repair, diapers, or clothing.

(5) To get AREN, you must have a good reason for not having enough money to pay for your housing or utility costs. You must prove that you:

(a) Did not have money available that you normally use to pay your rent and utilities due to an emergency situation that reduced your income (such as a long-term illness or injury);

(b) Had to use your money to pay for necessary or emergency expenses. Examples of necessary or emergency expenses include:

(i) Basic health and safety needs for shelter, food and clothing;

(ii) Medical care;

(iii) Dental care needed to get a job or because of pain;

(iv) Emergency child care;

(v) Emergency expenses due to a natural disaster, accident, or injury; and

(vi) Other reasonable and necessary expenses.

(c) Are currently homeless; or

(d) Had your family's cash grant reduced or suspended when we budgeted your expected income for the month, but the income will not be available to pay for the need when the payment is due. You must make attempts to negotiate later payments with your landlord or utility company before you can get AREN.

(6) In addition to having a good reason for not having enough money to pay for your costs, you must also explain how you will afford to pay for the on-going need in the future. We may deny AREN if your expenses exceed your income (if you are living beyond your means). We may approve AREN to help you get into housing you can afford.

(7) If you meet the above requirements, we decide the amount we will pay based on the following criteria.

(a) AREN payments may be made up to a maximum of fifteen hundred dollars.

(b) We can make the payment all at once or as separate payments over a thirty-day period. The thirty-day period starts with the date of the first payment.

(c) The amount of AREN is in addition to the amount of your monthly TANF, SFA, or RCA cash grant.

(d) We will decide the lowest amount we must pay to end your housing or utility emergency. We will contact your landlord, utility company, or other vendor for information to make this decision. We may take any of the following steps when deciding the lowest amount to pay:

(i) We may ask you to arrange a payment plan with your landlord or utility company. This could include us making a partial payment, and you setting up a plan for you to repay the remaining amount you owe over a period of time.

(ii) We may have you use some of the money you have available in cash, checking, or savings to help pay for the expense. We will look at the money you have available as well as your bills when we decide how much we will pay.

(iii) We may consider income that is excluded or disregarded for cash assistance benefit calculations, such as SSI, as available to meet your emergency housing need.

(iv) We may consider money other individuals such as family or friends voluntarily give you. We will not count loans of money that you must repay to friends or family members.

(v) We may consider money from a nonneedy caretaker relative that lives in the home.

(vi) We may look at what other community resources you currently have to help you with your need.

(8) Starting August 1, 2000, your family can get AREN for your emergency housing or utility needs for one thirty-day period every twelve months:

(a) The thirty-day period starts on the date we issue your first AREN payment and lasts thirty consecutive days.

(b) The twelve-month period starts the month we issued your first AREN payment. The next time you could be eligible for AREN is the first day of the twelfth month after we issued the first AREN payment. For example, if we issued you AREN on January 15th, you could be eligible again on the first of January the next year.

(c) The limit of one thirty-day period every twelve months applies to the following people even if they leave the assistance unit:

(i) Adults; and

(ii) Minor parents that get AREN when no adults are in the assistance unit.

(d) We do not look at AREN benefits you received before August 1, 2000 when we look to see if you received AREN in the last twelve months.

(9) We pay AREN:

(a) Directly to the landlord, mortgage company, utility, or other vendor whenever we can.

(b) If we cannot pay AREN directly to the landlord or other vendor, we will issue the AREN as a part of your TANF, SFA, or RCA cash grant. If we issue the AREN as a part of your grant, you must use it for your emergency need.

(10) We may assign you a protective payee for your monthly grant under WAC 388-265-1250.

[Statutory Authority: RCW 74.08.090, 74.04.050. 00-22-064, § 388-436-0002, filed 10/27/00, effective 12/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, and 74.08.090. 99-14-046, § 388-436-0002, filed 6/30/99, effective 8/1/99.]

WAC 388-436-0015 Consolidated emergency assistance program (CEAP). (1) CEAP is available to the following persons:

(a) A pregnant woman in any stage of pregnancy; or

(b) Families with dependent children.

(2) Applicants must be residents of Washington state as defined in WAC 388-468-0010.

(3) Applicants must demonstrate a financial need for emergency funds for one or more of the following basic requirements:

(a) Food;

(b) Shelter;

(c) Clothing;

(d) Minor medical care;

(e) Utilities;

(f) Household maintenance supplies;

(g) Necessary clothing or transportation costs to accept or retain a job; or

(h) Transportation for a minor, not in foster care, to a home where care will be provided by family members or approved caretakers.

(4) Payment under this program is limited to not more than thirty consecutive days within a period of twelve consecutive months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0020 CEAP assistance unit composition. (1) To be eligible for CEAP, a child must be living with:

(a) A parent or a relative of specified degree as defined under WAC 388-454-0010; or

(b) Has lived with such a relative within six months of the request for assistance.

(2) The following persons living in the household must be included as members of the CEAP assistance unit:

(a) All full, half, or adopted siblings under eighteen years of age, including a minor parent; and

(b) The parent, adoptive parent, or stepparent living with the child or children.

(3) The following persons living in the household do not have to be included but may be included as members at the option of the applicant:

(a) One caretaker relative of specified degree when the child's parent does not live in the home;

(b) Stepbrothers or stepsisters to all children in the assistance unit.

(4) The following persons may make up a CEAP assistance unit without including others living in the home:

(a) The child of a parent who is a minor when the minor parent is not eligible due to the income and resources of his/her parents; or

(b) A pregnant woman when no other child is in the home.

(5) The following persons living in the household are not included as members of the CEAP assistance unit:

(a) A household member receiving Supplemental Security Income (SSI);

(b) A household member ineligible due to reasons stated in WAC 388-436-0025 and 388-436-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0025 Eligibility conditions for CEAP—Job refusal. (1) Within thirty days of the date of application, applicants for CEAP cannot have refused without good cause:

(a) A bona fide job offer; or

(b) Training for employment.

(2) Applicants have good cause for refusal when the applicant:

(a) Can not perform the work satisfactorily because of a physical, mental, or emotional inability;

(b) Is not able to get to and from the job without undue cost or hardship;

(c) Would be forced to perform hazardous work;

(d) Would be working for less than minimum wage or the wages are not customary for that type of work;

(e) Is offered the job only because of a labor dispute; or

(f) Is not able to obtain necessary child care.

(3) An applicant who cannot demonstrate good cause for refusing a job offer makes the entire assistance unit ineligible for CEAP:

(a) For thirty days from the date of refusal; or

(b) Until the applicant accepts employment, whichever comes first.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0030 Eligibility for CEAP depends on other possible cash benefits. (1) Before the department approves CEAP benefits, we must determine that all household members are ineligible for benefits from any of the following programs:

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

(b) State family assistance (SFA);

(c) Refugee cash assistance (RCA);

(d) Diversion cash assistance (DCA).

(2) To receive CEAP, the applicant must take any required action to receive benefits from the following programs:

(a) TANF, SFA, and RCA;

(b) Supplemental security income (SSI);

(c) Medical assistance for those applicants requesting help for a medical need;

(d) Food assistance for those applicants requesting help for a food need;

(e) Housing assistance from any available source for those applicants requesting help for a housing need;

(f) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(3) The department may not authorize CEAP benefits to any household containing a member who is under a grant penalty for failure to comply with program requirements of TANF/SFA, RCA, or WorkFirst under chapter 388-310 WAC.

[Statutory Authority: RCW 74.04.660. 99-24-130, § 388-436-0030, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0035 Income and resources for CEAP. (1) Estimated income, resources and circumstances of the following persons are used in determining need and payment for CEAP:

(a) All persons included as members of the CEAP assistance unit;

(b) If living in the home, the spouses and minor brothers and sisters of persons included as members of the CEAP assistance unit.

(2) Public assistance payments plus authorized additional requirements received in the calendar month of CEAP application are considered as income.

(3) The value of resources not listed as excluded in WAC 388-436-0040 is considered available to meet the emergent needs of the CEAP assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0040 Excluded income and resources for CEAP. Resources and income listed below will not be considered in determining need or payment for CEAP:

(1) A home as defined under WAC 388-470-0030;

(2) One vehicle, running and used regularly by the assistance unit, with an equity value not to exceed one thousand five hundred dollars);

(3) Household furnishings being used by the assistance unit;

(4) Personal items being used by members of the assistance unit;

(5) Tools and equipment being used in the applicant's occupation;

(6) The value of the coupon allotment under the Food Stamp Act of 1977, as amended;

(7) Benefits received under the women, infants and children program (WIC) of the child nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended;

(8) Energy assistance payments;

(9) Grants, loans, or work study to a student under Title IV of the Higher Education Amendments or Bureau of Indian Affairs for attendance costs as identified by the institution;

(10) Income and resources of an SSI recipient;

(11) Livestock when the products are consumed by members of the assistance unit;

(12) All resources and income excluded for the TANF program under WAC 388-450-0015, 388-470-0020, and 388-470-0025 and by federal law.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0045 Income deductions for CEAP. The following deductions are allowed when determining the CEAP assistance unit's net income:

(1) A ninety dollar work expense from each member's earned income;

(2) Actual payments made by a member with earned income for care of a member child up to the following maximums:

Hours Worked Per Month	Each Child Under Two Years	Each Child Two Years Or Older
0 - 40	$ 50.00	$ 43.75
41 - 80	100.00	87.50
81 - 120	150.00	131.25
121 orMore	200.00	175.00

(3) Verified expenses for members of the assistance unit during the current month as follows:

(a) Medical bills;

(b) Child care paid in an emergency in order to avoid abuse;

(c) Dental care to relieve pain; or

(d) Costs incurred in obtaining employment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0050 Determining financial need and benefit amount for CEAP. (1) To be eligible for CEAP assistance, the assistance unit's nonexcluded income, minus allowable deductions, must be less than ninety percent of the TANF payment standard for households with shelter costs. The net income limit for CEAP assistance units is:

Assistance Unit Members	Net Income Limit
1	$ 314
2	396
3	491
4	577
5	666
6	756
7	873
8 or more	967

(2) The assistance unit's allowable amount of need is the lesser of:

(a) The TANF payment standard, based on assistance unit size, for households with shelter costs as specified under WAC 388-478-0020; or

(b) The assistance unit's actual emergent need, not to exceed maximum allowable amounts, for the following items:

Need Item: Maximum allowable amount by assistance unit size:

	1	2	3	4	5	6	7	8 or more
Food	$211	$268	$332	$391	$450	$511	$583	$645
Shelter	258	325	404	476	548	621	719	795
Clothing	30	38	47	56	64	73	83	94
Minor Medical Care	179	228	282	332	382	432	501	554
Utilities	87	110	136	160	184	210	243	268
Household maintenance	64	81	100	118	136	155	178	197
Job related transportation	349	440	546	642	740	841	971	1075

(3) The assistance unit's CEAP payment is determined by computing the difference between the allowable amount of need, as determined under subsection (2) of this section, and the total of:

(a) The assistance unit's net income, as determined under subsection (1) of this section;

(b) Cash on hand, if not already counted as income; and

(c) The value of other nonexcluded resources available to the assistance unit.

(4) The assistance unit is not eligible for CEAP if the amount of income and resources, as determined in subsection (3) of this section, is equal to or exceeds its allowable amount of need.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0050, filed 7/31/98, effective 9/1/98.]

Chapter 388-437 WAC
EMERGENCY ASSISTANCE FOR FOOD STAMPS

WAC

388-437-0001 Disaster food stamp program.

WAC 388-437-0001 Disaster food stamp program. (1) Assistance units that suffer a loss as a result of a federally declared disaster may receive disaster food stamp benefits.

(2) Food and nutrition services (FNS) must approve use of this program when a disaster is declared.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-437-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-438 WAC
EMERGENCY ASSISTANCE FOR MEDICAL NEEDS

WAC

388-438-0100 Medically indigent (MI) program.
388-438-0110 The alien emergency medical (AEM) program.

WAC 388-438-0100 Medically indigent (MI) program. (1) The medically indigent (MI) program is a state funded medical program limited to coverage for emergency medical services.

(a) An emergency medical condition is described in WAC 388-500-0005;

(b) The client must have had a qualifying emergency medical condition in the month of application or within the three months immediately preceding the month of application;

(c) A client must have incurred an emergency medical expense requirement (EMER) of two thousand dollars per family over a twelve-month period. Qualifying EMER expenses are:

(i) Emergency hospital services and related physician services in a hospital; and

(ii) Emergency ground or air ambulance transportation to a hospital.

(2) The EMER period:

(a) Begins on the first day of the month of certification for MI; and

(b) Continues through the last day of the following twelve-calendar months.

(3) If a client does not meet the EMER amount within the three month base period, as described in WAC 388-519-0100, the amount incurred can be applied to any other application for MI within twelve-month period described in subsection (2).

(4) A client is limited a singly three-month period of MI eligibility per twelve-month EMER period.

(5) A client in a nursing facility can exceed the three-month MI eligibility limit.

(6) Conditions which require the following services meet the definition of emergency for MI, but the client is exempt from the EMER requirement:

(a) Treatment under the involuntary treatment act (ITA); and

(b) DETOX services; and

(c) Institutional and/or waivered services.

(7) Pregnancy meets the definition of emergency for MI. A pregnant client must meet the EMER requirements.

(8) Resource rules for the MI program follow the TANF and TANF-related resource rules in chapter 388-470 WAC.

(9) If a client's income and/or resources exceed the standards for this program, as described in WAC 388-478-0070, the excess must be spent down as described in WAC 388-519-0100, for the client to be eligible for MI.

(10) A client is not eligible for MI if they:

(a) Are eligible for, or receiving, any other cash or medical program; or

(b) Entered the state specifically to obtain medical care; or

(c) Are an inmate of a federal or state prison.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0100, filed 7/31/98, effective 9/1/98. Formerly 388-503-0370, 388-518-1805, 388-518-1810 and 388-518-1850.]

Notice of Objection (1): It is the opinion of the Joint Administrative Rules Review Committee that the Department of Social and Health Services has not modified, amended, withdrawn or repealed WAC 388-100-005 to conform with the intent of the legislature, as expressed in both chapters 70.48 and 74.09 RCW.

Although the department has statutory authority in chapter 74.09 RCW, to determine who is eligible to receive assistance under the limited casualty medical program, that authority is not without limitation. The City and County Jail Act of 1977 requires the Department of Social and Health Services to reimburse the local government for inmate medical costs, provided that inmate is otherwise eligible for such care. Inmates have not been denied coverage based on their status as inmates since the enactment of the City and County Jail Act.

In determining legislative intent, a portion of a statute cannot be examined in a vacuum. Rather, all statutes relating to the same subject should be read together and given a harmonious interpretation. The legislature is presumed to enact law with knowledge of existing law. RCW 70.48.130 is made moot by the department's administrative denial of inmate medical coverage, and the legislature does not intend to enact "moot" legislation.

The Joint Administrative Rules Review Committee objects to WAC 388-100-005 and herewith directs the code reviser to publish this Notice of Objection...pursuant to RCW 34.04.240.

[Joint Administrative Rules Review Committee, Memorandum, July 10, 1987—Filed July 27, 1987, WSR 87-16-031]

Notice of Objection (2): The Joint Administrative Rules Review Committee (JARRC) held on July 27, 1987, that WAC 388-100-005 did not conform with the intent of the Legislature. This rule, adopted by the Department of Social and Health Services (DSHS), excluded inmates of federal or state prisons from eligibility for the limited casualty-medically indigent program of medical assistance.

As authority for its opinion, the committee cited RCW 70.48.130 of the City and County Jail Act of 1977 which requires DSHS to reimburse local governments for inmate medical costs provided to otherwise eligible inmates.

There has been no amendment to RCW 70.48.130 changing its meaning since 1986. Effective May 15, 1993, an amendment resulted in even further emphasis of the intent of the Legislature that all jail inmates receive cost-effective medical care. (1993 C 409 § 2)

On May 31, 1994, DSHS refiled a permanent rule, WSR 94-10-065, WAC 388-503-0370 which recodified WAC 388-100-005. The eligibility requirement that an applicant for the medically indigent program not be an inmate of a federal or state prison is retained in the new rule.

Since neither the statutory authority nor the substance of the rule has changed since the JARRC decision of July 27, 1987, the committee is of the opinion that DSHS has not modified, amended, withdrawn or repealed WAC

388-100-005 to conform with the intent of the Legislature. This being the case, pursuant to RCW 34.05.640 (5) and (6), the committee respectfully requests that the notice of objection published along with WAC 388-100-005 continue to be published along with WAC 388-503-0370.
[Joint Administrative Rules Review Committee, Memorandum February 21, 1995—Filed February 27, 1995, WSR 95-06-053.]

Reviser's Note: The substance of WAC 388-503-0370 was moved into WAC 388-438-0100 filed as WSR 98-16-044 on July 31, 1998.

WAC 388-438-0110 The alien emergency medical (AEM) program. (1) The alien emergency medical (AEM) program is a federally-funded program. It is for aliens who are ineligible for other Medicaid programs, due to citizenship or alien status requirements described in WAC 388-424-0005 and 388-424-0010.

(2) Except for the Social Security Number, citizenship, or alien status requirements, the alien must meet categorical Medicaid eligibility requirements as described in:

(a) WAC 388-505-0110, for an SSI-related person;

(b) WAC 388-505-0220, for family medical programs;

(c) WAC 388-505-0210, for a child under the age of nineteen; or

(d) WAC 388-523-0100, for medical extensions.

(3) When an alien has monthly income which exceeds the CN medical standards, the department will consider AEM medically needy coverage for children or for adults who meet SSI disability criteria. See WAC 388-519-0100.

(4) To qualify for the AEM program, the alien must have an emergency medical condition as described in WAC 388-500-0005.

(5) The alien's date of arrival in the United States is not used when determining eligibility for the AEM program.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 42 C.F.R. 435.139 and 42 C.F.R. 440.255. 99-23-082, § 388-438-0110, filed 11/16/99, effective 12/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0110, filed 7/31/98, effective 9/1/98.]

Chapter 388-440 WAC
EXCEPTION TO RULE

WAC

WAC 388-440-0001 Exceptions to rule. (1) The secretary of the department, or designee, authorizes department staff to request an exception to a rule in the Washington Administrative Code (WAC) for individual cases, except as noted in subsection (5) of this section, when:

(a) The exception would not contradict a specific provision of federal law or state statute; and

(b) The client's situation differs from the majority; and

(c) It is in the interest of overall economy and the client's welfare; and

(d) It increases opportunities for the client to function effectively; or

(e) A client has an impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment.

(2) The secretary or the secretary's designee makes the final decision on all requests for exceptions to a rule.

(3) Clients have no fair hearing rights as defined under chapter 388-08 WAC regarding exception to rule decisions by department staff.

(4) Clients who do not agree with a decision on an exception to rule may file a complaint according to chapter 388-426 WAC.

(5) This section does not apply to requests for noncovered medical or dental services or related equipment. See WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 00-03-034, § 388-440-0001, filed 1/12/00, effective 2/12/00; 98-16-044, § 388-440-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-440-0005 Exception to rule—Notification requirement. (1) Clients are notified in writing within ten days of:

(a) The department staff's decision to file an exception to rule request; and

(b) The department's decision to approve or deny an exception to rule request.

(2) The notice will include the complaint procedures as specified in chapter 388-426 WAC.

(3) This section does not apply to notification requirements for exceptions to rules concerning noncovered medical or dental services or related equipment. See WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 00-03-034, § 388-440-0005, filed 1/12/00, effective 2/12/00; 98-16-044, § 388-440-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-442 WAC
FELONS

WAC

WAC 388-442-0010 How being a felon impacts your eligibility for benefits. (1) You are not eligible for TANF/SFA, GA and/or food assistance if you are:

(a) Fleeing to avoid prosecution, custody, or confinement after conviction of a crime, or an attempt to commit a crime which is considered a felony in the place from which you are fleeing; or

(b) Violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision.

(2) You are not eligible for TANF/SFA and/or food assistance if you were convicted of a felony committed after August 21, 1996 involving an element of possession, use, or distribution of an illegal drug, unless you:

(a) Were convicted only of possession or use of an illegal drug; and

(b) Were not convicted of a felony for illegal drugs within three years of the latest conviction; and

(c) Were assessed as chemically dependent by a program certified by the division of alcohol and substance abuse (DASA); and

(d) Are taking part in or have completed a rehabilitation plan consisting of chemical dependency treatment and job services.

(3) If you are pregnant, but cannot get TANF/SFA because you were convicted of a drug-related felony, you can get SFA while you are pregnant if you meet all other TANF/SFA eligibility criteria under WAC 388-400-0005 or 388-400-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-442-0010, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-442-0010, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-442-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-444 WAC
FOOD STAMP EMPLOYMENT AND TRAINING

WAC

WAC 388-444-0005 The food stamp employment and training (FS E&T) program—General requirements. (1) To receive food assistance some clients must register for work and if required by the department, must participate in the food stamp employment and training (FS E&T) program.

(2) Clients who must register for work and may be required to participate in FS E&T are called nonexempt clients. All other members of the food assistance unit are called exempt clients.

(3) All nonexempt members of the food assistance unit are registered for work by the department, at the first food assistance application and once every twelve months thereafter. A person who enters an existing assistance unit will be registered for work and FS E&T, if not exempt.

(4) Clients must comply with all FS E&T program requirements as provided in subsection (5) of this section. Failure to comply without good cause will disqualify the client from receiving food assistance:

(a) Good cause rules are provided in WAC 388-444-0050; and

(b) Disqualification rules are provided in WAC 388-444-0055.

(5) Nonexempt clients are required to:

(a) Report to DSHS or the service provider and participate as required;

(b) Provide information regarding employment status and availability for work as requested;

(c) Report to an employer when referred by DSHS; and

(d) Accept a bona fide offer of suitable employment. Unsuitable employment is defined in WAC 388-444-0060.

(6) A nonexempt client will participate in one or more of the following activities:

(a) Job search;

(b) General education development (GED) classes; or

(c) English as a second language (ESL) classes.

(7) A client is not required to participate in FS E&T activities more than one hundred twenty hours in a month. Hours of participation may include a combination of FS E&T activities as described in subsection (6) of this section and hours worked for pay, either cash or in-kind.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0010 Clients who are required to register for work and must participate in FS E&T. The following clients are nonexempt, must register for work and are required to participate in FS E&T:

(1) Age sixteen through fifty-nine with dependents;

(2) Age sixteen or seventeen, not attending secondary school and not the head-of-household;

(3) Age fifty through fifty-nine with no dependents.

(4) Age eighteen to fifty, able-bodied and with no dependents as provided in WAC 388-444-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0015 When are clients not required to register for work or participate in FS E&T (exempt clients)? You (as a client) are not required to register for work or to participate in FS E&T if you meet any of the following conditions:

(1) Age sixteen or seventeen and not the head-of-household and:

(a) Attending school (such as high school or GED programs); or

(b) Enrolled at least half time (as defined by the institution) in a program under temporary assistance for needy families (TANF), a program under The Workforce Investment Act, (formerly the 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.

(2) Determined to be physically or mentally unable to work;

(3) Responsible for the care of a dependent child under six years of age or of a person determined to be incapacitated;

(4) Applying for or receiving unemployment compensation (UC);

(5) Participating in an employment and training program under TANF;

(6) Employed or self-employed person working thirty hours or more per week, or receiving weekly earnings equal to the federal minimum wage multiplied by thirty;

(7) Students eighteen or older enrolled at least half time as defined by the institution in:

(a) Any accredited school;

(b) Training program; or

(c) An institution of higher education. Students enrolled in higher education must follow the student criteria as defined in chapter 388-482 WAC, Student status.

(8) Regularly participating in a drug addiction or alcoholic treatment and rehabilitation program.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0015, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0020 When must clients register for work but are not required to participate in the food stamp employment and training program (FS E&T)? You, as a client must register for work, as provided in WAC 388-444-0005, even though you are exempt from participation in the FS E&T program if you are:

(1) Participating in a refugee assistance program;

(2) Living in an area where the FS E&T program is not provided (exempt area), see Food Stamp E&T Appendix 1 for exempt areas;

(3) Living one hour or more travel distance from available FS E&T services;

(4) Without a mailing address or message telephone;

(5) Temporarily unable to work and it is expected to last longer than sixty days; or

(6) A client who has dependent care needs that exceed the maximum amount payable by the department. The exemption continues until:

(a) A different work activity is available; or

(b) Circumstances change and monthly dependent care costs no longer exceed the reimbursement limit set by the department.

[Statutory Authority: RCW 74.04.510 and 74.04.050. 00-21-111, § 388-444-0020, filed 10/18/00, effective 11/18/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0025 Payments for FS E&T related expenses. (1) Some of a client's actual expenses needed to participate in the FS E&T program may be paid by the department. Allowable expenses are:

(a) Transportation related costs; and

(b) Dependent care costs for each dependent six through twelve years of age.

(2) Dependent care payments are not paid if:

(a) The child is thirteen years of age or older unless the child is:

(i) Physically and/or mentally incapable of self-care; or

(ii) Under court order requiring adult supervision; or

(b) Any member in the food assistance unit provides the dependent care.

(3) Dependent care payments paid by the department cannot be claimed as an expense and used in calculating the dependent care deduction as provided in WAC 388-450-0185.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0030 Work requirements for persons who are able-bodied adults without dependents (ABAWDS). (1) Clients who are age eighteen to fifty and have no dependents must, unless exempt, participate in specific employment and training activities to receive food assistance.

(2) Nonexempt clients who fail to participate are eligible for no more than three months of food assistance in a thirty-six month period.

(3) Except as provided in WAC 388-444-0035, a person is not eligible to receive food assistance for more than three full months in the thirty-six month period beginning January 1, 1997 unless that person:

(a) Works at least twenty hours a week averaged monthly; or

(b) Participates in and complies with the requirements of a work program for twenty hours or more per week; or

(c) Participates in a workfare program as provided in WAC 388-444-0040.

(4) A work program is defined as a program under:

(a) The Job Training Partnership Act (JTPA);

(b) Section 236 of the Trade Act of 1974; or

(c) A state-approved employment and training program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0035 When am I (able-bodied adult with no dependents) exempt from ABAWD provisions? You are exempt from the ABAWD rules provided in WAC 388-444-0030 if you are:

(1) Under eighteen or fifty years of age or older;

(2) Determined to be physically or mentally unable to work;

(3) A parent or other member of a household with responsibility for a dependent child under eighteen years of age or a person determined to be incapacitated;

(4) Pregnant;

(5) Living in an area approved as exempt by U.S. Department of Agriculture;

(6) Complying with the work requirements of an employment and training program under temporary assistance for needy families (TANF);

(7) Applying for or receiving unemployment compensation;

(8) Students enrolled at least half time as defined by the institution in:

(a) Any accredited school;

(b) Training program; or

(c) Institution of higher education. A student enrolled in higher education must follow the student criteria defined in chapter 388-482 WAC.

(9) Participating in a chemical dependency treatment program;

(10) Employed a minimum of thirty hours per week or receiving weekly earnings which equal the minimum hourly rate multiplied by thirty hours;

(11) Eligible for one of the annual federal-approved exemption slots under what is called the fifteen percent exemption rule.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0035, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0035, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0040 Work programs for ABAWDs in the food stamp employment and training program. Work programs are available to clients eighteen to fifty years of age who are able to work and have no dependents.

(1) The following are considered work programs:

(a) Workfare consists of:

(i) Thirty days of job search activities in the first month beginning with the first day of application, or sixteen hours of volunteer work with a public or private nonprofit agency; and

(ii) In subsequent months, sixteen hours per month of volunteer work with a public or private nonprofit agency allows the client to remain eligible for food stamps. Workfare is not enforced community service or for paying fines or debts due to legal problems.

(b) Work experience (WEX) is supervised, unpaid work for at least twenty hours a week. The work must be for a nonprofit agency or governmental or tribal entity. This work is to improve the work skills of the client.

(c) On-the-job training (OJT) is paid employment for at least twenty hours a week. It is job training provided by an employer at the employer's place of business and may include some classroom training time.

(2) The department may not require more than thirty hours a week of Workfare and paid work combined.

(3) The department may pay for some of a client's actual expenses needed for the client to participate in work programs. Standards for paying expenses are set by the department.

[Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0040, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0045 Regaining eligibility for food assistance. (1) A client who is ineligible for food assistance because that client has exhausted the three-month limit in WAC 388-444-0030, can regain eligibility by:

(a) Working eighty hours or more during a thirty-day period;

(b) Participating in and complying with a work program for eighty hours or more during a thirty-day period;

(c) Participating in and complying with the community service part of a Workfare program; or

(d) Meeting any of the work requirements in (a) through (c) of this subsection in the thirty days after an application for benefits has been filed.

(2) A client who regains eligibility for food assistance under subsection (1) of this section is eligible from the date of application and as long as the requirements of WAC 388-444-0030 are met.

(3) If otherwise eligible, a client who regains eligibility under the provision of subsection (1) of this section, may receive an additional three consecutive months of food assistance when the client:

(a) Loses employment; or

(b) Loses the opportunity to participate in a work program.

(4) The provisions in subsection (3) of this section are allowed only once in the thirty-six month period.

[Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0045, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0050 Good cause for failure to register for work or for not participating in the FS E&T program. (1) A nonexempt client may have good cause for refusing or failing to register for work or to participate in the FS E&T program.

(2) Good cause reasons include, but are not limited to:

(a) Illness of the client;

(b) Illness of another household member requiring the help of the client;

(c) A household emergency;

(d) The unavailability of transportation; or

(e) Lack of adequate dependent care for children six through twelve years of age.

(3) A client who is determined by the department to lack good cause for failing or refusing to participate in FS E&T is disqualified and is not eligible to receive food assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0055 What are the penalties for refusing or failing to comply? (1) If you are nonexempt you must follow the food assistance work requirements as defined in WAC 388-444-0005 or 388-444-0030 unless you have good cause as defined in WAC 388-444-0050. If you do not follow these rules, you will become an ineligible assistance unit member as provided in WAC 388-450-0140. The remaining members of the assistance unit continue to be eligible for food assistance.

(2) If you do not follow these rules unless you have good cause, you cannot receive food assistance for the following periods of time and until you comply with program requirements:

(a) For the first failure to comply, one month;

(b) For the second failure to comply, three months; and

(c) For the third or subsequent failure to comply, six months.

(3) If you become exempt under WAC 388-444-0015 and are otherwise eligible, you may begin to receive food assistance.

(4) If you are nonexempt and you do not comply with the work requirements of the following programs, you cannot receive food assistance:

(a) WorkFirst;

(b) Unemployment compensation;

(c) The refugee cash assistance program.

(5) Within ten days after learning of your refusal to participate in your program, the financial worker will send you a notice that your food assistance will end unless you comply with your program requirements.

(6) If you do not comply within ten days, you will be issued a notice disqualifying you from receiving food assis-

tance until you comply with your program, or until you meet the FS E&T disqualification requirements in subsection (2) of this section.

(7) After the penalty period in subsection (2) of this section is over, and you have complied with your program requirements, and you are otherwise eligible, you may receive food assistance:

(a) If you are alone in the assistance unit and apply to reestablish eligibility; or

(b) If you are a member of an assistance unit, you may resume receiving food assistance.

(8) During the penalty period, if you begin to participate in one of the programs listed in subsection (4)(a) through (c) and that penalty is removed, the FS E&T disqualification also ends. If you are otherwise eligible, you may begin to receive food assistance.

(9) You have a right to a fair hearing as provided in WAC 388-08-413.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0055, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0060 FS E&T—Unsuitable employment. Nonexempt clients participating in FS E&T must accept a bona fide offer of suitable employment. Employment is considered unsuitable when:

(1) The wage offered is less than the federal or state minimum wage, whichever is highest;

(2) The job offered is on a piece-rate basis and the average hourly yield expected is less than the federal or state minimum wage, whichever is highest;

(3) The employee, as a condition of employment, is required to join, resign from or is barred from joining any legitimate labor union;

(4) The work offered is at a site subject to strike or lockout at the time of offer unless:

(a) The strike is enjoined under the Taft-Hartley Act; or

(b) An injunction is issued under section 10 of the Railway Labor Act.

(5) The degree of risk to health and safety is unreasonable;

(6) The client is physically or mentally unable to perform the job as documented by medical evidence or reliable information from other sources;

(7) The employment offered within the first thirty days of registration for FS E&T is not in the client's major field of experience;

(8) The distance from the client's home to the job is unreasonable considering the wage, time and cost of commute:

(a) The job is not suitable when daily commuting time exceeds two hours per day, not including transporting a child to and from child care; and

(b) The job is not suitable when the distance to the job prohibits walking and public or private transportation is not available.

(9) The working hours or nature of the job interferes with the client's religious observances, convictions, or beliefs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0065 What happens if I quit my job? (1) You are not eligible for food assistance if you quit your current job without good cause as defined in WAC 388-444-0070, and you are in one of the following categories:

(a) You were working twenty hours or more per week or the job provided weekly earnings equal to the federal minimum wage multiplied by twenty hours;

(b) The quit was within sixty days before you applied for food assistance or any time after;

(c) At the time of quit you were an applicant and would have been required to register for work as defined in WAC 388-444-0010;

(d) If you worked or you were self-employed and working thirty hours a week or you had weekly earnings at least equal to the federal minimum wage multiplied by thirty hours.

(2) You are not eligible to receive food assistance if you have participated in a strike against a federal, state or local government and have lost your employment because of such participation.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0065, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0070 Good cause for quitting a job. Unless otherwise specified the following rules apply to all food assistance clients.

(1) Good cause for quitting a job includes the following:

(a) For all food assistance clients, the employment is unsuitable as defined under WAC 388-444-0060;

(b) The client is discriminated against 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;

(c) Work demands or conditions make continued employment unreasonable, such as working without being paid on schedule;

(d) The client accepts other employment or is enrolled at least half time in any recognized school, training program, or institution of higher education;

(e) The client must leave a job because another assistance unit member accepts a job or is enrolled at least half time in any recognized school, training program, or institution of higher education in another county or similar political subdivision and the assistance unit must move;

(f) The client who is under age sixty and retires as recognized by the employer;

(g) The client accepts a bona fide offer of employment of twenty or more a week or where the weekly earnings are equivalent to the federal minimum wage multiplied by twenty hours. However, because of circumstances beyond the control of the client, the job 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;

(h) The client leaves 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; and.

(i) For FS E&T participants, circumstances included under WAC 388-444-0050;

(2) A client who quits the most recent job is eligible for food assistance if the circumstances of the job involve:

(a) Changes in job 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.

(3) The client must verify good cause for quitting. Food assistance is not denied if the client and the department are unable to obtain verification.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0070, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0075 What are the disqualification periods for quitting a job without good cause? (1) If you are an applicant who quits a job without good cause sixty days before applying for food assistance, the department will deny your application. The penalty period in subsection (3) of this section begins from the date of application.

(2) If you are already receiving food assistance and you quit your job without good cause, the department must send you a letter notifying you that you are going to be disqualified from food assistance. The disqualification in subsection (3) of this section begins the first of the month following the notice of adverse action.

(3) You are disqualified for the following minimum periods of time and until the conditions in subsection (4) of this section are met:

(a) For the first quit, one month;

(b) For the second quit, three months; and

(c) For the third or subsequent quit, six months.

(4) You may re-establish eligibility after the disqualification, if otherwise eligible by:

(a) Getting a new job;

(b) In nonexempt areas, participating in the FS E&T program;

(c) Participating in Workfare as provided in WAC 388-444-0040.

(5) The department can end the disqualification period if you become exempt from the work registration requirements as provided in WAC 388-444-0015 unless you are applying for or receiving unemployment compensation (UC), or participating in an employment and training program under TANF.

(6) If you are disqualified and move from the assistance unit and join another assistance unit, you continue to be treated as an ineligible member of the new assistance unit for the remainder of the disqualification period.

(7) If you are disqualified and move to a FS E&T exempt area, you must serve the remainder of the disqualification period.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0075, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0075, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0075, filed 7/31/98, effective 9/1/98.]

Chapter 388-446 WAC
FRAUD

WAC

WAC 388-446-0001 Cash and medical assistance fraud. (1) All cash or medical assistance cases in which substantial evidence is found supporting a finding of fraud are referred to the county prosecuting attorney. The prosecuting attorney's office determines which cases are subject to criminal prosecution.

(2) An applicant or recipient is suspected of committing fraud if intentional misstatement or failure to reveal information affecting eligibility results in an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0001, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0140.]

WAC 388-446-0005 Disqualification period for cash assistance. (1) An applicant or recipient who has been convicted of unlawful practices in obtaining cash assistance is disqualified from receiving further cash benefits if:

(a) For TANF/SFA, the conviction was based on actions which occurred on or after May 1, 1997; or

(b) For general assistance, the conviction was based on actions which occurred on or after July 23, 1995.

(2) The disqualification period must be determined by the court and will be:

(a) For a first conviction, no less than six months; and

(b) For a second or subsequent conviction, no less than twelve months.

(3) The disqualification applies only to the person convicted and begins on the date of conviction.

(4) A recipient's cash benefits are terminated following advance or adequate notice requirements as specified in WAC 388-418-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0010 TANF disqualification period for fraud convictions of misrepresenting interstate residence. (1) An applicant or recipient is disqualified from receiving cash benefits under TANF if convicted of fraud by misrepresentation of residence in order to receive assistance from two or more states at the same time from any assistance program funded by the following:

(a) TANF and any other benefit authorized by Title IV-A of the Social Security Act; or

(b) Any benefit authorized by The Food Stamp Act of 1997; or

(c) Any benefit authorized by Title XIX, Medicaid; or

(d) SSI benefits authorized by Title XVI.

(2) The disqualification penalty is applied as follows:

(a) Only to convictions based on actions which occurred on or after May 1, 1997; and

(b) Only to the person convicted of fraud in federal or state court; and

(c) For a disqualification period of ten years or a period determined by the court, whichever is longer.

(3) The disqualification period begins the date the person is convicted of fraud by misrepresentation of residence in order to receive assistance from two or more states at the same time.

(4) The provisions of subsections (1) through (3) of this section do not apply when the President of the United States has granted a pardon for the conduct resulting in the conviction of fraud by misrepresentation of residence. 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, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0015 Intentional program violation (IPV) and disqualification hearings for food assistance. (1) An intentional program violation (IPV) is defined as an act in which a person intentionally:

(a) Makes a false or misleading statement;

(b) Misrepresents, conceals or withholds facts; or

(c) Acts in 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.

(2) Food assistance clients suspected of committing an (IPV) are subject to referral for an administrative disqualification hearing, if:

(a) The suspected IPV causes an overissuance of four hundred fifty dollars or more; and

(b) The administrative proceedings will not jeopardize criminal proceedings; and

(c) The person resides in Washington state, at the time of the referral; or

(d) The person resides outside Washington state, but is within one hour's reasonable drive to a CSO.

(3) An administrative disqualification hearing (ADH) is a formal hearing to determine if a person committed an IPV. ADHs are governed by the rules found in chapter 388-08 WAC. However, rules in this section are the overriding authority if there is a conflict.

(4) A client who commits one or more IPVs and is suspected of committing another, is referred for an ADH when the act of suspected violation occurred:

(a) After the department mailed the disqualification notice to the client for the most recent IPV; or

(b) After an order was entered in criminal proceedings for the most recent IPV.

(5) A person suspected of IPV is entitled to receive notice of an ADH at least thirty days in advance of the hearing date. The notice is sent by certified mail, or provided to the client by personal service and will contain the following:

(a) The date, time, and place of the hearing;

(b) The charges against the individual;

(c) A summary of the evidence, and how and where the evidence can be examined;

(d) A warning that a decision will be based solely on evidence provided by the department, if the individual fails to appear at the hearing;

(e) A statement that the individual has ten days from the date of the scheduled hearing to show good cause for failure to appear at the hearing and to request rescheduling;

(f) A warning that a determination of IPV will result in a disqualification period; and

(g) A statement that if a telephone hearing is scheduled, the individual can request an in-person hearing by filing a request with the administrative law judge one week or more prior to the date of the hearing.

(6) The person or a representative shall have the right to one continuance of up to thirty days if a request is filed ten days or more prior to the hearing date.

(7) The hearing will be conducted and a decision rendered even if the person or representative fail to appear, unless within ten days from the date of the scheduled hearing:

(a) The person can show good cause for failing to appear; and

(b) The person or representative requests the hearing be re-instated.

(8) A scheduled telephone hearing may be changed to an in-person hearing if requested one week or more in advance. If requested less than one week in advance the person must show good cause for the requested change.

(9) The ALJ issues a preliminary decision based on evidence presented by the department establishing the person committed and intended to commit an IPV. The department and the client each have the right to request a review of the ALJ's decision by writing to the department's board of appeals as specified in WAC 388-08-464.

(10) A final decision of the disqualification hearing is mailed by the department's board of appeals.

(11) A client's disqualification is not implemented and benefits continue at the current amount when:

(a) The client can show good cause for not attending the hearing within thirty days from the date the disqualification notice was mailed; and

(b) An administrative law judge determines the client had good cause; or

(c) The client files a petition for review to appeal the disqualification

(12) An administrative disqualification hearing and an overissuance hearing can be combined when the cause for both hearings is related. The hearing procedures and notice requirements are the same as for administrative disqualification hearings.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0020 Food assistance disqualification penalties. (1) Disqualification penalties apply only to the person or persons found to have committed an intentional program violation (IPV) as follows:

(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 (1)(a) of this section:

(i) Six months for the first violation;

(ii) Twelve months for the second violation;

(iii) Permanently for the third violation.

(2) The disqualification and penalty period for a person convicted in another state stays in effect until satisfied regardless of where a person moves.

(3) Multiple program violations are considered as one violation when determining the penalty for disqualification when the violations occurred before the department notified the household of the penalties, as described in subsection (1), (4) and (5) of this section.

(4) Disqualification penalties for persons convicted by a federal, state, or local court of trading or receiving food coupons for a controlled substance are:

(a) Two years for a first conviction; and

(b) Permanently for a second conviction.

(5) A first conviction by federal, state, or local court permanently disqualifies persons who:

(a) Trade or receive food coupons for firearms, ammunition, or explosives; or

(b) Knowingly buy, sell, trade, or present for redemption food coupons totalling five hundred dollars or more in violation of section 15 (b) & (c) of the Food Stamp Act of 1977, as amended.

(6) Persons convicted of providing false identification or residency information to receive multiple coupon benefits are disqualified for ten years.

(7) When a court convicts a person of an IPV, the disqualification penalties specified in subsection (1) through (5) apply as follows;

(a) In addition to any civil or criminal penalties; and

(b) Within forty-five days of the date of conviction; unless

(c) Contrary to the court order.

(8) Disqualification penalties are applied after notifying the household of the disqualification, the effective date, the amount of benefits the household will receive during the disqualification period and the need to reapply when the certification period expires.

(9) Even though only the individual is disqualified, the food assistance household is responsible for making restitution for the amount of any overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-448 WAC
INCAPACITY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-448-0005 The following criteria is used to determine if a child is deprived of parental support due to incapacity. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0005, filed 7/31/98, effective 9/1/98.] Repealed by 00-15-051, filed 7/17/00, effective 9/1/00. Statutory Authority: RCW 74.04.057, 74.08.090.

WAC 388-448-0001 Establishing incapacity for general assistance unemployable. For the purposes of this chapter, "we" and "us" refer to the department of social and health services. "You" means the applicant or recipient. In order for you to receive general assistance unemployable (GAU) benefits, we must first determine if you are incapacitated.

(1) We determine you are incapacitated if you are:

(a) Eligible for payments based on Social Security Administration (SSA) disability criteria;

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

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

(d) At least sixty-five years old;

(e) Eligible for services from aging and adult services administration; or

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

(2) We consider you to be incapacitated for ninety days following your release from:

(a) An inpatient psychiatric treatment facility if:

(i) You directly participate in outpatient mental health treatment; and

(ii) The release from in-patient treatment was not against medical advice.

(b) A medical institution where you received long-term care services from the aging and adult services administration.

[Statutory Authority: RCW 74.04.057, 74.08.090. 00-15-018, § 388-448-0001, filed 7/10/00, effective 9/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-448-0010 How we decide if you are incapacitated. When you apply for general assistance unemployable (GAU) program benefits, you must provide medical evidence to us to show that you are unable to work. If we say that you are **"incapacitated,"** it means that you are incapable of gainful employment as a result of a physical or mental impairment that is expected to continue for ninety days or more from the date of application.

(1) If you are gainfully employed at the time of your application for GAU, we deny incapacity. **"Perform gainful employment"** means you can perform, in a regular and predictable manner, an activity usually done for pay or profit. We do not consider work to be gainful employment when you are:

(a) Working under special conditions, like a sheltered workshop we have approved; or

(b) Working occasionally or part-time if your medical condition limits the hours you can work compared to unimpaired workers in the same job.

(2) We decide if you are able to perform gainful employment when:

(a) We receive an application for benefits. We may waive this decision if medical documentation requirements are waived under WAC 388-448-0001;

(b) You become employed; or

(c) We get new information that indicates you may be employable.

(3) Unless medical documentation requirements are waived under WAC 388-448-0001, we determine if incapacity exists using the progressive evaluation process (PEP). When we receive your medical evidence, we use the PEP to decide if there is a medical impairment that prevents you from being gainfully employed. The PEP is a sequence of seven-steps.

(4) You are not eligible for GAU benefits if you are incapacitated only because of alcoholism or drug addiction. If you have a physical or mental impairment and you are impaired by alcohol or drug addiction, we decide if you are eligible for general assistance. If you qualify for both GAU and ADATSA shelter, you may choose either program.

(5) In determining incapacity, we consider only your ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: sitting, standing, walking, lifting, carrying, handling, seeing, hearing, communicating, and understanding and following instructions.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0010, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0020 How and from whom you can get medical evidence for incapacity determination. Before we can find out if you are eligible, you must give us medical evidence that meets the requirements in WAC 388-448-0030. Medical evidence provides us with the details of your impairment and how it affects your ability to be gainfully employed. If you cannot get medical evidence without cost to you, we will pay the fees or other expenses based on our published policies and payment limits.

We accept medical evidence from the sources listed below:

(1) For a physical impairment, we only accept reports from the following licensed medical professionals as primary evidence:

(a) A physician;

(b) An advanced registered nurse practitioner (ARNP) in the ARNP's area of certification;

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

(d) A physician assistant when the report is co-signed by the supervising physician.

(2) For a mental impairment, we only accept reports from one of the following licensed professionals as primary evidence:

(a) A psychiatrist;

(b) A psychologist;

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

(d) A person who provides mental health services in a community mental health services setting and meets the mental health practitioner qualifications set by the local community mental health agency, which consist of having a Master of Arts (MA) degree and two years experience; or

(e) The physician who is currently treating you for a mental disorder.

(3) **"Supplemental medical evidence"** means a report from a practitioner that can be used to support medical evidence given by any of the practitioners listed in subsections (1) and (2) of this section. We accept as supplemental medical evidence reports from:

(a) A practitioner who is providing on-going treatment to you, such as a chiropractor, nurse, physician assistant; or

(b) DSHS institutions and agencies that are providing or have provided services to you.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0020, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0030 The kind of medical evidence you need to provide for determination of incapacity. You must provide medical evidence that clearly explains what physical or mental health problem you have that incapacitates you. **"Impairment"** means any diagnosable physical or mental condition except alcoholism or drug addiction. The following describes how we decide if the medical evidence that you provide regarding your impairment meets the requirements:

(1) We only accept written medical evidence. It must contain clear, objective medical documentation that includes:

(a) A diagnosis for the incapacitating condition;

(b) The effect of the condition on your ability to perform work-related activities; and

(c) Relevant medical history and sufficient medical documentation to support conclusions of incapacity.

(2) The medical evidence must be based on an exam within the last ninety days.

(3) When making an incapacity decision, we do not use your report of symptoms as evidence unless medical findings show there is a medical condition that could reasonably be expected to produce the symptoms reported. In those cases, you must provide us with clear and objective medical information, including observation by the medical practitioner and relevant medical history that supports conclusions about:

(a) The existence and persistence of the symptom(s); and

(b) Its effect on your ability to perform basic work activities.

(4) We decide incapacity based solely on the objective information we receive. We are not obligated to accept a decision that you are incapacitated or unemployable made by another agency or person.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0030, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0035 How we assign severity ratings to your impairment. (1) **"Severity rating"** means a rating of the extent of your incapacity, and how severely it impacts your ability to perform the basic work activities. Severity ratings are assigned in Steps II through IV of the PEP. The following chart provides a description of levels of limitations on work activities and the severity ratings that would be assigned to each.

Effect on work activities	Severity rating
(a) There is no effect on your performance of basic work-related activities.	1
(b) There is no significant effect on your performance of basic work-related activities.	2
(c) There are significant limits on your performance of at least one basic work-related activity.	3
(d) There are very significant limits on your performance of at least one basic work-related activity.	4
(e) You are unable to perform at least one basic work-related activity.	5

(2) We use the severity rating given by the medical evidence provider:

(a) If the rating is supported by and consistent with the medical evidence;

(b) If the provider's assessment of your limitations is consistent with our definition of the rating; and

(c) If the rating is consistent with other medical evidence provided to us.

(3) If the medical evidence provider assigns a severity rating that is not consistent with the objective evidence and your symptoms from your impairment as described in the medical evidence, we take the following action:

(a) If your limitations are more severe than the rating given, we raise your severity rating; or

(b) If your limitations are less severe than the rating given, we lower your severity rating; and

(c) We give clear and convincing reasons for adjusting the rating.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0035, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0040 PEP step I—Review of medical evidence required for eligibility determination. When we receive your medical evidence, we review it to see if it is complete and to decide whether your circumstances match GAU program requirements.

(1) We require a written medical report to determine incapacity. The report must:

(a) Contain sufficient information as described under WAC 388-448-0030;

(b) Be written by an authorized medical professional;

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

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

(2) If the information received is not clear, we may require more information before we decide your ability to be gainfully employed. As examples, we may require you to get more medical tests or be examined by a medical specialist.

(3) We deny incapacity when:

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

(b) A reported impairment is not expected to last ninety days (twelve weeks) or more from the date of application;

(c) The practitioner is not able to determine that the physical or mental impairment would remain incapacitating after at least sixty days of abstinence from alcohol and drugs; or

(d) We do not have clear and objective medical evidence to approve incapacity.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0040, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0050 PEP step II—How we determine the severity of mental impairments. If you are diagnosed with a mental impairment, we use information from the provider to determine if your impairment prevents you from being gainfully employed. We review the psychological evidence to determine the severity of your mental impairment.

(1) The severity of your mental impairment is based on:

(a) Psychosocial and treatment history;

(b) Clinical findings;

(c) Results of psychological tests; and

(d) Symptoms observed by the examining practitioner that show impairment of your ability to perform basic work-related activities.

(2) If you are diagnosed with mental retardation, the diagnosis must be based on the Wechsler Adult Intelligence Scale (WAIS). The following test results determine the severity rating:

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

70 or lower	5

(3) If you are diagnosed with a mental impairment with physical causes, we assign a severity rating based on the most severe of the following three areas of impairment:

(a) Memory defect for recent events;

(b) Impoverished, slowed, perseverative thinking, with confusion or disorientation; or

(c) Labile, shallow, or coarse affect.

(4) We base the severity of the functional psychotic or nonpsychotic disorder, excluding alcoholism or drug addiction, on:

(a) Clinical assessment of these twelve symptoms: depressed mood, suicidal trends, verbal expression of anxiety or fear, expression of anger, social withdrawal, motor agitation, motor retardation, paranoid behavior, hallucinations, thought disorder, hyperactivity, preoccupation with physical complaints; and

(b) Clinical assessment of the intensity and pervasiveness of your symptoms and their effect on work activities.

(5) We base the severity rating for a functional mental impairment on accumulated severity ratings for the twelve symptoms in subsection (4)(a) of this section as follows:

Symptom Ratings or Condition	Severity Rating
(a) The functional mental impairment is diagnosed with psychotic features; (b) You have had two or more hospitalizations for psychiatric reasons in the past two years; (c) You have had more than six months of continuous psychiatric hospital or residential treatment in the past two years; (d) The overall assessment of symptoms is rated three; or (e) At least three symptoms are rated three or higher.	3
(f) The overall assessment of symptoms is rated four; or (g) At least three symptoms are rated four or five.	4
(h) The overall assessment of symptoms is rated five; or (i) At least three symptoms are rated five.	5

(6) If you have more than one type of mental impairment, we assign a severity rating as follows:

Condition	Severity Rating
(a) Two or more disorders with ratings of three; or (b) One or more disorders rated three; and one rated four.	4
(c) Two or more disorders rated four.	5

(7) We deny incapacity when you do not have a significant physical impairment and your overall mental severity rating is one or two;

(8) We approve incapacity when you have an overall mental severity rating of five, regardless of whether you have a physical impairment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0050, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0060 PEP step III—How we determine the severity of physical impairments. We must decide if your physical impairment is serious enough to limit your ability to be gainfully employed. "Severity of a physical impairment" means the degree that an impairment restricts you from performing basic work-related activities (see WAC 388-448-0010). Severity ratings range from one to five, with five being the most severe. We will assign severity ratings according to the table in WAC 388-448-0035.

(1) We assign to each physical impairment a severity rating that is supported by medical evidence.

(2) If your physical impairment is rated two, and there is no mental impairment or a mental impairment that is rated one, we deny incapacity.

(3) If your physical impairment is consistent with a severity rating of five, we approve incapacity.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0060, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0070 PEP step IV—How we determine the severity of multiple impairments. (1) If you have more than one impairment we decide the overall severity rating by deciding if your impairments have a combined effect on your ability to be gainfully employed. Each diagnosis is grouped by affected organ or function into one of twelve "body systems." The twelve body systems consist of:

(a) Musculo-skeletal,

(b) Special senses,

(c) Respiratory,

(d) Cardiovascular,

(e) Digestive,

(f) Genito-urinary,

(g) Hemic and lymphatic,

(h) Skin,

(i) Endocrine,

(j) Neurological,

(k) Neoplastic, and

(l) Immune systems.

(2) We follow these rules when there are multiple impairments:

(a) We group each diagnosis by body system.

(b) When you have two or more diagnosed impairments that limit work activities, we assign an overall severity rating as follows:

Your Condition	Severity Rating
(i) All impairments are in the same body system, are rated two and there is no cumulative effect on basic work activities.	2
(ii) All impairments are in the same body system, are rated two and there is a cumulative effect on basic work activities. (iii) All impairments are in different body systems, are rated two and there is a cumulative effect on basic work activities.	3

Your Condition	Severity Rating
(iv) Two or more impairments are in different body systems and are rated three. (v) Two or more impairments are in different body systems; one is rated three and one is rated four.	4
(vi) Two or more impairments in different body systems are rated four.	5

(c) We deny incapacity when the overall severity rating is two.

(d) We approve incapacity when the overall severity rating is five.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0070, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0080 PEP step V—How we determine your ability to function in a work environment if you have a mental impairment. If you have a mental impairment we evaluate your cognitive and social functioning in a work setting. Functioning means your ability to perform the tasks that would be required of you on the job and your ability to get along with your co-workers, supervisors and other people you would be in contact with while on the job.

(1) We evaluate cognitive factors by assessing your ability to:

(a) Understand, remember, and follow simple, one- or two-step instructions;

(b) Understand, remember, and follow complex instructions, with three or more steps;

(c) Learn new tasks;

(d) Exercise judgment and make decisions; and

(e) Perform routine tasks without undue supervision.

(2) We approve incapacity when the practitioner's evaluation shows you are:

(a) At least moderately impaired in your ability to understand, remember, and follow simple instructions and at least moderately limited in your ability to:

(i) Learn new tasks, exercise judgment, and make decisions; and

(ii) Perform routine tasks without undue supervision; or

(b) Able to understand, remember, and follow simple instructions, but are:

(i) At least moderately impaired in the ability to understand, remember, and follow instructions with three or more steps; and

(ii) Markedly impaired in the ability to learn new tasks, exercise judgment and make decisions, and perform routine tasks without undue supervision.

(3) The practitioner's evaluation reports your social factors after assessing your ability to:

(a) Relate appropriately to coworkers and supervisors;

(b) Relate appropriately in contacts with the public;

(c) Tolerate the pressures of a work setting;

(d) Perform self-care activities, including personal hygiene; and

(e) Maintain appropriate behavior in a work setting.

(4) We approve incapacity if you are rated at least two in one area of social functioning and at least three in all other areas of social functioning.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0080, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0090 PEP step V—How we determine your ability to function in a work environment if you have a physical impairment. In Step V of the PEP we review the medical evidence you provide and make a determination of how your physical impairment prevents you from working. This determination is then used in Steps VI and VII of the PEP to determine your ability to perform either work you have done in the past or other work.

(1) **"Exertion level"** means the ability to lift, carry, stand and walk with the strength needed to fulfill job duties in the following work categories. For this section, "occasionally" means less than one-third of the time and "frequently" means one-third to two-thirds of the time. We only consider your strength, mobility, and flexibility. We review any work limits you have in the following areas, and then assign an exertion level and determine exertional limitations.

The following table is used to determine your exertion level. Included in this table is a strength factor, which is your ability to perform physical activities, as defined in Appendix C of the Dictionary of Occupational Titles (DOT), Revised Edition, published by the U.S. Department of Labor.

If you	Then we assign this exertion level
(a) Can not lift at least two pounds or stand and/or walk.	Severely limited
(b) Can lift ten pounds maximum and frequently lift and/or carry lightweight articles. Walking and standing are only required for brief periods.	Sedentary
(c) Can lift twenty pounds maximum and frequently lift and/or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday, with sitting and pushing/ pulling arm or leg movements most of the day.	Light
(d) Can lift fifty pounds maximum and frequently lift and/or carry up to twenty-five pounds.	Medium
(e) Can lift one hundred pounds maximum and frequently lift and/or carry up to fifty pounds.	Heavy

(2) **"Exertionally-related limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. If you have exertionally-related limitations, we consider them in determining your ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility you can apply to work-related activities. We consider the effect of the physical impairment on the ability to perform work-related activities

when the physical impairment is assigned an overall severity rating of three or four. We determine functional physical capacity based on your exertional, exertionally related and non-exertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

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

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

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

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0090, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0100 PEP step VI—How we evaluate capacity to perform relevant past work. If your overall severity rating is three or four and we have reached this stage of the PEP and have not approved or denied your application, we decide if you can do the same or similar work as you have done in the past. We look at your current physical and/or mental limitations and vocational factors to make this decision. Vocational factors are education, relevant work history, and age.

(1) We evaluate education in terms of formal schooling or other training that enables you to meet job requirements. We classify education as:

If you	Then your education level is
(a) Can not read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b) Have no formal schooling beyond the eleventh grade; or (c) Have participated in special education.	Limited education
(d) Have received a high school diploma or general equivalency degree (GED); or (e) Have received skills training and were awarded a certificate, degree or license.	High school and above level of education

(2) We evaluate your work experience to determine if you have relevant past work. "Relevant past work" means work that:

(a) Is normally done for pay or profit. We exclude work done in a sheltered workshop, a job where you were given special consideration, or activities you may have performed as a student or homemaker;

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

(c) You have done long enough for you to have acquired the knowledge and skills to continue performing the job. You must meet the specific vocational preparation level as defined in Appendix C of the Dictionary of Occupational Titles.

(3) For each relevant past work situation you have had, we determine:

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

(b) Current cognitive, social, or nonexertional factors that significantly limit your ability to perform past work.

(4) After considering vocational factors, we approve or deny incapacity based on the following:

If you	Then we take this action on incapacity
(a) Have the physical or mental ability to perform past work and there is no significant cognitive, social or nonexertional limitation.	Deny
(b) Have recently acquired specific work skills through completion of vocational training, enabling you to work within your current physical or mental capacities.	Deny
(c) Are fifty-five years of age or older and have an impairment that is assigned an overall severity rating of at least three and do not have the physical or mental ability to perform past work or do not have work experience.	Approve

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0100, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0110 PEP step VII—How we evaluate your capacity to perform other work. If we decide you cannot do work that you've done before, we then decide if you can do any other work. In making this decision, we again consider vocational factors of age, education and limited English proficiency (LEP).

(1) We approve incapacity if you have a physical impairment only and meet the vocational factors below:

Highest work level assigned by the practitioner	Your age	Your education level	Other vocational factors
Sedentary	Any age	Any level	Does not apply
Light	Fifty and older	Any level	Does not apply
Light	Thirty-five and older	Illiterate or LEP	Does not apply
Light	Eighteen and older	Limited education	Does not have any past work
Medium	Fifty and older	Limited education	Does not have any past work
Medium	Fifty-five and older	Any level	Does not apply
Heavy	Fifty-five and older	Any level	Environmental restrictions apply

(2) We approve incapacity when you have a mental impairment only and meet the age and social functioning limitations below:

Social limitation	Age
(a) Can not appropriately relate to coworkers and supervisors (rated three); and (b) Can not tolerate the pressures of a work setting (rated four).	Fifty years and older
(c) Can not tolerate the pressures for a work setting (rated five).	Eighteen to fifty-four
(d) A mental disorder severity rated four; (e) One or more symptoms from WAC 388-448-0050(4) (rated five); (f) Can not appropriately relate to coworkers and supervisors (rated three); and (g) Can not tolerate the pressures of a work setting (rated four).	Eighteen to forty-nine

(3) We approve incapacity when you have both mental and physical impairments and vocational factors interfere with working as follows:

Your age	Your education	Your other restrictions
Any age	Any level	(a) Can not appropriately relate to coworkers and supervisors (rated three; and (b) Can not tolerate pressures of a work setting (rated four).
Fifty or older	Limited education	(c) Restricted to medium work level or less.
Eighteen to forty-nine	Limited education	(d) Restricted to light work level.

(4) If we do not find that you are incapacitated by the end of Step VII of the PEP, an administrative review team (ART) makes the incapacity decision. The review team consists of two or more persons within the community service office (CSO) who are not in the position of providing direct eligibility or incapacity services to you. The ART reviews the medical evidence and your vocational factors.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0110, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0120 How we decide how long you are incapacitated. We decide the maximum length of time you are eligible for GAU based on incapacity according to the medical evidence and expected length of recovery from the incapacitating condition as follows:

(1) Thirty-six months when we decide it is evident you meet federal disability criteria to receive Social Security Supplemental Security Income (SSI); or

(2) Twelve months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0120, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0130 Treatment and referral requirements. We refer you to medical providers or other agencies for treatment or rehabilitation to improve your ability to engage in gainful employment or reduce your need for GAU. **"Available medical treatment"** means medical, surgical, chemical dependency, or mental health services, or a combination of them.

(1) We give you written information regarding your treatment requirements when you are initially approved, and at each redetermination.

(2) You must accept and follow through on required medical treatment unless you have a convincing reason for not doing so. Examples of good cause are found in WAC 388-448-0140.

(3) If your basic claim of incapacity is alcoholism or drug dependency, we refer you for evaluation under the alcoholism and drug addiction treatment and support act (ADATSA).

(4) We may require you to undergo alcohol or drug treatment before re-evaluating eligibility for GAU.

(5) You may request a fair hearing if you disagree with the treatment or referral requirements we set for you. If you request a fair hearing we will not reduce or stop your benefits as a result of your refusal to follow the requirement until the fair hearing is decided.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0130, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0140 Good cause for refusing medical treatment or other agency referrals. We may determine that you have good cause for refusing required treatment or referrals to other agencies. We may require you to provide documentation to support your good cause claim. Valid reasons for refusing treatment and other agency referrals include, but are not limited to, the following:

(1) Treatment referrals:

(a) You are so fearful of the treatment that your fear could interfere with the treatment or reduce its benefits;

(b) Treatment could cause further limitations or loss of a function or an organ and you are not willing to take that risk;

(c) You practice an organized religion that prohibits treatment; or

(d) Treatment is not available without cost to you.

(2) Treatment or other agency referrals:

(a) You did not have enough information on the requirement or did not receive written notice of the requirement;

(b) The requirement was made in error;

(c) You are temporarily unable to participate because of documented interference, or

(d) Your medical condition or limitations are consistent with the definition of necessary supplemental accommodation (NSA), WAC 388-200-1300, and your condition or limitations contributed to your refusal.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0140, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0150 Penalty for refusing medical treatment or other agency referrals. (1) If you refuse required treatment or agency referral without having good cause, we will stop your GAU benefits.

(2) We stop your GAU benefits until you agree to accept and pursue the required treatment service or referral.

(3) If you reapply, you must wait for a penalty period to pass before you begin getting benefits. The penalty is based on how often you have refused:

Refusal	Penalty
First	One week
Second within six months	One month
Third and subsequent within one year	Two months

[Statutory Authority: RCW 74.04.050, 74.04 055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0150, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0160 Review of your incapacity. (1) In order to review your incapacity, we must have sufficient written medical information based on an examination within the last sixty days. We may also require information about your progress with required treatment or agency referrals according to WAC 388-448-0130.

(2) We cannot extend GAU eligibility beyond the current eligibility end date if we do not receive current medical evidence that we decide is enough to show that you continue to be incapacitated.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0160, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0170 Termination requirement—How we determine you are no longer incapacitated. (1) Before we can decide you are no longer incapacitated, we must demonstrate that at least one of the following conditions exists:

(a) The incapacitating condition has clearly improved since incapacity was established. **"Clear improvement"** means that since incapacity was established:

(i) The physical or mental impairment that incapacity was based on has decreased in severity to the point where you are capable of gainful employment;

(ii) The effect of that impairment on work-related activities has been significantly decreased through treatment or rehabilitation, and you are now capable of gainful employment; or

(iii) We decide you are gainfully employed.

(b) There was a previous error in the eligibility decision. **"Previous error"** means incapacity was previously established based on:

(i) Faulty or insufficient information; or

(ii) We made a procedural error in one of our previous determinations, based on a rule in effect at the time.

(2) If we decide you are clearly improved but are receiving services through the division of vocational rehabilitation (DVR), we have the option of approving continued GAU through an exception to rule (ETR).

(3) We do not apply the clear improvement or previous error criteria when:

(a) You have a break in assistance of over thirty days and do not meet the criteria for retroactive reinstatement as required under WAC 388-448-0190; or

(b) You do not meet the categorical eligibility requirements for the general assistance unemployable program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0170, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0180 How we redetermine your eligibility if it is evident you meet federal disability criteria for SSI. We may extend your incapacity period up to thirty-six months from the last date of incapacity determination without additional medical documentation when it is evident that you meet federal disability criteria for Supplemental Security Income (SSI) eligibility.

(1) We determine your eligibility at the end of the thirty-six-month period, using current medical evidence.

(2) If you applied for SSI, were denied, and the denial was upheld by an administrative appeal before the end of the thirty-six-month incapacity period, we adjust the incapacity period to be sixty days after the SSI denial date.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0180, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0190 Reinstating your eligibility after termination due to lack of medical evidence. If your assistance was terminated due to lack or insufficiency of medical evidence, we reinstate your eligibility the day following the termination date if the following conditions are met:

(1) The termination was not due to your failure to cooperate in gathering the evidence;

(2) You provided the medical evidence within thirty days after the termination, establishing that you have been incapacitated since the date of termination; and

(3) The medical evidence substantiates incapacity.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0190, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0200 Eligibility for general assistance unemployable pending SSI eligibility. If you are applying for SSI and we determine you may become eligible for SSI, we approve you for GAU benefits. The assistance is authorized through the month SSI payments begin if you:

(1) Apply for SSI and follow through with your application;

(2) Assign the initial or reinstated SSI payment to DSHS as provided under WAC 388-448-0210; and

(3) Are otherwise eligible.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0200, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0210 Assignment and recovery of interim assistance. You can get assistance to meet your basic needs from only one government source at a time. When you are approved for SSI, you may receive a payment going back to the date you applied for SSI. This means you are being paid a back payment for your basic needs. When

you have received GAU during that time period, the amount paid to you in the form of GAU must be reimbursed to the state.

(1) **"Assign"** means that the Social Security Administration (SSA) will pay DSHS directly from your reimbursement amount. The assignment will be up to the amount of interim assistance we provide to you.

(2) **"Interim assistance"** means the state funds we provide to you to meet basic needs during:

(a) The time between your SSI application date and the month recurring SSI payments begin; or

(b) The period your SSI payments were suspended or terminated, and later reinstated for that period.

(3) We pay up to twenty-five percent of the interim assistance reimbursement that we receive from the SSA to the attorney who has successfully represented you in your effort to receive SSI.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0210, filed 8/2/00, effective 9/1/00.]

Chapter 388-450 WAC
INCOME

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-450-0060 Lump sum payments. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0060, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0060, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-450-0180 Effect of countable income on eligibility and benefit level for cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0180, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-450-0205 Budgeting income deductions for food assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0205, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-450-0220 Retrospective budgeting. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0220, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0220, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-450-0235 Discontinued income. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0235, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0235, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-450-0240 Effect of net lump sum payments for cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0240, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-450-0250 Income of a new assistance unit member. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0250, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0250, filed 7/31/98, effective 9/1/98.] Repealed by 00-01-012, filed 12/3/99, effective 1/1/00. Statutory Authority: RCW 74.04.510.

WAC 388-450-0005 Income—Ownership and availability. (1) For TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs:

(a) All available income owned or possessed by a client is considered when determining the client's eligibility and benefit level.

(b) Ownership of income is determined according to applicable state and federal laws pertaining to property ownership and eligibility for assistance programs. For married persons, ownership of separate and community income is determined according to chapter 26.16 RCW.

(c) Income owned by a client is considered available when it is at hand and may be used to meet the client's current need. The gross amount of available income is counted in the month it is received.

(i) If income is usually available on a specific day, it is considered available on that date.

(ii) If income is usually received monthly or semi-monthly and the pay date changes due to a reason beyond the client's control, such as a weekend or holiday, it is counted in the month it is intended to cover rather than the month it is actually received.

(iii) If income is usually received weekly or bi-weekly and the pay date changes due to a reason beyond the client's control, it is counted in the month it is received.

(d) The income of a person who is not a member of a client's assistance unit may be considered available to the client under the rules of this chapter if the person is financially responsible for the client and lives in the home with the client. For medical programs, financial responsibility is described in WAC 388-408-0055.

(e) For medical programs, the income of a financially responsible person, not living in the home is considered available to the extent it is contributed.

(f) Funds deposited into a bank account which is held jointly by a client and another are considered income possessed by and available to the client unless:

(i) The client can show that all or part of the funds belong exclusively to the other account holder and are held or used solely for the benefit of that holder; or

(ii) The funds have been considered by the Social Security Administration (SSA) when determining the other account holder's eligibility for SSI benefits.

(g) Potential income is income a client may have access to that can be used to reduce the need for assistance. For cash and medical programs, when the department determines that a potential income source exists, the client may be denied assistance when the client fails or refuses to make a reasonable effort to make the income available.

(i) A client's eligibility is not affected until the income is received as long as the client makes reasonable efforts to make potential income available; and

(ii) A client may choose whether to receive TANF/SFA or Supplemental Security Income (SSI) benefits.

(2) For TANF/SFA, RCA, GA and food assistance programs the income of an alien's sponsor is considered available to the alien under the rules of this chapter when determining the alien's eligibility and benefit level.

(3) For SSI-related medical:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the clients needs for food, clothing and shelter, except as provided in WAC 388-511-1130.

(b) Loans and certain other receipts are not defined as income for SSI-related medical purposes as described in 20 C.F.R. Sec. 416.1103.

(4) For medical programs, trusts are described in WAC 388-505-0595.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590 and 388-506-0610.]

WAC 388-450-0010 Liens against potential time-loss compensation. This section applies to TANF/SFA, RCA, GA and TANF/SFA-related medical programs.

(1) By accepting public assistance, adult and minor clients assign to the department the right to recover time-loss compensation.

(2) When an assistance unit consists of unmarried parents only, the portion of cash assistance received by the injured parent and the injured parent's natural, adoptive or stepchildren is recoverable by the department.

(3) When a client or client's attorney claims allowable attorney fees and costs incidental to an increased award, the office of financial recovery (OFR) will:

(a) Determine what portion of the award, if any, resulted directly from the attorney's involvement;

(b) Determine the department's proportionate share of attorney fees and costs applicable to the duplicate coverage period; and

(c) Deduct the department's share of cost in subsection (b) of this section from the lien for duplicated assistance; or

(d) Issue the proportionate share refund to the attorney with a copy of the account summary to the client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0015 Excluded and disregarded income. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Excluded income is income that is not counted when determining a client's eligibility and benefit level. Types of excluded income include but are not limited to:

(a) Bona fide loans as defined in WAC 388-470-0025, except certain student loans as specified under WAC 388-450-0035.

(b) Federal earned income tax credit (EITC) payments;

(c) Title IV-E and state foster care maintenance payments if the foster child is not included in the assistance unit;

(d) Energy assistance payments;

(e) Educational assistance as specified in WAC 388-450-0035;

(f) Native American benefits and payments as specified in WAC 388-450-0040;

(g) Income from employment and training programs as specified in WAC 388-450-0045;

(h) Money withheld from a client's benefit to repay an overpayment from the same income source. For food assistance, this exclusion does not apply when the money is withheld to recover an intentional noncompliance overpayment

from a federal, state, or local means tested program such as TANF/SFA, GA, and SSI; and

(i) Child support payments received by TANF/SFA recipients.

(2) For food assistance programs, the following income types are excluded:

(a) Emergency additional requirements authorized to TANF/SFA and RCA clients under WAC 388-436-0001 and paid directly to a third party;

(b) Cash donations based on need received directly by the household if the donations are:

(i) Made by one or more private, nonprofit, charitable organizations; and

(ii) Do not exceed three hundred dollars in any federal fiscal year quarter.

(c) Infrequent or irregular income, received during a three-month period by a prospectively budgeted assistance unit, that:

(i) Cannot be reasonably anticipated as available; and

(ii) Does not exceed thirty dollars for all household members.

(3) All income that is not excluded is considered to be part of an assistance unit's gross income.

(4) For food assistance households not containing an elderly or disabled member, the assistance unit is ineligible if its gross income exceeds one hundred thirty percent of the federal poverty level as specified in WAC 388-478-0060.

(5) Disregarded income is income that is counted when determining an assistance unit's gross income but is not used when determining an assistance unit's countable income. Types of disregarded income include but are not limited to:

(a) Earned income incentives and disregards for cash assistance; and

(b) Earned income disregard and income deductions for food assistance.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-450-0015, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0020 Income exclusions for SSI-related medical. This section describes the types of income which are excluded or not counted when determining how much of a client's income is compared to the income standards in WAC 388-478-0065 through 388-478-0085 to determine eligibility.

(1) The first twenty dollars per month of a client's earned or unearned income, which is not otherwise excluded in this section, is excluded. This exclusion:

(a) Can only be allowed once for a husband and wife; and

(b) Does not apply to income paid on the basis of an eligible person's needs, which is funded totally or partially by the federal government or a private agency.

(2) The first sixty-five dollars per month of a client's earned income, plus one-half of the remainder is considered a work incentive and is deducted from the earned income. This deduction does not apply to income already excluded in this section.

(3) Income a client does not reasonably anticipate or which a client receives infrequently or irregularly is excluded when it is:

(a) Unearned and does not exceed twenty dollars per month; or

(b) Earned and does not exceed ten dollars per month.

(4) A client's work related expenses including child care are excluded when they specifically enable:

(a) A blind client to work; or

(b) A permanently or totally disabled client to continue to work.

(5) Any portion of self-employment income normally allowed as an income deduction by the Internal Revenue Service (IRS) is excluded.

(6) Any payment a client receives for the foster care of a child who lives in the same household, is excluded when the child:

(a) Was placed in the client's home by a public or nonprofit child placement or child care agency; and

(b) Is not SSI eligible.

(7) One-third of any payment for child support a client receives from an absent parent for a minor child, who is not institutionalized, is excluded.

(8) A portion of an SSI-related person's income to meet the needs of an ineligible minor child living in the household is excluded when:

(a) The SSI-related parent is single; or

(b) If married, the spouse does not have income (see WAC 388-450-0150 if the spouse has income); and

(c) The excluded amount is:

(i) One-half of the one person federal SSI benefit rate, as described in WAC 388-478-0055; and

(ii) Minus any income of the child.

(9) Unless income is specifically contributed to the client, all earned income of an ineligible or nonapplying person, under twenty-one years of age, is excluded when this person is a student:

(a) Attending a school, college, or university; or

(b) Pursuing a vocational or technical training program designed to prepare the student for gainful employment.

(10) A client's veteran's benefits are excluded when they are designated for the veteran's:

(a) Dependent; or

(b) Aid and attendance/household allowance and unreimbursed medical expense allowance (UME). For an institutional client see WAC 388-513-1345.

(11) Any federal SSI income or state supplement payment (SSP), which is based on financial need is excluded.

(12) COLA increases in Title II Social Security Administration benefits are excluded for a noninstitutionalized client when:

(a) Received by the client after the client's termination from SSI/SSP or;

(b) Received by the client's spouse or other financially responsible person living in the household during the time period after the SSI/SSP termination.

(13) Income which causes a client to lose SSI eligibility due solely to the reduction in the SSP is excluded.

(14) Increases in a client's burial funds, established on or after November 1, 1982, are excluded if these increases are the result of:

(a) Interest earned on excluded burial funds;

(b) Appreciation in the value of an excluded burial arrangement which is left to accumulate and become part of separately identified burial funds.

(15) An essential expense incurred by a client to receive unearned income is excluded.

(16) A client's refund by any public agency of taxes paid on real property or on food is excluded.

(17) Tax rebates or special payments excluded under other statutes are excluded.

(18) The amount of a client's EITC payment is excluded.

(19) 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 are excluded.

(20) Income a client's ineligible or nonapplying spouse receives from a governmental agency for services provided to an eligible client, such as chore services, are excluded.

(21) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services are excluded.

(22) 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 are excluded. Any interest earned on this income is considered as unearned income, under WAC 388-450-0025.

(23) Payments to a client under section 500 through 506 of the Austrian General Social Insurance Act are excluded. Any interest earned on this income is considered unearned income under WAC 388-450-0025.

(24) Payments to a client from the Dutch government, under the Netherlands' Act on Benefits for Victims of Persecution (WUV) are excluded. Any interest earned on this income is considered unearned income under WAC 388-450-0025.

(25) Other payments excluded under federal or state law, including but not limited to those described in WAC 388-450-0015 (1)(b) through (g).

(26) Payments from Susan Walker v. Bayer Corporation, et al., 96-c-5024 (N.D. Ill.) (May 8, 1997) settlement funds are excluded as income. Any interest earned on this income is considered unearned income under WAC 388-450-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140 and 388-519-1910.]

WAC 388-450-0025 Unearned income. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Unearned income is income a person receives from a source other than employment or self-employment. Examples of unearned income include but are not limited to:

(a) Railroad Retirement;

(b) Unemployment Compensation; or

(c) Veteran Administration benefits.

(2) For food assistance programs, unearned income includes the amount of cash benefits due the client prior to any reductions caused by the client's failure to perform an action required under a federal, state, or local means-tested public assistance program.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-450-0025, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0030 Earned income definition. Unless specifically stated, this section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Earned income is:

(a) Income a person receives in the form of cash or in-kind, which is a gain or benefit to the person, when earned as a wage, salary, tips, gratuities, commissions, or profit from self-employment activities.

(b) Income over a period of time for which settlement is made at one time, such as sale of farm crops, livestock, or poultry.

(2) For food assistance programs only, income in-kind is excluded.

(3) Earned income from self-employment is determined as specified under WAC 388-450-0080.

(4) For TANF/SFA, RCA, GA-H, and TANF/SFA-related medical assistance, earned income includes time-loss compensation as specified in WAC 388-450-0075.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-450-0030, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0035 Educational benefits. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs. Unless otherwise stated, exclusions and disregards of educational benefits apply to clients engaged in undergraduate studies only.

(1) We exclude the educational assistance in the form of grants, loans or work study, issued from Title IV of the Higher Education Amendments (Title IV - HEA) and Bureau of Indian Affairs (BIA) education assistance programs. Examples of Title IV - HEA and BIA educational assistance include but are not limited to:

(a) College work study (federal and state);

(b) Pell grants; and

(c) BIA higher education grants.

(2) We do not count the following types of educational assistance, in the form of grants, loans, or work study when determining a student's need:

(a) Assistance under the Carl D. Perkins Vocational and Applied Technology Education Act, P.L. 101-391 for attendance costs identified by the institution as specified in subsections (3) and (4) of this section; and

(b) Educational assistance made available under any program administered by the Department of Education (DOE) to an undergraduate student. Examples of programs administered by DOE include but are not limited to:

(i) Christa McAuliffe Fellowship Program;

(ii) Jacob K. Javits Fellowship Program; and

(iii) Library Career Training Program.

(3) Educational assistance under subsection (2)(a) of this section is disregarded when used for the following attendance costs when a student is attending school less than half-time:

(a) Tuition;

(b) Fees; and

(c) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study.

(4) Educational assistance under subsection (2)(a) of this section that is used for the following expenses is disregarded in addition to the costs specified in subsection (3) of this section when the student is attending school at least half-time:

(a) Books;

(b) Supplies;

(c) Transportation;

(d) Dependent care; and

(e) Miscellaneous personal expenses.

(5) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, the amount of a student's remaining educational assistance equal to the difference between the student's appropriate need standard and payment standard is excluded.

(6) Any remaining income is unearned income and budgeted using the appropriate budgeting method for the assistance unit.

(7) When a student participates in WorkFirst work study, educational assistance made available to the student is:

(a) Disregarded for cash and medical assistance;

(b) Counted as earned income for food assistance.

(8) When a student participates in a work study program that is not excluded by subsections (1) and (2) or (7)(a) of this section, the income received is treated as earned income:

(a) Applying the applicable earned income disregards;

(b) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, excluding the difference between the student's appropriate need standard and payment standard; and

(c) Budgeting remaining income using the appropriate budgeting method for the assistance unit.

(9) When a student receives Veteran's Administration Educational Assistance:

(a) All applicable attendance costs are subtracted; and

(b) The remaining unearned income is budgeted using the appropriate budgeting method for the assistance unit.

(10) When a student participates in graduate school studies, educational assistance made available to the student is counted as:

(a) Assistance from another agency for cash and medical assistance;

(b) Earned income for food assistance if there are work requirements; or

(c) Unearned income for food assistance if there are no work requirements.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 00-18-057, § 388-450-0035, filed 9/1/00, effective 9/4/00. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0040 Native American benefits and payments. This section applies to TANF/SFA, RCA, GA medical and food assistance programs.

(1) The following types of income are not counted when a client's benefits are computed:

(a) Up to two thousand dollars per individual per calendar year received under the Alaska Native Claims Settlement Act, P.L. 92-203 and 100-241;

(b) Income received from Indian trust funds or lands held in trust by the Secretary of the Interior for an Indian tribe or individual tribal member. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(c) Income received from Indian judgement funds or funds held in trust by the Secretary of the Interior distributed per capita under P.L. 93-134 as amended by P.L. 97-458 and 98-64. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(d) Up to two thousand dollars per individual per calendar year received from leases or other uses of individually owned trust or restricted lands, P.L. 103-66;

(e) Payments from an annuity fund established by the Puyallup Tribe of Indians Settlement Act of 1989, P.L. 101-41, made to a Puyallup Tribe member upon reaching twenty-one years of age; and

(f) Payments from the trust fund established by the P.L. 101-41 made to a Puyallup Tribe member.

(2) Other Native American payments and benefits that are excluded by federal law are not counted when determining a client's benefits. Examples include but are not limited to:

(a) White Earth Reservation Land Settlement Act of 1985, P.L. 99-264, Section 16;

(b) Payments made from submarginal land held in trust for certain Indian tribes as designated by P.L. 94-114 and P.L. 94-540; and

(c) Payments under the Seneca Nation Settlement Act, P.L. 101-503.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140.]

WAC 388-450-0045 Income from employment or training programs. This section applies to TANF/SFA, RCA, GA, and food assistance programs.

(1) Payments issued under the Job Training Partnership Act (JTPA) are considered as follows:

(a) Wages paid under JTPA including wages for on-the-job training are counted as earned income.

(b) For TANF/SFA, RCA, and GA assistance, needs based payments issued under JTPA including payments for on-the-job training are considered as follows:

(i) Payments which cover special needs not covered in the need standard are excluded.

(ii) Payments which duplicate items contained in the need standard are excluded up to the difference between the student's appropriate need standard and payment standard.

(c) For food assistance:

(i) Living allowances and incentive payments under JTPA are excluded as income; and

(ii) Earnings received from on-the-job training programs under JTPA are:

(A) Counted as earned income for persons:

(I) Age nineteen and older; or

(II) Age eighteen or younger and not under parental control.

(B) Excluded income for persons eighteen years of age or younger and under parental control.

(2) Payments issued under the National and Community Service Trust Act of 1993 (AmeriCorps) are considered as follows:

(a) For cash assistance, living allowances or stipends paid under AmeriCorps are counted as earned income.

(b) For food assistance, living allowances or stipends paid under AmeriCorps are excluded income.

(3) AmeriCorps/VISTA stipends and living allowances paid to VISTA volunteers under the Domestic Volunteer Act of 1973:

(a) For TANF/SFA, RCA, and GA assistance, are disregarded as income; and

(b) For food assistance, are counted as earned income. The payments are disregarded if the client received:

(i) Food assistance or cash assistance at the time they joined the Title I program; or

(ii) An income disregard for the Title I program at the time of conversion to the Food Stamp Act of 1977. Disregard of Title I program income will continue through temporary interruptions in food assistance participation.

(4) For TANF/SFA, RCA, and GA assistance, needs based payments issued under AmeriCorps are considered the same way as JTPA payments as provided in subsection (1)(b) of this section.

(5) For food assistance, training allowances from vocational and rehabilitative programs are counted as earned income when:

(a) Recognized by federal, state, or local governments; and

(b) Not a reimbursement.

(6) For training allowances received by GA-U clients:

(a) The earned income incentive and work expense deduction specified under WAC 388-450-0175 is applied when applicable; and

(b) For clients enrolled in a remedial education or vocational training course, the actual cost of uniforms or special clothing required for the course is deducted from the training allowance.

(7) Support service payments received by or made on behalf of WorkFirst participants are not considered income.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0050 How are your cash assistance and food assistance benefits determined when you are participating in the community jobs (CJ) program?

(1) The department estimates your total monthly income from your community jobs (CJ) position based on the number of hours you, your case manager and the CJ contractor expect you to work for the month multiplied by the federal or state minimum wage, whichever is higher.

(2) Once the department determines what your total monthly income is expected to be the department will not redetermine your cash benefit amount even if you do not work the number of hours you were expected to work.

(3) The department considers the total income it expects you to get each month from your CJ position as:

(a) Earned income for determining your cash assistance benefits.

(b) Unearned income for determining your food assistance benefits.

(4) When determining your benefits the department will use:

(a) One-half of your CJ income for figuring cash assistance benefits for the second and following months of your CJ participation. The department will not use any of the CJ income you receive in your first month of CJ participation to determine your cash assistance benefit amount for that month.

(b) All of your CJ income for figuring food assistance benefits.

(5) Monthly reports are not required for CJ participants.

(6) If your anticipated CJ income is more than your grant amount:

(a) Your cash grant will be suspended, see WAC 388-450-0245(1). The grant suspension can be up to a maximum of nine months; and

(b) Each month your cash grant is suspended will count toward your assistance unit's sixty month lifetime time limit, see WAC 388-484-0005.

(7) You, your case manager and the CJ contractor will review your CJ position every ninety days during your nine-month placement. During this review they will look at:

(a) Your continued TANF/SFA eligibility; and

(b) Any earned or unearned income received by you or another member of your assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-09-054, § 388-450-0050, filed 4/19/99, effective 6/1/99; 98-16-044, § 388-450-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0055 Assistance from other agencies and organizations. Unless specifically stated, this section applies to TANF/SFA, RCA, GA, medical and food assistance programs.

(1) Funds received from other agencies and organizations are excluded when determining the amount of assistance to be paid as long as no duplication exists between the assistance provided by the other agency and that provided by the department.

(2) To assure nonduplication, aid from other agencies will be considered in relation to:

(a) The different purposes for which such aid is granted;

(b) The provision of goods and services not included in the department's standards; and

(c) Conditions that preclude its use for current living costs.

(3) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, if the assistance from another agency is available to meet need, the assistance shall be disregarded up to the difference between the need standard and the payment standard.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0065 Gifts—Cash and noncash. A gift is an item furnished to a client without work or cost on his or her part.

(1) A cash gift is a gift that is furnished as money, cash, checks or any other readily negotiable form.

(a) For TANF/SFA, RCA, GA-S, GA-H, and TANF/SFA-related medical programs, cash gifts totaling no more than thirty dollars per calendar quarter for each assistance unit member are disregarded as income.

(b) For GA-U, cash gifts are treated as unearned income.

(c) For food assistance programs:

(i) Cash gifts to the assistance unit are excluded if they total thirty dollars or less per quarter;

(ii) Cash gifts in excess of thirty dollars per quarter are counted in full as unearned income.

(2) For TANF/SFA, RCA, GA-S, GA-H, GA-U and TANF/SFA-related medical programs, a noncash gift is treated as a resource.

(a) If the gift is a countable resource, its value is added to the value of the client's existing countable resources and the client's eligibility is redetermined as specified in chapter 388-470 WAC.

(b) If the gift is an excluded or noncountable resource, it does not affect the client's eligibility or benefit level.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0065, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0070 A child's earned income. Unless otherwise specified, this section applies to TANF/SFA, RCA, GA-H and TANF/SFA-related medical programs. The earned income of a dependent child is:

(1) Excluded when determining if the total income of the assistance unit is more than one hundred eighty-five percent of the need standard in WAC 388-478-0015. This exclusion is limited to:

(a) Children who are full-time students; and

(b) No more than six month's in any calendar year.

(2) Not counted when determining the assistance unit's need and benefit level when the child is a:

(a) Full-time student; or

(b) Part-time student who is employed less than full-time.

(3) For food assistance programs, all earned income of a child is not counted when a child is:

(a) Seventeen years of age or younger; and

(b) Attending elementary or secondary school at least half time.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0070, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0075 Income from time-loss compensation. (1) Temporary disability insurance payments and temporary worker's compensation payments are treated as earned income for TANF/SFA, RCA, GA-S, GA-H, and TANF/SFA-related medical when such payments are:

(a) Employer funded and are analogous to sick pay; and

(b) Made to an individual who remains employed during recuperation from a temporary illness or injury pending return to the job.

(2) Recurrent time loss benefits from the department of labor and industries are examples of benefits meeting this criteria.

(3) For TANF/SFA, RCA, GAS, GA-H and TANF/SFA-related medical programs, temporary disability insurance payments and temporary worker's compensation payments not considered to be earned income as described in subsection (1) and (2) of this section, are treated as unearned income as specified in WAC 388-450-0025.

(4) For the GA-U program, temporary disability insurance payments and temporary worker's compensation payments are treated as unearned income as specified in WAC 388-450-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0075, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0080 Self-employment income—General rules. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Self-employment earned income is used to reduce a client's need for assistance. The income is treated as earned income as provided in WAC 388-450-0030.

(2) Self-employment earned income is defined as gross business income minus total allowable business expenses as defined in WAC 388-450-0085.

(3) In order to establish eligibility for assistance, a self-employed client must maintain and make available to the department a record clearly documenting all business expenses and income.

(4) Income from the following is treated as self-employment income:

(a) Adult family home;

(b) Farming;

(c) Roomers and boarders;

(d) Rental and lease of personal property or real estate owned by the client is counted as unearned income unless the following conditions are met:

(i) For TANF/SFA clients, the use of the property is part of an approved individual responsibility plan;

(ii) For food assistance clients, the client spends at least twenty hours per week managing the property; or

(iii) For RCA or GA clients, there are no specific requirements of a self-sufficiency plan or a set number of hours managing the property.

(e) Self-produced or supplied items.

(5) For food assistance, when two or more assistance units share a residence, the money paid from one assistance unit to the other assistance unit for shelter costs is roomer income when:

(a) One assistance unit owns or is buying the residence; or

(b) One assistance unit is renting a residence and charges the other assistance unit an amount that is in excess of the total cost of renting the residence.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0080, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0080, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0085 Self-employment income—Allowable expenses. The following self-employment expenses are allowed as deductions from gross self-employment income for TANF/SFA, RCA, GA, medical and food assistance programs unless otherwise specified:

(1) Rent or lease of business equipment or property;

(2) Utilities;

(3) Postage;

(4) Telephone;

(5) Office supplies;

(6) Advertising;

(7) Business related insurance, taxes, licenses and permits;

(8) Legal, accounting, and other professional fees;

(9) For TANF/SFA, RCA, and GA assistance programs only, the cost of goods sold, including wages paid to employees producing salable goods, raw materials, stock, and replacement or reasonable accumulation of inventory, provided inventory has been declared exempt on the basis of the individual responsibility plan or other plan approved by the department;

(10) Repairs to business equipment and property, excluding vehicles;

(11) Interest on business loans used to purchase income-producing property or equipment;

(12) Gross wages and salaries paid to employees who are not:

(a) Producing salable goods; or

(b) A member of the assistance unit

(13) Commissions paid to agents and independent contractors;

(14) Seed, fertilizer, and feed grain for a self-employed farmer;

(15) Other reasonable and necessary costs of doing business;

(16) The cost of the place of business:

(a) For TANF/SFA, RCA, GA, and medical assistance, if any portion of the client's home is used as the place of business, it must be used exclusively for business to be an allowable business expense. The percentage of the home used for business can be an allowable business expense;

(b) For food assistance, there is no requirement for a portion of the home to be used exclusively for business. The percentage of the home used for business can be an allowable business expense

(17) The following transportation expenses are allowed as a deduction from gross self-employment income:

(a) Actual, documented costs for:

(i) Gas, oil, and fluids;

(ii) Replacing worn items such as tires;

(iii) Registration and licensing fees;

(iv) Auto loan interest; and

(v) Business related parking and tolls; or

(b) A cost per mile established by the department.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0085, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0085, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0090 Self-employment expenses that are not allowed as income deductions. (1) The following expenses cannot be deducted from self-employment income for TANF/SFA, RCA, GA, TANF/SFA-related medical or food assistance programs:

(a) Payments on the principle of the purchase price of income-producing:

(i) Real estate and capital assets;

(ii) Equipment;

(iii) Machinery; and

(iv) Other durable goods.

(b) Payments on the principal of loans to the business;

(c) Amounts claimed as depreciation;

(d) Any amount claimed as a net loss sustained in any prior period; and

(e) Entertainment expenses.

(2) The following expenses cannot be deducted from self-employment income for food assistance programs only:

(a) Federal, state, and local income taxes;

(b) Retirement funds; or

(c) Personal work-related expenses.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0090, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0095 Allocating income—General. This section applies to TANF/SFA, RCA, and GA assistance programs.

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit.

(2) In-bound allocation means income possessed by a financially responsible person outside the assistance unit which is considered available to meet the needs of legal dependents in the assistance unit.

(3) Out-bound allocation means income possessed by a financially responsible assistance unit member which is set aside to meet the needs of a legal dependent outside the assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0095, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0100 Allocating income—Definitions. The following definitions apply to the allocation rules for TANF/SFA, RCA, and GA programs:

(1) **"Dependent"** means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) **"Financially responsible person"** means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) A **"disqualified assistance unit member"** means a person who is:

(a) An unmarried pregnant or parenting minor under age eighteen who has not completed a high school education or general education development (GED) certification and is not participating in those educational activities which would lead to the attainment of a high school diploma or GED;

(b) An unmarried pregnant or parenting minor under age eighteen who is not living in a department-approved living situation;

(c) The financially responsible person who does not report to the department within five days of the date it becomes reasonably clear that the absence of a child will exceed ninety days;

(d) A person who has been convicted in federal or state court of having made a fraudulent statement or representation about their place of residence in order to receive assistance from two or more states at the same time as defined in WAC 388-446-0010; and

(e) A person who has been convicted of unlawfully receiving public assistance as defined under WAC 388-446-0005.

(4) **"Ineligible assistance unit member"** means an individual who is:

(a) Ineligible for cash assistance due to citizenship/alien status requirement in WAC 388-424-0005;

(b) Ineligible to receive assistance under WAC 388-442-0010 for having been convicted after August 21, 1996, under federal or state law, of possession, use or distribution of a controlled substance;

(c) Ineligible to receive assistance under WAC 388-442-0010 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime;

(d) Ineligible to receive assistance under WAC 388-442-0010 for violating a condition of probation or parole which was imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction;

(e) The spouse of a woman who receives cash benefits from the GA-S program; or

(f) The adult parent of a minor parent's child.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0100, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0100, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0105 Allocating the income of a financially responsible person included in the assistance unit. This section applies to TANF/SFA, GA-S, RCA, RMA and TANF-related medical programs. The income of a financially responsible person included in the assistance unit is countable to meet the needs of the assistance unit after the income is reduced by the following:

(1) Any applicable earned income incentive and work expense or deduction for the financially responsible person in the assistance unit, if that person is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0105, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0106 Allocating the income of a financially responsible person included in the assistance unit to household members excluded because of their alien status. This section applies to TANF/SFA, RCA, RMA and TANF/SFA-related medical programs.

When a financially responsible person, as defined in WAC 388-450-0100(3), is included in the assistance unit, that person's income is allocated to household members who are excluded from the assistance unit because of their alien status, as defined in WAC 388-450-0100 (4)(a), after allowing the following deductions:

(1) The fifty percent earned income incentive for TANF/SFA assistance units or the ninety dollar work expense deduction for RCA assistance units, if the income is earned;

(2) An amount equal to the difference between the payment standards:

(a) That would include the eligible assistance unit members and those individuals excluded from the assistance unit because of their alien status; and

(b) Only the eligible assistance unit members.

(3) The payment standard amount equal to the number of ineligible persons, as defined in WAC 388-450-0100 (4)(b) through (f);

(4) An amount not to exceed the need standard, as defined in WAC 388-478-0015, for court or administratively ordered current or back support paid for legal dependents; and

(5) The employment related child care expenses for which the household is liable.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0106, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0106, filed 11/24/98, effective 12/25/98.]

WAC 388-450-0110 Allocating the income of a GA-U client to legal dependents. This section applies to the GA-U program.

(1) The income of a GA-U client is reduced by the following:

(a) The GA-U earned income disregard and work expense disregard, as specified in WAC 388-450-0175; and

(b) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(2) When a GA-U client in a medical institution, alcohol or drug treatment center, congregate care facility or adult family home has income, the income is countable to meet the client's needs after the income is reduced by the following:

(a) The payment standard amount for the nonapplying spouse and legal dependents living in the home; and

(b) The standard of assistance the client is eligible for while in an alternative care facility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1910.]

WAC 388-450-0115 Allocating the income of a financially responsible person excluded from the assistance unit. This section applies to TANF/SFA, RCA and GA-S programs.

The income of a financially responsible person excluded from the assistance unit is available to meet the needs of the assistance unit after the income is reduced by the following:

(1) A ninety dollar work expense deduction from the financially responsible person(s) excluded from the assistance unit who is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0115, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0116 Allocating the income of a financially responsible person excluded from the assistance unit because of their alien status. This section applies to TANF/SFA and RCA programs.

When a financially responsible person, as defined in WAC 388-450-0100(3), is excluded from the assistance unit because of their alien status, as defined in WAC 388-450-0100 (4)(a), that person's income, after allowing the following deductions, is countable income available to the assistance unit:

(1) The fifty percent earned income incentive for TANF/SFA assistance units or the ninety dollar work expense deduction for RCA assistance units, if the income is earned;

(2) An amount equal to the difference between the payment standards:

(a) That would include the eligible assistance unit members and those individuals excluded from the assistance unit because of their alien status; and

(b) Only the eligible assistance unit members.

(3) The payment standard amount equal to the number of ineligible persons, as defined in WAC 388-450-0100 (4)(b) through (f);

(4) An amount not to exceed the need standard, as defined in WAC 388-478-0015, for court or administratively ordered current or back support paid for legal dependents; and

(5) The employment related child care expenses for which the household is liable.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0116, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0116, filed 11/24/98, effective 12/25/98.]

WAC 388-450-0120 Allocating the income of financially responsible parents to a pregnant or parenting minor. This section applies to TANF/SFA, RCA and GA-S programs.

The income of nonapplying financially responsible parent(s) of a pregnant or parenting minor is countable to meet the needs of the minor and the child(ren) after the income is reduced by the following:

(1) A ninety dollar work expense from the financially responsible parent's gross income from employment;

(2) An amount not to exceed the department's standard of need for:

(a) The financially responsible parent and dependent living in the home who are not applying for or receiving cash benefits and not a disqualified individual; and

(b) Court or administratively ordered current or back support for legal dependents.

(3) Spousal maintenance payments made to meet the needs of individuals not living in the home.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0120, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0125 Allocating the income of the father of the unborn child to a pregnant woman. This section applies to TANF/SFA, RCA and GA-S programs.

(1) Income of the father of the unborn child is allocated to a pregnant woman under the following conditions:

(a) The need standard, as provided in WAC 388-478-0015 that reflects the number of people in the assistance unit as though the child were born when applying the one hundred eighty-five percent of need test as specified in WAC 388-450-0015. The father is included when he is residing in the client's home.

(b) The payment standard, as provided in WAC 388-478-0025 that reflects the number of people in the assistance unit as though the child were born. The father is included when he is residing in the client's home.

(2) When the parents are married and the father resides in the client's home, his income is allocated according to rules in WAC 388-450-0115.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0125, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0130 Allocating the income of a nonapplying spouse to a caretaker relative. This section applies to TANF/SFA and RCA programs.

(1) The community income of the nonapplying spouse and applying spouse is combined. See WAC 388-450-0005 to determine what income is available as community income.

(2) Subtract a one person payment standard as specified in WAC 388-478-0020.

(3) The remainder is allocated to the caretaker relative.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0130, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0135 Allocating income of an ineligible spouse to a GA-U client. (1) This section applies to the GA-U program.

(2) When a GA-U client is married and lives with the nonapplying spouse, the following income is available to the client:

(a) The remainder of the client's wages, retirement benefits or separate property after reducing the income by:

(i) The GA-U work incentive and work expense deduction, as specified in WAC 388-450-0175; and

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(b) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(i) The GA-U work expense deduction;

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents; and

(iii) The payment standard amount as specified under WAC 388-478-0030 which includes ineligible assistance unit members.

(c) One-half of all other community income, as provided in WAC 388-450-0005.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0135, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0140 Income of ineligible assistance unit members—Food assistance. (1) When a food assistance household contains a person who is disqualified for intentional program violation or failure to meet work requirements as provided in chapter 388-444 WAC, all income of the disqualified person is included as part of the entire household's income:

(a) The standard deduction and allowable deductions for earned income, medical costs, dependent care, and excess shelter costs are applied; and

(b) The households benefits are not increased as a result of the exclusion of the disqualified person.

(2) When a household contains a person who is ineligible due to alien status, felon status as described in WAC 388-442-0010, failure to sign the application attesting to citizenship or alien status, or who has been disqualified for refusal to obtain or provide a Social Security number:

(a) The income of the ineligible person is prorated among all household members. The ineligible person's share is excluded, and the remainder is counted as income to the eligible household members;

(b) Apply the twenty percent earned income disregard to the ineligible person's earned income attributed to the household; and

(c) Divide the portion of the household's allowable shelter expenses evenly among all members of the household, when the ineligible members have income.

(3) The ineligible or disqualified household member is not counted when determining the household's size for purposes of:

(a) Comparing the household's total monthly income to the income eligibility standards; and

(b) Computing benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0140, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0140, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0145 Income of a person who is not a member of a food assistance unit. (1) A cash payment made to a food assistance unit from a person who is not a member of the assistance unit is counted as unearned income.

(2) The following types of income are not available to the assistance unit:

(a) The nonmember's income; and

(b) Payments made by a nonmember to a third party for the benefit of the assistance unit.

(3) When the nonmember's earnings are not clearly separate from the earnings of food assistance unit members, the earnings are:

(a) Divided equally among the working persons, including the nonmember; and

(b) The portion of the nonmember is not counted.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0145, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0150 SSI-related medical income allocation. (1) When a client is applying for SSI-related categorically needy (CN) or medically needy (MN) medical assistance, a portion of the income of a spouse or parent is allocated to the needs of the applicant. This occurs when the spouse or parent is:

(a) Financially responsible for the SSI-related person as described in chapter 388-408 WAC; and

(b) Lives in the same household; and

(c) Is not receiving SSI; and

(d) Is either not related to SSI or is not applying for medical assistance.

(2) If the conditions in subsection (1) of this section are met, the income exclusions listed below are applied and the remainder of the parent's income is allocated to their SSI-related minor child applying for either (CN) or (MN) medical assistance:

(a) Income exclusions as described in WAC 388-450-0020; and

(b) One-half of the federal benefit rate (FBR), as described in WAC 388-478-0055, for each SSI ineligible child in the household, minus any income of that child; and

(c) A one person FBR for a single parent, or two person FBR for two parents.

(3) The income of the financially responsible spouse of an SSI-related client applying for CN or MN medical assistance is allocated to the applicant's needs.

(a) The income exclusions in WAC 388-450-0020 (3) through (26) are allowed to reduce the nonapplying spouse's income; and

(b) One-half of the FBR for any non-SSI eligible child in the household, minus any income of that child, is allowed as a deduction; and

(c) Allocate the applying spouse:

(i) Zero income when the financially responsible spouse's income equals or is less than one-half of the FBR after allowing the income exclusions in WAC 388-450-0020 (1) and (2); or

(ii) All of the financially responsible spouse's income when the income exceeds one-half of the FBR after allowing the income exclusions in WAC 388-450-0020 (1) and (2).

(4) If the income of the financially responsible spouse described in subsection (3) of this section is less than the MNIL, a portion of the SSI-related applicant's income is

added to the financially responsible spouse's income to raise it to the MNIL.

(5) If an alien client is ineligible for SSI cash assistance because of income or resources of a sponsor allocated or deemed available to the client, the SSI-related client is still considered eligible for CN or MN medical assistance. Only the income or resources actually contributed to the alien client are considered available to that client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0150, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0630 and 388-519-1910.]

WAC 388-450-0155 Deeming income—Alien sponsorship. This section applies to TANF/SFA and GA programs.

(1) Deeming is the process of determining the amount of an alien's sponsor's income available to the alien.

(2) Any alien whose sponsor is a public or private organization is ineligible for assistance for three years from the date of entry for permanent residence into the United States, unless the agency or organization is:

(a) No longer in existence; or

(b) Has become unable to meet the alien's needs.

(3) A sponsor is any individual or public or private organization who executes an affidavit or similar agreement on behalf of an alien (who is not the dependent child of the sponsor or the sponsor's spouse) as a condition of the alien's entry into the United States.

(a) The affidavit or agreement is irrevocable, and

(b) Extends for a minimum of three years after the alien's entry for permanent residence into the United States.

(4) For a period of three years following entry for permanent residence into the United States, an individually sponsored alien is responsible for:

(a) Providing the department with any information and documentation necessary to determine the income of the sponsor that can be deemed available to the alien; and

(b) Obtaining any cooperation necessary from the sponsor.

(5) For all subsections in this section, the income of an individual sponsor (and the sponsor's spouse if living with the sponsor) is deemed to be the unearned income of an alien for three years following the alien's entry for permanent residence into the United States.

(6) Monthly income deemed available to the alien from the individual sponsor or the sponsor's spouse not receiving TANF/SFA or SSI is:

(a) The sponsor's total monthly unearned income, added to the sponsor's total monthly earned income reduced by twenty percent (not to exceed one hundred seventy-five dollars) of the total of any amounts received by the sponsor in the month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred in producing self-employment income in the month.

(b) The amount described in (a) of this subsection reduced by:

(i) The basic requirements standard for a family of the same size and composition as the sponsor and those other persons living in the same household as the sponsor claimed by the sponsor as dependents to determine the sponsor's federal personal income tax liability but who are not TANF/SFA recipients;

(ii) Any amounts actually paid by the sponsor to persons not living in the household claimed by the sponsor as dependents to determine the sponsor's federal personal income tax liability; and

(iii) Actual payments of spousal maintenance or child support with respect to persons not living in the sponsor's household.

(7) In any case where a person is the sponsor of two or more aliens, the sponsor's income is divided equally among the aliens to the extent that the income would be deemed the income of any one of the aliens under provisions of this section.

(8) The income deemed to a sponsored alien in determining the need of other unsponsored members of the alien's family is not considered except to the extent that the income is actually available.

(9) For the GA-U program, the alien's sponsor's income is deemed as available to the alien as provided for the TANF/SFA program:

(a) At application, for applications filed on or after July 8, 1994. For the purposes of this rule, re-application filed following a break in assistance of thirty days or more is considered an application; and

(b) For all other GA-U clients, the income of an alien's sponsor is not deemed as available to the client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0155, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0160 Sponsored alien—Food assistance. For food assistance, this section applies to aliens for whom a sponsor has signed an affidavit of support or similar statement on or after February 1, 1983:

(1) For the purpose of this rule, income of the sponsor means:

(a) Income of the sponsor; and

(b) Income of the sponsor's spouse when the spouse lives with the sponsor.

(2) Portions of the income of a sponsor is counted as unearned income and applied to the food assistance benefits of a sponsored alien. The income of an alien's sponsor is available for three years following the alien's admission for permanent residence to the U.S.

(3) The income of the alien's sponsor must be verified by the client at application or recertification for food assistance.

(4) The available income is computed as follows:

(a) Total monthly earned and unearned income of the sponsor:

(i) Minus twenty percent of the gross earned income; and

(ii) Minus the amount of the gross income eligibility standard for a household size equal to the sponsor, the sponsor's spouse, and all dependents.

(b) Plus any actual money paid to the alien by the sponsor or sponsor's spouse in excess of the amount computed in subsection (4)(a) of this section is treated as unearned income.

(5) The net income in subsection (4) of this section is available to a sponsored alien who:

(a) Applies for and receives food assistance; or

(b) Is recertified for food assistance.

(6) If the sponsored alien can show the sponsor is also sponsoring other aliens, the available income is divided by the number of sponsored aliens applying for, or receiving food assistance.

(7) If an alien changes sponsors during the certification period, available income is reviewed based on the required information about the new sponsor as soon as possible after the information is supplied and verified by the client.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0160, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0160, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0162 The department uses countable income to determine if you are eligible and the amount of your cash and food assistance benefits. The department uses countable income to determine if the client is eligible and the amount of the cash and food assistance benefits.

(1) Countable income is all income that remains after we subtract the following:

(a) Excluded or disregarded income under WAC 388-450-0015;

(b) Deductions or earned income incentives under WAC 388-450-0170 through 388-450-0200;

(c) Allocations to someone outside of the assistance unit under WAC 388-450-0095 through 388-450-0160.

(2) Countable income includes all income that must be deemed or allocated from financially responsible persons who are not members of your assistance unit.

(3) For cash assistance:

(a) We compare your countable income to the payment standard in WAC 388-478-0020 and 388-478-0030.

(b) You are not eligible for benefits when your assistance unit's countable income is equal to or greater than the payment standard plus any authorized additional requirements.

(c) Your benefit level is the payment standard and authorized additional requirements minus your assistance unit's countable income.

(4) For food assistance:

(a) We compare your countable income to the monthly net income standard specified in WAC 388-478-0060.

(b) You are not eligible for benefits when your assistance unit's income is equal to or greater than the monthly net income standard.

(c) Your benefit level is the maximum allotment in WAC 388-478-0060 minus thirty percent of your countable income.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0162, filed 11/19/99, effective 1/1/00.]

WAC 388-450-0165 Gross earned income limit for TANF/SFA. When applying the gross earned income limit as required under WAC 388-478-0035:

(1) "Family" means:

(a) All adults and children who would otherwise be included in the assistance unit under WAC 388-408-0015, but who do not meet TANF/SFA eligibility requirements;

(b) The unborn child of a woman in her third trimester of pregnancy; and

(c) The husband of a woman in her third trimester of pregnancy, when residing together.

(2) "Gross earned income" does not include excluded income, as provided in WAC 388-450-0015.

(3) The following amounts are disregarded when determining a family's gross earned income:

(a) Court or administratively ordered current or back 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 WAC 388-255-1050 through 388-255-1250.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0165, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0170 TANF/SFA earned income incentive and deduction. (1) This section applies to:

(a) TANF/SFA, GA-S, GA-H; and

(b) TANF/SFA-related medical programs except as specified under WAC 388-450-0210.

(2) When determining countable income, fifty percent of a client's monthly gross earned income is disregarded as an incentive to employment.

(3) The actual cost of care of each dependent child or incapacitated adult living in the same home and receiving TANF/SFA is deducted when determining countable income under the following conditions:

(a) An applicant is eligible for a dependent care deduction for expenses incurred prior to the open effective date in the month of grant opening on a prorated basis;

(b) A recipient is eligible for a dependent care deduction if:

(i) The assistance unit received AFDC on October 13, 1988;

(ii) The dependent care deduction was applied when determining the benefit level for that month;

(iii) The assistance unit has remained continuously eligible for AFDC or TANF/SFA since that time; and

(iv) The assistance unit has chosen to use the deduction rather than state-paid dependent care.

(4) The dependent care deduction specified in subsection (3) of this section is not allowed unless:

(a) The care provided by a parent or stepparent;

(b) The care provider verifies the cost incurred;

(c) The cost is incurred for the month of employment being reported; and

(d) The amount deducted for each dependent child or incapacitated adult, depending on the number of hours worked per month does not exceed the following:

Dependent Care Maximum Deductions

Hours Worked Per Month	Dependent Two Years of Age or Older	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 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0170, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0175 GA-U earned income incentive and deduction. This section applies to the GA-U cash assistance program.

(1) When a client's countable income is determined, eighty-five dollars plus one half of the remainder of a client's monthly gross earned income is disregarded as an incentive to employment.

(2) In addition to the work incentive provided in subsection (1) of this section, work expenses are disregarded in an amount equal to twenty percent of the gross earned income; or

(3) At the option of the client, actual verified work expenses, including:

(a) Mandatory deductions required by law or as a condition of employment, such as FICA, income tax, and mandatory retirement contributions;

(b) Union dues when union membership is required for employment;

(c) Clothing costs when the clothing is necessary for employment;

(d) Tools necessary for employment;

(e) Other expenses reasonably associated with employment, such as legally binding contracts with employment agencies; and

(f) Transportation expenses as follows:

(i) If public transportation (other than for-hire vehicles such as taxis) is available and practical, the actual monthly cost, based on a commuter's pass, ticket book, or tokens at reduced quantity rates, even if the client does not use public transportation; or

(ii) If public transportation is not available or practical, the actual amount if the client pays another person to drive; or

(iii) If public transportation is not available or practical and the client uses his or her own vehicle, the costs, based on the percentage of work-related miles driven, for service and repairs, replacement of worn parts, registration and license fees, the interest on car payments, and either eight cents per mile or the actual cost for gas, oil, fluids, and depreciation.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0175, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0185 General information about earned income disregard and income deductions for food assistance programs. The following amounts are deducted from a household's income to compute food assistance program benefits:

(1) One hundred thirty-four dollars per household per month (standard deduction);

(2) Twenty percent of the household's gross earned income (earned income disregard);

(3) The amount of the household's incurred or expected monthly dependent care expense:

(a) The care must be needed for an assistance unit member to seek, accept or continue employment; or

(b) The care must be needed for an assistance unit member to attend training or education in preparation for to employment;

(c) The expense must be payable to someone outside of the food assistance household; and

(d) The deduction cannot exceed:

(i) Two hundred dollars for each dependent under two years of age; or

(ii) One hundred seventy-five dollars for each dependent age two or older.

(4) Nonreimbursable monthly medical expenses over thirty-five dollars incurred or expected to be incurred by an elderly or disabled household member as specified under WAC 388-450-0200.

(5) Legally obligated child support paid for a person who is not a member of the household.

(6) Shelter costs as provided in WAC 388-450-0190.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0185, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0185, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0190 Shelter cost income deductions for food assistance. (1) Shelter costs include:

(a) Rent, lease payments and mortgage payments; and

(b) Utility costs.

(2) Shelter costs are deducted from gross income if the costs are in excess of fifty percent of the assistance unit's income after deducting the standard, earned income, medical, child support, and dependent care deductions:

(a) For an assistance unit containing an elderly or disabled member the entire amount of excess shelter costs is deducted;

(b) For all other assistance units the excess shelter cost deduction cannot exceed two hundred seventy-five dollars.

(3) Shelter costs may include:

(a) Costs for a home not occupied because of employment, training away from the home, illness, or abandonment caused by casualty loss or natural disaster if the:

(i) Assistance unit intends to return to the home;

(ii) Current occupants, if any, are not claiming shelter costs for food assistance purposes; and

(iii) The home is not being leased or rented during the assistance unit's absence.

(b) Charges for the repair of the home which was substantially damaged or destroyed due to a natural disaster.

(c) The standard utility allowance as provided in WAC 388-450-0195.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0190, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0190, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0195 Utility allowances for food assistance programs. (1) For food assistance programs, **"utilities"** include the following:

(a) Heating and cooking fuel;

(b) Cooling and electricity;

(c) Water and sewerage;

(d) Garbage and trash collection; and

(e) Basic telephone service.

(2) The department uses the amounts below if you have utility costs separate from your rent or mortgage payment.

We add your utility allowance to your rent or mortgage payment to determine your total shelter costs. We use total shelter costs to determine your food assistance benefits.

(3) If you have heating or cooling costs, you get a standard utility allowance (SUA) that depends on your assistance unit's size.

Assistance Unit (AU) Size	Utility Allowance
1	$230
2	$237
3	$244
4	$251
5	$258
6 or more	$265

(4) If your AU does not qualify For the SUA and you have utility costs other than telephone costs, you get a limited utility allowance (LUA) of one hundred eighty-five dollars.

(5) If your AU has only telephone costs and no other utility costs, you get a telephone utility allowance (TUA) of thirty-one dollars.

[Statutory Authority: RCW 74.04.510. 00-22-065, § 388-450-0195, filed 10/27/00, effective 11/1/00. Statutory Authority: RCW 74.040.510 [74.04.510]. 99-24-052, § 388-450-0195, filed 11/29/99, effective 12/1/99. Statutory Authority: RCW 74.04.510. 99-09-055, § 388-450-0195, filed 4/19/99, effective 5/20/99. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6). 99-01-069, § 388-450-0195, filed 12/14/98, effective 1/14/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0195, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0200 Medical expenses may be used as an income deduction for food assistance households containing an elderly or disabled household member. (1) Food assistance households can use medical expenses in excess of thirty-five dollars monthly as an income deduction for members that are:

(a) Age sixty or older; or

(b) Disabled as defined in WAC 388-400-0040.

(2) The department allows deductions for expenses to cover services, supplies, or medication prescribed by a state licensed practitioner or other state certified, qualified, health professional, such as:

(a) Medical, psychiatric, naturopathic physician, dental, or chiropractic care;

(b) Prescription drugs;

(c) Over the counter drugs;

(d) Eye glasses;

(e) Medical supplies other than special diets;

(f) Medical equipment.

(g) Hospital and outpatient treatment including:

(i) Nursing care; or

(ii) Nursing home care including payments made for a person who was an assistance unit member at the time of placement.

(h) Health insurance premiums paid by the client including:

(i) Medicare premiums or cost sharing; and

(ii) Insurance deductibles and co-payments.

(i) Spenddown expenses as defined in WAC 388-519-0010. Spenddown expenses are allowed as a deduction as they are estimated to occur or as the expense become due;

(j) Dentures, hearing aids, and prosthetics;

(k) Cost of obtaining and caring for a seeing eye or hearing animal, including food and veterinarian bills. We do not allow the expense of guide dog food as a deduction if you receive Ongoing Additional Requirements under WAC 388-255-1050 to pay for this need;

(l) Reasonable costs of transportation and lodging to obtain medical treatment or services;

(m) Attendant care necessary due to age, infirmity, or illness. If your household provides most of the attendant's meals, we allow an additional deduction equal to a one-person allotment.

(3) There are two types of deductions:

(a) One-time expenses are expenses that cannot be estimated to occur on a regular basis. You can choose to have us:

(i) Allow the one-time expense as a deduction when it is billed or due; or

(ii) Average the expense through your certification period.

(b) Recurring expenses are expenses that happen on a regular basis. We estimate your monthly expenses for the certification period.

(4) We do not allow a medical deduction if:

(a) The expense has already been paid;

(b) The expense is repaid by someone else;

(c) The expense is paid or will be paid by another agency;

(d) The expense is covered by medical insurance;

(e) You claim the expense later than the first billing, even if:

(i) You did not claim the expense the first time it was billed;

(ii) The expense is included in the current billing; and

(iii) You paid the bill.

(f) We previously allowed the expense, and you did not pay it. We do not allow the expense again even if it is part of a repayment agreement;

(g) You included the expense in a repayment agreement after failing to meet a previous agreement for the same expense;

(h) You claim the expense after you have been denied for presumptive SSI; and you are not considered disabled by any other criteria; or

(i) The provider considers the expense overdue.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0200, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0200, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0200, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0210 Countable income for medical programs. (1) For purposes of medical program eligibility, a client's countable income is income which remains when:

(a) The income cannot be specifically excluded; and

(b) All appropriate deductions and disregards allowed by a specific program, have been applied.

(2) A client's countable income cannot exceed the income standard for the specific medical programs described in WAC 388-478-0065 through 388-478-0085 unless:

(a) The program allows the spenddown of excess income; or

(b) The program makes an allowance for those limits to be exceeded.

(3) Unless modified by subsection (4) of this section, the TANF/SFA income methodology, as described in this chapter, is used to determine a client's countable income for the following programs:

(a) TANF/SFA-related categorically needy (CN) or medically needy (MN);

(b) TANF/SFA-related CN extended medical as described in chapter 388-523 WAC;

(c) Pregnant women's program, CN or MN;

(d) Children's medical program, CN or MN;

(e) Children's health program;

(f) SFA-related medical; and

(g) Medically Indigent (MI) program.

(4) Exceptions to the TANF/SFA cash assistance methodology apply as follows:

(a) The financial responsibility of relatives is more limited when a client is applying for medical as specified in chapter 388-408 WAC;

(b) Income is always prospectively budgeted for medical;

(c) Actual work related child care expenses, which are the client's responsibility, are income deductions (the limits on this deduction in WAC 388-450-0170 (3) and (4) do not apply);

(d) Court or administratively ordered current or back support paid to meet the needs of legal dependents, are income deductions;

(e) Income actually contributed to an alien client from the alien's sponsor;

(f) TANF/SFA gross earned income limits as described in WAC 388-450-0165 do not apply;

(g) The fifty percent work incentive is not used to calculate countable income for programs with income levels based upon the Federal Poverty Level (FPL). These programs are listed in subsection (3)(b), (c), (d) and (e) of this section. The only work related income deductions for these programs are:

(i) Ninety dollars; and

(ii) Actual work related child care expenses, as described in subsection (4)(c) of this section.

(h) A nonrecurring lump sum payment is considered as income in the month the client receives payment, and a resource if the client retains the payment after the month of receipt.

(5) SSI income methodology is used to determine a client's countable income for:

(a) SSI-related CN or MN; and

(b) Medicare cost sharing programs.

(6) Exceptions to the SSI income methodology apply as follows:

(a) Lump sum payments are excluded as income;

(b) The interest portion of a payment a client receives from a sales contract which is a nonexcluded resource is treated as unearned income; and

(c) The principle and interest portions of a payment a client receives from a sales contract, which meets the definition in WAC 388-470-0040(3), are treated as unearned income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580, 388-505-0590 and 388-519-1910.]

WAC 388-450-0215 How the department estimates income to determine your eligibility and benefits. The department uses prospective budgeting to determine eligibility and benefits.

(1) The department determines the amount of benefits an assistance unit can receive each month based on an estimate of your income and circumstances for that month. This is known as prospective budgeting.

(2) We base this estimate on what can be reasonably expected based on your current, past and future circumstances.

(3) We determine if our estimate is reasonable by looking at documents, statements, and other verification.

(4) There are two methods of estimating a client's income:

(a) Anticipating monthly income: We estimate the actual amount of income you expect to receive in the month; and

(b) Averaging income: We estimate your income based on adding the total income you expect to receive for a period of time and dividing by the number of months in the time period.

(5) We must use the anticipating monthly method in the following circumstances:

(a) If you are a destitute migrant or destitute seasonal farmworker as defined in WAC 388-406-0021;

(b) If you are receiving SSI, Social Security, or SSI-related medical benefits;

(c) If you have income allocated to someone receiving SSI-related medical benefits under WAC 388-450-0150; or

(d) If you have already received income in the month that you apply for benefits.

(6) When using the anticipating monthly method, we estimate the actual amount of income you expect to receive in the month. Your benefits will vary based on the income that is expected for that month.

(7) When using the averaging method, the expected changes in your income are taken into consideration so your benefits do not change as much:

(a) Clients that receive their income weekly or every other week will have their income converted to a monthly amount. If you are paid:

(i) Weekly, we multiply your expected pay by 4.3; or

(ii) Every other week, we multiply your expected pay by 2.15.

(b) Clients that receive their income other than weekly or every other week will have their monthly income estimated by:

(i) Adding the total amount of income expected to be received for the period of time; and

(ii) Dividing by the number of months in the period of time.

(8) We will not make you repay an overpayment or increase your benefits if your actual income is different than your estimated income unless:

(a) The information you provided was incomplete or false; or

(b) We made an error in calculating your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0215, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0215, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0215, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0225 How the department calculates the benefit amount for the first month of eligibility for cash assistance. (1) To determine the client's benefit amount for the first month of eligibility for cash assistance, the department compares the countable income to the payment standard as described in WAC 388-450-0162.

(2) Even if your countable income exceeds the payment standard, you can still receive additional requirements.

(3) When your countable income is less than the payment standard, we prorate your grant amount based on the date you are eligible.

(4) We do not prorate the approved additional requirements.

(5) We prorate your grant by:

(a) Dividing the grant amount by the number of days in the first month of eligibility; and

(b) Multiplying the figure in (5)(a) of this section by the number of days from the date of eligibility to the last day of the month.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0225, filed 11/19/99, effective 1/1/00; 99-16-024, § 388-450-0225, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0225, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0230 Treatment of income in the month of application for destitute food assistance households. (1) When a migrant or seasonal farm worker is determined destitute under WAC 388-406-0021, eligibility and benefit amount for the month of application is determined by:

(a) Counting the household's income that is received from the first of the month through the date of application; and

(b) Excluding income from a new source that the household expects to receive during the ten days after the date of application.

(2) A household member changing jobs but continuing to work for the same employer is considered to be receiving income from the same source.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0230, filed 11/19/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0230, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0245 When are my benefits suspended? (1) In the TANF/SFA, RCA, GA and food assistance programs, the word "suspend" means that the department stops your benefits for one month.

(2) We suspend your benefits for one month when your expected countable income as defined in WAC 388-450-0162:

(a) Exceeds the dollar limits for your household size; and

(b) Exceeds those limits for only that one month.

(3) We end your benefits when your expected countable income exceeds the limits for your household size for two or more consecutive months.

(4) If your expected income drops below the limits for your household size, you may be eligible if you reapply for benefits.

[Statutory Authority: RCW 74.04.510. 00-01-012, § 388-450-0245, filed 12/3/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0245, filed 7/31/98, effective 9/1/98.]

Chapter 388-452 WAC
INTERVIEW REQUIREMENTS

WAC

WAC 388-452-0005 Do I have to be interviewed in order to get benefits? (1) You will have only one interview when you apply for or have a review for cash or food assistance or both.

(2) You are not required to attend an interview when your application or review is just for medical benefits. If we deny your application for cash or food assistance because you did not appear for an interview, we will continue to process your request for medical benefits:

(a) For a pregnant woman;

(b) For a child under the age of nineteen;

(c) For a family with children under the age of nineteen; or

(d) When we have enough information to determine if you are eligible or can get the information by mail.

(3) You or another person who can give information about your assistance unit must attend the interview. You may bring another person to the interview. You may choose another person to go to the interview for you when:

(a) You cannot come to the local office for us to decide if you are eligible for cash assistance; or

(b) You have an authorized representative as described in WAC 388-460-0005 for food assistance.

(4) We usually have interviews at the local office. You can have a scheduled telephone interview or an interview in your home if attending an interview at the local office causes a hardship for you or your representative. Examples of hardships include:

(a) If your entire assistance unit is elderly or mentally or physically disabled;

(b) If you live in a remote area or have transportation problems;

(c) Severe weather;

(d) If someone in your assistance unit (AU) is ill, or you have to stay home to care for an AU member;

(e) Your work or training hours make it difficult to come into the office during regular business hours;

(f) Someone in your AU is affected by family violence such as physical or mental abuse, harassment, or stalking by the abuser; or

(g) Any other problem which would make it difficult for you to come into the office for an interview.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 00-22-087, § 388-452-0005, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 42 C.F.R. 435.907. 99-11-075, § 388-452-0005, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0420.]

WAC 388-452-0010 What does the family violence amendment mean for TANF/SFA 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) and state family assistance (SFA) recipients.

(1) For TANF/SFA, 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(2) 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 or 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/SFA recipients for a history of family violence;

(b) Notify TANF/SFA recipients about the family violence amendment both verbally and in writing;

(c) Maintain confidentiality as stated in RCW 74.04.060;

(d) Offer referral to social services or other resources for clients who meet the criteria in subsection (1) of this section;

(e) Waive WorkFirst requirements that unfairly penalize victims of family violence, would make it more difficult to escape family violence or place victims at further risk. Requirements to be waived may include:

(i) Time limits for TANF/SFA recipients, for as long as necessary (after fifty-two months of receiving TANF/SFA);

(ii) Cooperation with the division of child support.

(f) Develop specialized work activities for instances where participation in regular work activities would place the recipient at further risk of family violence.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-454 WAC
LIVING WITH A RELATIVE

WAC

WAC 388-454-0005 Living in the home of a relative or guardian requirement for TANF, SFA and GA-H. (1) To be eligible for TANF or SFA, a child must live in the home of a parent or other relative as defined in WAC 388-454-0010.

(2) To be eligible for GA-H, a child must be living in the home of a person who is:

(a) A court-appointed legal guardian or court-appointed custodian; and

(b) Not a relative as defined in the TANF program.

(3) A home is defined as a family setting that is being maintained or is in the process of being established. A family setting exists when the relative or guardian assumes and continues to be responsible for the day to day care and control of the child. A family setting exists when a family is living in temporary shelter or has no shelter.

(4) A child or caretaker temporarily absent from the home remains eligible for assistance under the conditions described in WAC 388-454-0015 and 388-454-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0010 Definition of a parent or other relative for TANF and SFA. To be eligible for TANF or SFA, a child must be living with a person who meets the following definition of a parent or relative.

(1) A child's parent is the child's natural or adoptive parent or a step-parent who is legally obligated to support the child.

(2) A man is considered to be a child's natural father if the relationship is:

(a) Established under a judgment or order determining the parent and child relationship entered under RCW 26.26.130; or

(b) Presumed under the Uniform Parentage Act (RCW 26.26.040).

(3) Nonparental relatives include:

(a) The following blood relatives (including those of half blood): siblings, first cousins (including first cousins once removed), nephews and nieces, and persons of preceding generations (including aunts, uncles and grandparents) as denoted by prefixes of great, great-great, or great-great-great;

(b) A natural parent whose parental rights have been terminated by a court order;

(c) A stepparent whose obligation to support the child has been terminated by the death of the child's natural or adoptive parent or the entry of a court order; and

(d) A step sibling even though the marriage of the step sibling's parent to the child's natural or adoptive parent is terminated by death, divorce or dissolution.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0015 Temporary absence from the home. The child or the caretaker is temporarily absent from the home as long as the caretaker continues to be responsible

for the care and control of the child. Temporary absences cannot exceed ninety days except as described below. A caretaker must report a child's absence in excess of ninety days as required under WAC 388-418-0005. Temporary absences include:

(1) Receiving care in a hospital or public or private institution. If the temporary care exceeds ninety days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(2) Receiving care in a substance abuse treatment facility. If the care exceeds ninety days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(3) Visits in which the child or parent will be away for ninety days or less, including visits of a child to a parent who does not reside in the child's home.

(4) Placement of a child in foster care when the child's caretaker is receiving care in a residential treatment facility or for other reasons as determined by the division of children and family services (DCFS). DCFS must determine that the child is expected to return to the home within ninety days of the foster care placement.

(5) Placement of a child in foster care or in the temporary care of a relative, when:

(a) A parent or other relative applies for TANF or SFA on behalf of the child;

(b) DCFS has determined the child will be placed in the care of the applying relative within thirty days following the authorization of assistance; and

(c) No concurrent TANF or SFA payments are made for the child while in the temporary care of a relative.

(6) The child or caretaker is attending school or training as described in WAC 388-454-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0020 Temporary absence to attend school or training. A child or caretaker is temporarily absent from the home to attend school or training when:

(1) The child's caretaker is attending a department approved vocational training program; or

(2) The child attends school or training away from home, as long as:

(a) The child returns to the family home during a year's period, at least for summer vacation; and

(b) The absence is necessary because:

(i) Isolation of the child's home makes it necessary for the child to be away to attend school;

(ii) The child is enrolled in an Indian boarding school administered through the Bureau of Indian Affairs; or

(iii) Specialized education or training is not available in the child's home community and is recommended by local school authorities.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0025 Notice to parent when child lives with nonparental relative. (1) When TANF/SFA has been approved for a child who is living with a nonparental caretaker relative, the department will make reasonable efforts to notify the parent with whom the child most recently lived that:

(a) Assistance has been authorized for the child;

(b) Family reconciliation services may be requested from the department; and

(c) The parent has the right to request the child's address and location.

(2) The parent will be notified within seven calendar days of assistance authorization.

(3) The parent will not be notified if there is a substantiated claim that the parent has abused or neglected the child.

(4) Release of the child's address and location will be subject to the requirements of chapter 388-428 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0025, filed 7/31/98, effective 9/1/98.]

Chapter 388-455 WAC
LUMP SUM INCOME

WAC

WAC 388-455-0005 How lump sum payments affect benefits. (1) For the purpose of determining benefits for cash assistance, temporary assistance for needy families (TANF)/state family assistance (SFA)-related medical assistance, and food assistance, a lump sum payment is money that the client receives but does not expect to receive on a continuing basis.

(2) For cash assistance and TANF/SFA-related medical assistance:

(a) The department counts payments awarded for wrongful death, personal injury, damage, or loss of property as resources as described in WAC 388-455-0010.

(b) We count all other lump sum payments as income as described in WAC 388-455-0015.

(3) For food assistance, all lump sum payments are counted as resources as described in WAC 388-470-0055.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0005, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0010 How the department treats lump sum payments as a resource for cash assistance and TANF/SFA-related medical assistance. This section applies to cash assistance and TANF/SFA-related medical assistance.

(1) In the month the payment is received, the department does not count any amount of a lump sum payment awarded for:

(a) Wrongful death;

(b) Personal injury;

(c) Damage; or

(d) Loss of property.

(2) In the month following the month of receipt, we count the entire amount as a resource except for the portion of the payment designated for:

(a) Repair or replacement of damaged or lost property; or

(b) Medical bills.

(3) We do not count the portion described in subsection (2) of this section for sixty days following the month the payment is received. At the end of the sixty-day period, we count any amount that remains as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0010, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0015 How the department treats lump sum payments as income for cash assistance and TANF/SFA-related medical assistance. For cash assistance and TANF/SFA-related medical assistance, lump sum payments not awarded for wrongful death, personal injury, damage, or loss of property are counted as income. They are budgeted against the client's benefits according to the effective dates in WAC 388-418-0020. The rules in this section describe what portion is countable and when the department counts it. For rules on how lump sum payments awarded for wrongful death, personal injury, damage, or loss of property affect benefits, see WAC 388-450-0010.

(1) To identify what portion of the lump sum the department will count as income, we take the following steps:

(a) First, we subtract the value of your existing resources from the resource limit as described in WAC 388-470-0005;

(b) Then, we subtract the difference in (1)(a) from the total amount of the lump sum; and

(c) The amount left over is the countable amount of the lump sum.

(2) For cash assistance, the amount of the lump sum that is countable may change if any or all of the lump sum becomes unavailable for reasons beyond your control. See WAC 388-450-0005. When the countable amount of the lump sum is:

(a) Less than your payment standard plus additional requirements, we consider it as income in the month it is received.

(b) More than one month's payment standard plus additional requirements but less than two months:

(i) We consider the portion equal to one month's payment standard plus additional requirements as income in the month it is received; and

(ii) We consider the remainder as income the following month.

(c) Equal to or greater than the total of the payment standard plus additional requirements for the month of receipt and the following month, we consider the payment as income for those months.

(3) If you are ineligible or disqualified from receiving cash benefits and you receive a one-time lump sum payment:

(a) We allocate the payment to meet your needs as specified in WAC 388-450-0105; and

(b) The remainder is treated as a lump sum payment available to the eligible assistance unit members according to the rules of this section.

(4) You can avoid having the lump sum budgeted against your benefits if you request termination of your cash assistance the month before you receive the lump sum.

(5) For TANF/SFA-related medical assistance:

(a) We consider lump sum payments as income in the month of receipt.

(b) We consider any money that remains on the first of the next month as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0015, filed 11/19/99, effective 1/1/00.]

Chapter 388-458 WAC
NOTICES TO CLIENTS

WAC

WAC 388-458-0001 How the department requests information or action needed when a client applies for assistance or reports a change. (1) When the department needs additional information in order to determine the client's eligibility and benefit amount, we send a written request. The client has at least ten days from the date we send the request to respond.

(2) We send these kinds of request when:

(a) You must provide additional information, verification or participate in some activity to qualify for benefits.

(b) Additional information is necessary to determine how a change affects your benefit amount.

(c) Verification is required before we increase your benefit amount.

(3) The request must state:

(a) What information or action is needed, and

(b) The date the information or action is due, and

(c) That we may reduce or deny benefits if the client fails to provide the information or take the action.

(4) If the client fails to provide requested information or take an action within the ten days, we may deny, reduce or discontinue the client's benefits.

(5) If the client later provides the requested information or takes the requested action during the advance notice period:

(a) Assistance continues unchanged if the action or information does not result in a reduction of benefits.

(b) The information or action is treated as a newly reported change under chapter 388-418 WAC if the action or information results in a reduction of benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0001, filed 11/10/99, effective 1/1/00.]

WAC 388-458-0005 Adequate notice of denial or withdrawal. (1) When a client's application for cash, medical or food assistance is denied or withdrawn, the client receives a written notice of denial or withdrawal which includes:

(a) The reason or reasons for the denial or withdrawal and the rules to support the department's decision;

(b) The date of the decision; and

(c) The right to a fair hearing.

(2) When the applicant does not provide requested information and there is not enough information available for the department to determine eligibility, the denial notice also includes:

(a) A description of the information that was requested and not provided, including the date the information was requested;

(b) A statement that eligibility for assistance cannot be established based on information available to the department; and

(c) That eligibility will be redetermined if, within thirty days from the date of the denial notice, the applicant:

(i) Provides all specified information previously requested but not provided; and

(ii) The applicant's circumstances have not changed.

(3) Notice of a decision to deny or withdraw an application must be provided as required under chapter 388-406 WAC.

(4) Notices to clients who qualify for necessary supplemental accommodation services will be provided as required under WAC 388-200-1300.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-458-0010 Adequate notice of adverse action to recipients. (1) Before we change the benefits a client receives, we send a written notice that explains:

(a) When the benefit amount will change;

(b) If the change is an increase or decrease;

(c) The reasons for the intended action;

(d) The specific rule, regulation or law supporting the action;

(e) The recipient's right to request a fair hearing, including the circumstances under which assistance may be continued if a hearing is requested.

(2) For cash, medical and food assistance, a notice must be sent ten days in advance of an action to reduce, suspend, restrict or discontinue assistance benefits.

(a) The advance notice period begins the day we send the notice.

(b) The advance notice period ends:

(i) On the tenth day after we send the notice; or

(ii) On the next regular mail delivery day if the tenth day falls on a Sunday or holiday.

(3) For certain situations the advance notice period can be less than ten days. A shorter advance notice period is allowed when:

(a) The recipient asks the department to reduce or discontinue benefits.

(b) The department has documented information that the assistance unit has moved to another state or will move to another state before the next benefits are issued.

(c) The department has documented information that all members of the assistance unit have died.

(d) A change in law or regulation requires the department to change benefits for all clients in a certain group.

(4) When a shorter advance notice period is allowed, the notice must be mailed or given to the recipient:

(a) For cash and medical assistance, by the date of the action.

(b) For food assistance, by the date the benefits are received or should have been received.

(5) A separate adverse action notice is not required:

(a) For cash and food assistance, when:

(i) The client was notified when benefits were approved that the amount of benefits for each month varied; or

(ii) The client was already notified when a supplemental payment or increased allotment to restore lost benefits would end.

(b) For cash assistance, when the recipient was already notified that an emergent need payment was for one month only.

(6) For clients who qualify for necessary supplemental accommodation services, we provide notices as required under WAC 388-200-1300.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0010, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2520.]

WAC 388-458-0015 Translation of written communications with limited English proficient clients. The following written communications concerning cash, medical and food assistance programs are translated into the primary language of clients with limited English proficiency:

(1) Notices requesting information or action which require a response from the client to determine:

(a) Initial eligibility; or

(b) Continuing eligibility for assistance.

(2) Notices of approval, denial, or withdrawal of applications for assistance;

(3) Notices of termination, suspension, reduction or restriction of assistance;

(4) Notices describing client rights and responsibilities;

(5) Notices requiring a client's signature or informed consent; and

(6) Notice of overpayments of cash, medical and food assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-460 WAC
PAYEES ON BENEFIT ISSUANCES

WAC

WAC 388-460-0001 Payee for cash, medical and food assistance benefits. (1) Cash assistance may be issued in the name of the following persons:

(a) A client who is the recipient of the benefits;

(b) An ineligible parent or other relative receiving benefits on behalf of an eligible child;

(c) A person, facility, organization, institution or agency acting as a protective payee or representative payee for a client;

(d) A guardian or agent acting on behalf of a client; or

(e) A vendor of goods or services supplied to an eligible client.

(2) When medical coverage accompanies cash assistance, the medical identification (MAID) card for the assistance unit members is issued in the name of the person listed as payee for the cash benefit.

(3) For other medical assistance units, the MAID card is issued to the person named as the head of the assistance unit.

(4) Food assistance benefits are issued to the person named as the head of the food assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0005 Authorized representative for food assistance benefits. An authorized representative is an adult who is not a member of the food assistance unit but has the knowledge and consent of the assistance unit to act on their behalf.

(1) A responsible member of the food assistance unit can name, in writing, an authorized representative. An authorized representative has authority to:

(a) Apply for food assistance on behalf of the food assistance unit;

(b) Redeem the food coupon authorization (FCA) card for the unit; and

(c) Purchase food for the food assistance unit using the unit's authorized benefit allotment.

(2) A responsible member of the food assistance unit can name, in writing, an emergency authorized representative to transact a particular FCA card when no responsible member is able to transact the card. Both the responsible member of the food assistance unit and the person named must sign the written statement.

(3) The food assistance unit members are liable for any over-issuance that may result from information supplied to the department by the authorized representative.

(4) An authorized representative may act on behalf of more than one food assistance unit when approved by the CSO administrator.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0010 Food assistance authorized representative—Treatment centers and group homes. (1) Residents in group homes may choose to have food assistance benefits authorized as follows:

(a) On their own behalf;

(b) Through an authorized representative of their choosing; or

(c) Through a facility acting as authorized representative.

(2) Residents in chemical dependency treatment centers are required to have a designated employee of the facility act as an authorized representative.

(3) The authorized representative for residents in a chemical dependency treatment center or a group home must:

(a) Be aware of the resident's circumstances;

(b) Notify the department of any changes in income, resources or circumstances within ten days of the change;

(c) Use the resident's food assistance benefit allotment for meals served to the resident; and

(d) Maintain enough benefits in the facility electronic benefits transfer (EBT) account to allow the department to transfer one-half of a client's monthly allotment to the client's own account. The client is entitled to one-half of the food assistance benefits when the client leaves the facility on or before the fifteenth of the month.

(4) When assigning an employee as the authorized representative for residents, a facility accepts responsibility for:

(a) Any misrepresentation or intentional program violation; and

(b) Liability for food assistance benefits held at the facility on behalf of the resident.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-460-0010, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0015 Persons who may not be an authorized representative for a food assistance unit. (1) A person acting as an authorized representative for a food assistance unit will be disqualified for one year when that person:

(a) Knowingly provides false information to the department;

(b) Misrepresents the food assistance unit's circumstances; or

(c) Misuses the food assistance benefits.

(2) The authorized representative and the head of the food assistance unit are notified thirty days prior to the disqualification taking effect.

(3) The following persons may act as an authorized representative for a food assistance unit only with written approval of the CSO administrator and only when no one else is available:

(a) An employee of the department;

(b) Any person disqualified from the food assistance program because of an intentional program violation;

(c) A retailer authorized to accept coupons;

(4) A public or private nonprofit organization providing meals for homeless persons may not be an authorized representative under any conditions.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-462 WAC
PREGNANCY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-462-0005 Pregnancy requirement for GA-S. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-045, filed 6/30/99, effective

8/1/99. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-462-0010 Temporary assistance for needy families (TANF) or state family assistance (SFA) eligibility for pregnant women. (1) If you are already receiving TANF or SFA benefits, your pregnancy will not change your eligibility or benefit level.

(2) If you are not currently receiving TANF or SFA benefits, you may be eligible for these benefits if your pregnancy and expected date of delivery has been verified by a licensed medical practitioner.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0010, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-462-0011 Post adoption cash benefit. (1) Under RCW 74.04.005 (6)(g) recipients of TANF or SFA who lose their eligibility solely because of the birth and relinquishment of the qualifying child may receive general assistance through the end of the month in which the period of six weeks following the birth of the child falls.

(2) The department will consider income and resources when determining eligibility and benefit amount for post adoption cash benefit in the same manner as TANF. Refer to chapters 388-450, 388-470, and 388-488 WAC.

(3) To receive the post adoption cash benefit, a client must have been receiving TANF or SFA in Washington state.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0011, filed 6/30/99, effective 8/1/99.]

WAC 388-462-0015 Medical programs for pregnant women. (1) A pregnant woman is eligible for medical services described in this chapter only when her pregnancy is confirmed by a licensed medical practitioner, licensed laboratory, community clinic, family planning clinic, or health department clinic.

(2) A pregnant woman is eligible for CN medical coverage if she meets the following requirements as described in WAC 388-503-0505:

(a) Citizenship or immigration status (chapter 388-424 WAC); and

(b) Social Security Account Number (chapter 388-474 WAC); and

(c) Washington state residence (chapter 388-468 WAC); and

(d) Countable income meets the standard described in WAC 388-478-0075.

(3) A pregnant woman is considered for medically needy (MN) program coverage if she meets the requirements in subsection (2)(a) through (c) of this section and:

(a) Her countable income is greater than the standard in subsection (2)(d) of this section; and

(b) Her countable resources do not exceed the standard in WAC 388-478-0070.

(4) A pregnant woman is eligible for CN scope of care under the state-funded pregnant woman program if she is not eligible for programs in subsection (2) of this section due to citizenship, immigrant or Social Security Number requirements.

(5) A pregnant woman is considered for MN scope of care under the state-funded pregnant woman program if:

(a) She is not eligible for the program under subsection (4) of this section because her income exceeds the standard; and

(b) Her resources do not exceed the standard in WAC 388-478-0070.

(6) A pregnant woman is considered for the medically indigent (MI) program if her resources exceed the standards in WAC 388-478-0070.

(7) Only the income of an unmarried father of an unborn actually contributed to a pregnant woman is considered as income to her.

(8) There are no resource limits for the programs described in subsections (2) and (4) of this section.

(9) The assignment of child support and medical support rights as described in chapter 388-422 WAC do not apply to pregnant women.

(10) Unless stated otherwise, this section contains the only eligibility requirements for pregnant women to qualify for medical coverage.

(11) A woman who was eligible for and received medical on the last day of pregnancy is eligible for extended medical benefits for postpartum care through the end of the month:

(a) Which includes the sixtieth day from the end of the pregnancy, for a pregnant woman receiving Medical in any program except Medically Indigent (MI); or

(b) The pregnancy ends, for a pregnant woman receiving MI benefits.

(12) A woman who was eligible for a medical program on the last day of pregnancy is eligible for family planning services for twelve months from the end of the pregnancy.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0820, 388-508-0830, 388-522-2230 and 388-508-0835.]

Chapter 388-464 WAC
QUALITY ASSURANCE

WAC

WAC 388-464-0001 Requirement to cooperate with quality assurance. (1) To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or federal food stamp benefits, the following clients are required to cooperate in the quality assurance review process:

(a) All adult recipients or payees in a TANF or SFA assistance unit; or

(b) All household members in a food assistance unit.

(2) Assistance units become ineligible for benefits upon a determination of noncooperation by quality assurance and remain ineligible until the client meets quality assurance requirements or:

(a) For TANF/SFA clients, one hundred twenty days from the end of the annual quality assurance review period; or

(b) For food assistance household members, ninety-five days from the end of the annual quality assurance review period.

(3) The quality assurance review period covers the federal fiscal year which runs from October 1st of one calendar year through September 30th of the following year.

(4) Individuals reapplying for TANF, SFA, or federal food stamps after the sanction period has ended must provide verification of all eligibility requirements. However, individuals meeting expedited service criteria only need to provide expedited service verification requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-464-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-466 WAC
REFUGEE PROGRAM

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-466-0015	Work and training requirements for refugee cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0015, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.
388-466-0020	Exemptions to work and training requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0020, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.
388-466-0025	Penalties for not complying with work and training requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0025, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.

WAC 388-466-0005 Immigration status requirement for refugee assistance. (1) To be eligible for refugee cash assistance (RCA) and refugee medical assistance (RMA), a person must prove, by providing documentation issued by the Immigration and Naturalization Service (INS), that he or she was:

(a) Admitted as a refugee under section 207 of the Immigration and Nationalities Act (INA);

(b) Paroled into the U.S. as a refugee or asylee under section 212 (d)(5) of the INA;

(c) Granted conditional entry under section 203 (a)(7) of the INA;

(d) Granted asylum under section 208 of the INA;

(e) Admitted as an Amerasian Immigrant from Vietnam through the orderly departure program, under section 584 of the Foreign Operations Appropriations Act, incorporated in the FY88 Continuing Resolution P.L. 100-212;

(f) A Cuban-Haitian entrant who was admitted as a public interest parolee under section 212 (d)(5) of the INA.

(2) A permanent resident alien meets the immigration status requirements for RCA and RMA if the individual was previously in one of the statuses described in subsections (1)(a) through (f) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-466-0010 Treatment of income and resources for refugee assistance. The income and resources of refugee cash assistance and refugee medical assistance (RCA/RMA) clients are treated according to the rules for the TANF program in chapters 388-450 and 388-470 WAC, except that RCA/RMA clients do not qualify for:

(1) The fifty percent work incentive allowed under WAC 388-450-0190. Instead, the first ninety dollars of an RCA/RMA client's monthly gross earned income is disregarded;

(2) The three thousand dollars savings account exclusion allowed to recipients under WAC 388-470-0050;

(3) The exclusion of a motor vehicle used to transport a physically disabled household member under WAC 388-470-0070; and

(4) The five thousand dollars vehicle equity value exclusion in WAC 388-470-0070. Instead, the equity value exclusion for a vehicle owned by an RCA/RMA client is fifteen hundred dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-466-0130 Refugee medical assistance (RMA). (1) Who can apply for refugee medical assistance?

Any individual can apply for refugee medical assistance (RMA) and have eligibility determined by the department of social and health services (DSHS).

(2) **Who is eligible for refugee medical assistance?**

(a) You are eligible for RMA if you meet all of the following conditions:

(i) Immigration status requirements of WAC 388-466-0005;

(ii) Income and resource requirements of WAC 388-466-0010;

(iii) Monthly income standards up to two hundred percent of the federal poverty level (FPL). Spenddown is available for applicants whose income exceeds two hundred percent of FPL (see WAC 388-519-0110); and

(iv) Provide the name of the voluntary agency (VOLAG) which helped bring you to this country, so that DSHS can promptly notify the agency (or sponsor) about your application for RMA.

(b) You are eligible for RMA if you meet one of the following conditions:

(i) Receive refugee cash assistance (RCA) and are not eligible for Medicaid or children's health insurance program (CHIP); or

(ii) Choose not to apply for or receive RCA and are not eligible for Medicaid or CHIP, but still meet RMA eligibility requirements.

(3) **Who is not eligible for refugee medical assistance?**

You are not eligible to receive RMA if you are:

(a) Already eligible for Medicaid or CHIP;

(b) A full-time student in an institution of higher education unless the educational activity is part of a department-approved individual responsibility plan (IRP);

(c) A nonrefugee spouse of a refugee.

(4) **If I have already received a cash assistance grant from voluntary agency (VOLAG), will it affect my eligibility for RMA?**

No. A cash assistance payment provided to you by your VOLAG is not counted in determining eligibility for RMA.

(5) **If I get a job after I have applied but before I have been approved for RMA, will my new income be counted in determining my eligibility?**

No. Your RMA eligibility is determined on the basis of your income and resources on the date of the application.

(6) **Will my sponsor's income and resources be considered in determining my eligibility for RMA?**

Your sponsor's income and resources are not considered in determining your eligibility for RMA unless your sponsor is a member of your assistance unit.

(7) **How do I find out if I am eligible for RMA?**

DSHS will send you a letter in both English and your primary language informing you about your eligibility. DSHS will also let you know in writing every time there are any changes or actions taken on your case.

(8) **Will RMA cover my medical expenses that occurred after I arrived in the U.S. but before I applied for RMA?**

You may be eligible for RMA coverage of your medical expenses for three months prior to the first day of the month of your application. Eligibility determination will be made according to Medicaid rules.

(9) **If I am an asylee, what date will be used as an entry date?**

If you are an asylee, your entry date will be the date that your asylum status is granted. For example, if you entered the United States on December 1, 1999 as a tourist, then applied for asylum on April 1, 2000, interviewed with the asylum office on July 1, 2000 and granted asylum on September 1, 2000, your date of entry is September 1, 2000. On September 1, 2000 you may be eligible for refugee medical assistance.

(10) **When does my RMA end?**

Your refugee medical assistance will end on the last day of the eighth month from the month of your entry into the United States. Start counting the eight months from the first day of the month of your entry into the U.S. For example, if you entered the U.S. on May 28, 2000, your last month is December 2000.

(11) **What happens if my earned income goes above the income standards?**

(a) If you are getting RMA, your medical eligibility will not be effected by the amount of your earnings;

(b) If you were getting Medicaid and it was terminated because of your earnings, we will transfer you to RMA for the rest of your RMA eligibility period. You will not need to apply.

(12) **Will my spouse also be eligible for RMA, if he/she arrives into the U.S. after me?**

When your spouse arrives in the U.S., we will determine his/her eligibility for Medicaid and other medical programs. Your spouse may be eligible for RMA; if so, he/she would have a maximum of eight months of RMA starting on the first day of the month of his/her arrival.

(13) **What do I do if I disagree with a decision or action that has been taken by DSHS on my case?**

If you disagree with the decision or action taken on your case by department you have the right to request a review of your case or request a fair hearing (see WAC 388-02-0090). Your request must be made within ninety days of the decision or action).

(14) **What happens to my medical coverage after my eligibility period is over?**

We will determine your eligibility for other medical programs. You may have to complete an application for another program.

[Statutory Authority: RCW 74.08.090, 74.08A.320. 00-21-065, § 388-466-0130, filed 10/16/00, effective 11/1/00.]

WAC 388-466-0150 Refugee employment and training services. (1) **What are refugee employment and training services?**

Refugee employment and training services provided to eligible refugees may include information and referral, employment oriented case management, job development, job placement, job retention, wage progression, skills training, on-the-job training, counseling and orientation, English as a second language, and vocational English training.

(2) **Am I required to participate in refugee employment and training services?**

If you are receiving refugee cash assistance (RCA) you are required to participate in refugee employment and training services, unless you are exempt.

(3) **How do I know if I am exempt from mandatory employment and training requirements?**

(a) You may be exempt from participation in employment and training requirements if:

(i) You are needed in the home to personally provide care for your child under three months of age (see WAC 388-310-0300);

(ii) You are sixty years of age or older.

(b) You can not be exempt from work and training requirements solely because of an inability to communicate in English.

(4) **If I am required to participate, what do I have to do?**

You are required to:

(a) Register with your employment service provider;

(b) Accept and participate in all employment opportunities, training or referrals, determined appropriate by the department.

(5) **What happens if I do not follow these requirements?**

If you refuse without good reason to cooperate with the requirements, you are subject to the following penalties:

(a) If you are applying for refugee cash and medical assistance, you will be ineligible for thirty days from the date of your refusal to accept work or training opportunity; or

(b) If you are already receiving refugee cash and medical assistance, your cash benefits will be subject to financial penalties.

(c) The department will notify your voluntary agency (VOLAG) if financial penalties take place.

(6) **What are the penalties to my grant?**

The penalties to your grant are:

(a) If the assistance unit includes other individuals as well as yourself, the cash grant is reduced by the sanctioned refugee's amount for three months after the first occurrence. For the second occurrence the financial penalty continues for the remainder of the sanctioned refugee's eight-month eligibility period.

(b) If you are the only person in the assistance unit your cash grant is terminated for three months after the first occurrence. For the second occurrence, your grant is terminated for the remainder of your eight-month eligibility period.

(7) **How can I avoid the penalties?**

You can avoid the penalties, if you accept employment or training before the last day of the month in which your cash grant is closed.

(8) **What is considered a good reason for not being able to follow the requirements?**

You have a good reason for not following the requirements if it was not possible for you to stay on the job or to follow through on a required activity due to an event outside of your control. See WAC 388-310-1600(3) for examples.

[Statutory Authority: RCW 74.08.090. 00-22-085, § 388-466-0150, filed 10/31/00, effective 12/1/00.]

Chapter 388-468 WAC
RESIDENCY

WAC

WAC 388-468-0005 Residency. (1) A resident is an individual who:

(a) Currently lives in Washington and intends to continue living here; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) With the exception of subsection (4) of this section, a client can temporarily be out of the state for more than one month. If so, they must supply the department with adequate information to demonstrate their intent to continue to reside in the state of Washington.

(4) Noncategorically eligible food assistance households remaining out of the state more than one calendar month lose their state residence status.

(5) Residency is not a requirement for the following:

(a) The medically indigent (MI) program; or

(b) Detoxification services.

(6) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency, prior to entering the facility.

(7) A person who enters Washington state temporarily just to get medical care does not meet the definition of a resident and is not eligible for those services.

(8) For purposes of medical programs a client's residence is the state:

(a) Making a state Supplemental Security Income (SSI) 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 appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(d) Where a client is residing if the person becomes incapable before reaching twenty-one years of age; or

(e) Making a placement in an out-of-state institution.

(9) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

(10) A former resident of the state can apply for the GA-U program while living in another state if:

(a) The person:

(i) Plans to return to this state; and

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in subsection (10)(i), (ii), and (iii) being met, the absence must be the result of one of the following:

(i) Is enforced and beyond the person's control; or

(ii) Is essential to the person's welfare and is due to physical or social needs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-468-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-470 WAC
RESOURCES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-470-0080 Compensatory award or related settlement lump sum payments. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0080, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-470-0005 Resource eligibility and limits. (1) A resource is personal property or real property or certain types of payments that are not considered income that is owned by and available to a client.

(2) A client may own and keep excluded resources or countable resources up to the resource limit.

(3) For SSI-related medical a resource is considered available when the client or spouse:

(a) Owns the resource; and

(b) Has the authority to convert the resource to cash; and

(c) Is not legally restricted from using the resource for the person's support and maintenance.

(4) For an SSI-related client a resource is available on the first day of the month following receipt of the resource.

(5) Available resources may be:

(a) Excluded which means it is not counted toward the resource limit;

(b) Partially excluded:

(i) The resource is not counted up to a specified dollar amount; but

(ii) Any amount over that amount is counted toward the resource limit; or

(c) Countable which means the entire value is counted toward the resource limit.

(6) For medical programs, if the household consists of more than one medical assistance unit (MAU), the resources for each MAU are considered according to the related program.

(7) An assistance unit's resources are determined by:

(a) Disregarding all excluded resources;

(b) Adding the value of:

(i) Resources that are in excess of the excluded dollar amounts; and

(ii) Resources that are countable; and

(c) Comparing the total countable resources to the applicable resource limit for the assistance unit;

(d) If the total resources exceed the applicable resource limit, the assistance unit's benefits are denied or terminated except for institutional medical programs as described in WAC 388-513-1395.

(8) The value of a resource is the equity value. The equity value is the amount a person could receive for the resource (fair market value) minus the legal amount still owing. Limits for countable resources are:

(a) For cash assistance and TANF-related medical, an eligible assistance unit's countable resources must be at or below one thousand dollars;

(b) For food assistance, an eligible assistance unit's countable resources must be at or below:

(i) Three thousand dollars for any household with an elderly member; or

(ii) Two thousand dollars for all other households.

(9) For food assistance, assistance units in which all members are receiving cash assistance or SSI do not have to meet the resource limits in subsection (8)(b) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0010 How to determine who owns a resource. Unless specifically stated, this section applies to all cash, TANF-related medical and food assistance programs.

(1) A client owns a resource when the client holds the title to real or personal property or has possession of the property but there is no title.

(2) A client may provide evidence to clarify ownership when doubt exists about:

(a) Ownership (full or partial);

(b) Legal control; or

(c) Value.

(3) Community property is an available resource unless the client can provide proof to the contrary.

(4) Real or personal property is considered to be community property when it is in the name of either the husband or wife or both and can be disposed of by either of them.

(5) For cash assistance, community property owned by the husband or wife or both will be used to determine eligibility for the assistance unit, regardless that one or both are clients.

(6) Resources are considered separate property rather than community property when the property was:

(a) Acquired and paid for by either spouse before marriage;

(b) Acquired and paid for entirely out of income from separate property; or

(c) Received by one of the spouses as a gift or inheritance.

(7) Property is no longer considered separate when both community and separate properties are used to purchase or improve real or personal property.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0012 How do the resources of an ineligible or disqualified person effect eligibility for cash assistance? (1) As used in this section; ineligible, disqualified and financially responsible persons are defined in WAC 388-450-0100.

(2) When determining the cash eligibility of an assistance unit, the department includes the countable resources of a financially responsible person who lives in the home even when the person is ineligible or disqualified from receiving cash assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-09-053, § 388-470-0012, filed 4/19/99, effective 5/20/99.]

WAC 388-470-0015 Availability of resources. (1) A resource is considered available when a cash, TANF/SFA-related medical or food assistance program client has:

(a) Actual title;

(b) Control over and can legally dispose of it; and

(c) The ability to transfer it to a buyer or convert it into cash.

(2) Only resources that are actually available will affect eligibility. However, for cash assistance only, the client must take reasonable action to make the resource available.

(3) A client may provide evidence that a resource is unavailable.

(4) For medical programs a resource is considered unavailable when the client or spouse:

(a) Does not own the resource;

(b) Does not have the authority to convert the resource to cash;

(c) Is legally restricted from using the resources for the person's support and maintenance;

(d) Cannot convert the resource to cash within twenty work days; and

(e) Makes a reasonable effort to convert noncash resources to cash.

(5) Resources of persons residing in a shelter for battered women and children are not considered available when:

(a) The resource is owned jointly with members of the former household; and

(b) Availability of the resource depends on an agreement of the joint owner.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-507-0730.]

WAC 388-470-0020 Excluded resources. Resources that do not count toward a cash, medical or food assistance client's resource limit are:

(1) Burial plot:

(a) For cash assistance and TANF/SFA-related medical programs other than SSI-related, one burial plot for each assistance unit member is excluded.

(b) For food assistance, one burial plot for each assistance unit member including ineligible members is excluded.

(c) For SSI-related medical the limits are described in WAC 388-470-0040 (14) and (15).

(2) Energy assistance payments;

(3) Household goods such as furniture;

(4) Noncash Resources are excluded for categorically needy (CN) and medically needy (MN) medical programs when the client:

(a) Cannot convert the noncash resource to cash within twenty work days; and

(b) Makes an ongoing attempt to convert the noncash resources to cash.

(5) Personal items such as clothing is excluded. For cash assistance programs, personal property of "great sentimental value" can be excluded due to personal attachment or hobby interest, without consideration to its value;

(6) The value of a sales contract is excluded for TANF-related medical. Sales contracts for SSI-related medical are described in WAC 388-470-0040;

(7) Resources excluded by federal law;

(8) Trust accounts when not available to the assistance unit except as specified in WAC 388-470-0015(2).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580.]

WAC 388-470-0025 Excluded resources for cash assistance. The following resources do not count toward the resource limits for cash assistance:

(1) Adoption support payments when the adopted child is excluded from the assistance unit.

(2) Bona fide loans which means the loan is a debt a client owes and has an obligation to repay.

(3) Earned income tax credit and advanced earned income tax credit in the month received and the following month.

(4) Excess real property on which a client is not living:

(a) When, for a period not to exceed nine months, a client:

(i) Makes a good-faith effort to sell the excess property; and

(ii) Signs an agreement to repay the amount of benefits received or the net proceeds of the sale, whichever is less.

(b) Upon cash assistance approval, the agreement to repay is sent to office of financial recovery to file a lien without a specified amount; or

(c) Is used in a self-employment enterprise and meets the criteria in subsection (10) of this section.

(5) Food coupon allotment from the food assistance programs.

(6) Food service payments provided for children under the National School Lunch Act of 1966, PL 92-433 and 93-150.

(7) Foster care payments provided under Title IV-E and/or state foster care maintenance payments.

(8) Housing and Urban Development (HUD) community development block grant funds.

(9) Income tax refunds are excluded in the month the refund is received.

(10) A bank account jointly owned with an SSI recipient when SSA counted the funds to determine the SSI recipient's eligibility.

(11) Real and personal property used in a self-employment enterprise if:

(a) The property is necessary to restore the client's independence or will aid in rehabilitating the client or the client's dependents; and

(b) The client has an approved self-employment plan; and

(c) For WorkFirst participants, the self-employment enterprise is a component of the participant's approved individual responsibility plan (IRP).

(12) Retroactive cash benefits or TANF benefits resulting from a court order modifying a department policy.

(13) Self-employment-accounts receivable that a client bills to the client's customer but has been unable to collect.

(14) SSI recipient's income and resources.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0025, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0030 Excluding a home as a resource. (1) For cash and TANF-related medical assistance programs a home with a reasonable amount of surrounding property is excluded when the home is owned and used as a resident by the client or the client's dependents.

(2) If a client and his or her dependents are absent from the home for more than ninety consecutive days, the total value of the home will count toward the resource limit, unless the absence is due to:

(a) Hospitalization; or

(b) Other health reasons; or

(c) A natural disaster.

(3) If the absence is due to hospitalization or other health reasons the client may be absent for more than ninety days and continue to have the home excluded as a resource when:

(a) At least one of three physicians provides a written statement that in their medical opinion, the client can return to the home during the client's lifetime; or

(b) The home continues to be occupied by a spouse or dependent children or children with disabilities.

(4) If the absence is due to a natural disaster the client may be absent for more than ninety days and continue to have the home excluded as a resource when:

(a) The home is not fit to live in; and

(b) The home will become fit to live in with reasonable effort and expense to the client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0035 Excluded resources for food assistance. The following resources do not count toward a client's resource limit.

(1) Earned income tax credit is excluded:

(a) In the month it is received and the following month if the person was not a food assistance recipient when the credit was received; or

(b) For twelve months when the person:

(i) Was a food assistance recipient when the credit was received; and

(ii) Remains a food assistance recipient continuously during this period.

(2) Essential property needed for employment or self-employment of a household member is excluded. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(3) Excluded funds that are deposited in a bank account with countable funds continue to be excluded up to six months from the date of deposit.

(4) Governmental disaster payments to repair a damaged home when the household can be sanctioned if the funds are not used for this purpose.

(5) A home a client is living in including the surrounding property that is not separated by property owned by others is excluded. Public right of ways do not affect this exclusion;

(6) A home that the household is not living in and surrounding property is excluded if the household:

(a) Is making a good faith effort to sell; or

(b) Is planning to return to the home and it is not occupied due to:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Unlivable conditions caused by a natural disaster or casualty.

(7) Any other property is excluded if the household:

(a) Has offered the property for sale through a professional real estate broker; and

(b) Has not declined an offer equivalent to fair market value.

(8) Indian lands that are held jointly by the tribe or can be sold only with the approval from the Bureau of Indian Affairs (BIA) are excluded;

(9) Installment contracts:

(a) Installment contracts or agreements for the sale of land or property are excluded when they are producing income consistent with their fair market value;

(b) Value of property sold under an installment contract or held for security is excluded if the purchase price is consistent with fair market value.

(10) Insurance policies and pension funds:

(a) Cash value of life insurance policies and pension funds, except IRAs and Keogh Plans, are excluded.

(b) Prepaid burial plans are excluded when the plan:

(i) Is death insurance as opposed to a bank account; and

(ii) Requires repayment for allowable withdrawals.

(11) Land. Where a client plans to build a permanent home or is excluded where their property is not separated by land owned by others. The land is countable if the assistance unit owns another home.

(12) A resource is excluded when it is owned by an assistance unit member who receives TANF/SFA or SSI.

(13) Resources that are owned by persons who are not members of the household are excluded.

(14) A resource is excluded when, if it is sold, would only result in a gain to the household of one-half of the applicable resource limit as defined under WAC 388-470-0005. The resource must be something other than stocks, bonds, negotiable financial instruments, or a vehicle.

(15) Prorated income for self-employed persons or ineligible students. These monies retain their exclusion for the period of time the income is prorated even when commingled with other funds.

(16) Real or personal property when:

(a) It produces yearly income that is equal to its fair market value even when used only on a seasonal basis;

(b) Secured by a lien for a business loan and the lien prevents the household from selling it; or

(c) It is directly related to the maintenance or use of a vehicle excluded in WAC 388-470-0075.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0040 Additional excluded resources for SSI-related medical assistance. In addition to other SSI-related resource exclusions in this chapter the resources in this section are excluded when a client's eligibility for SSI-related medical assistance is determined.

(1) A client's household goods and personal effects are excluded.

(2) One home, which may be any shelter in which the client has ownership interest, is excluded when:

(a) The client uses the home as the principal place of residence;

(b) The client's spouse resides in the home; or

(c) The client does not currently live in the home and the client:

(i) Intends to return to the home; and

(ii) Provides the department with an oral or written statement of their intent to return; or

(d) A relative resides in the home when:

(i) The relative is financially or medically dependent on the client; and

(ii) The client or dependent relative provides the department with a written statement of the dependency.

(3) Proceeds, including cash or a sales contract, from the sale of the home described in subsection (2) of this section are excluded when the client purchases another home within three months of receipt of the proceeds of the sale. Only the portion of the sales contract payment which represents interest is counted as unearned income. See WAC 388-450-0040.

(4) The value of a sales contract is excluded:

(a) When the current market value of the contract is zero or the contract is unsalable; or

(b) When combined with other resources, it exceeds the resource limit, and the sales contract was executed:

(i) On or before November 30, 1993; or

(ii) On or after December 1, 1993, and:

(A) Was received as compensation for the sale of the client's principle place of residence;

(B) Provides interest within the prevailing interest rate at the time of the sale;

(C) Requires the repayment of a principal amount equal to the fair market value of the property; and

(D) Payment on the amount owed does not exceed thirty years.

The income a client receives which represents the principle and interest portion of a sales contract meeting the definition of this subsection is counted as unearned income. See WAC 388-450-0040.

(5) A sales contract is a nonexcluded resource when:

(a) It does not meet the conditions in subsection (4); or

(b) The client transferred it to someone other than the client's spouse. See WAC 388-513-1365.

(6) When a client owns a sales contract as described in subsection (5), the portion of the payment which represents the:

(a) Principle is counted as an available resource; and

(b) Interest is counted as unearned income.

(7) The equity value of one vehicle up to five thousand dollar is excluded. The five thousand dollars limitation does not apply when the client or a member of the client's household, uses the vehicle which is:

(a) Necessary for employment; or

(b) Necessary for the treatment of specific or regular medical problem; or

(c) Modified for operation by, or transportation of, a person with disabilities; or

(d) Necessary due to climate, terrain, distance, or similar factors to provide the client transportation to perform essential daily activities.

(8) Property which is essential to self-support is excluded when:

(a) The client uses the property for an income producing activity:

(i) In a trade or business; or

(ii) As an employee for work.

(b) The client uses nonbusiness property with a value up to six thousand dollars in equity, to produce:

(i) Goods or services essential to daily activities, solely for the client's household;

(ii) An annual income return of six percent or more of the exempt equity; or

(iii) A six percent return within a twenty-month period when the client uses the property, or is expected to resume using the property within twelve months, for the activities described in this subsection.

(9) Resources necessary for a client, who is blind or disabled, to enable them to fulfill an approved self-sufficiency plan are excluded.

(10) Alaska Native Claims Settlement Act benefits are excluded, including:

(a) Shares of stock held in a regional or village corporation;

(b) Cash or dividends on stock received from a native corporation up to two thousand dollars per person per year;

(c) Stock issued by a native corporation as a dividend;

(d) A partnership interest;

(e) Land or an interest in land; and

(f) An interest in a settlement trust.

(11) The total cash surrender value (CSV) of a life insurance policy or policies when the total face value of all policies held by the client is fifteen hundred dollars or less are not counted. The CSV of a client's policies in excess of fifteen hundred dollars is applied to the client's resource limit as described in WAC 388-478-0070 and 388-478-0080.

(12) Restricted allotted land owned by an enrolled tribal member and spouse, if the land cannot be disposed of without the permission of the other person, the tribe, or an agency of the federal government is not counted.

(13) A settlement the client receives for the purpose of repairing or replacing a specific excluded resource is not counted for a period of:

(a) Nine months when the client uses the total amount of the cash to repair or replace the excluded resource;

(b) Nine additional months when:

(i) Circumstances beyond the control of the client prevent the repair or replacement of the excluded resource; and

(ii) The client uses the total amount of the cash to repair or replace the excluded resource.

(c) Twelve additional months, for a maximum of thirty months, when:

(i) The settlement is a result of a catastrophe which is declared a major disaster by the President of the United States;

(ii) The excluded resource is geographically within the disaster area as defined by the presidential order;

(iii) The client intends to repair or replace the excluded resource; and

(iv) Circumstances beyond the control of the client prevented the repair or replacement of the excluded resource in the time frames described under subsection (13)(a) and (b) of this section.

(d) Except, any settlement excluded and not used within the allowable time period as described under this subsection as an available resource.

(14) Burial spaces for the client and any member of the client's immediate family, as described in subsection (16) are not counted. Burial spaces include:

(a) Conventional grave sites;

(b) Crypts;

(c) Mausoleums; or

(d) Urns and other repositories customarily used for the remains of deceased persons.

(15) A burial space purchase agreement is also defined as a burial space. The value of the purchase agreement is excluded, as well as any interest accrued on the purchase agreement, which is left to accumulate as part of the value of the burial space purchase agreement.

(16) Immediate family, for purposes of subsection (14) of this section includes the client's:

(a) Spouse;

(b) Minor and adult children, including adopted and stepchildren;

(c) Siblings;

(d) Parents and adoptive parents;

(e) Spouses of any of the above.

None of the family members listed above need to be dependent upon or living with the client, to be considered immediate family members.

(17) The following types of burial funds are excluded as resources:

(a) Up to fifteen hundred dollars each for a client or a client's spouse when funds are specifically set aside solely for burial expenses;

(b) A revocable burial contract, burial trust, cash, account, or other financial instrument with a definite cash value; and

(c) Any interest earned and appreciation in the value of excluded burial funds when left to accumulate and become part of the burial fund.

(18) Funds which a client has specifically set aside solely for burial expenses, as described in subsection (17) of this section are funds which:

(a) Are kept separate from all other resources except nonexcluded funds the client intends to use solely for burial related items or services and identified as a burial fund; and

(b) May be designated as burial funds back to the first day of the month in which the person intended the funds to be set aside for burial.

(19) The limitation described under subsection (17)(a) of this section is reduced by:

(a) The face value of insurance policies owned by the client or spouse if the policies have been excluded as provided in subsection (11) of this section; and

(b) Amounts in an irrevocable burial trust.

(20) A client's burial funds lose excluded status when:

(a) They are mixed with other resources; or

(b) The burial funds, interest, or appreciated values are used for other purposes. These funds are then considered available income:

(i) On the first of the month of use; if

(ii) When added to other nonexcluded resources, the amount exceeds the resource limit as described in WAC 388-478-0080.

(21) All resources specifically excluded by federal statute are not counted.

(22) Retroactive SSI payments, including benefits a client receives under the interim assistance reimbursement agreement with the Social Security Administration, or Social Security Disability Insurance (OASDI) payments are excluded for six months following the month of receipt. This exclusion applies to:

(a) Payments received by the client, spouse, or any other person the client is financially responsible for;

(b) SSI payments made to the client for benefits due for a month before the month of payment;

(c) OASDI payments made to the client for benefits due for a month that is two or more months before the month of payment; and

(d) Payments held as cash, in a checking account, or in a saving account. This exclusion does not apply once the payments have been converted to any other type of resource.

(23) Cash payments an SSI recipient receives from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(24) Payments from the Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV) are excluded. Interest earned on these payments is counted as unearned income as specified under chapter 388-450 WAC.

(25) Payments to survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act are excluded. Interest earned on these payments is counted as unearned income as specified under chapter 388-450 WAC.

(26) Earned income tax credit refunds and payments are excluded as resources during the month of receipt and the following month.

(27) Payments from a state administered victim's compensation program are excluded for a period of nine calendar months after the month of receipt.

(28) Payments under section 500 through 506 of the Austrian General Social Insurance Act are not counted as a resource or income when a client's eligibility or post-eligibility (for institutionalized clients) is determined. A post-eligibility determination is the process of determining a client's share of the cost of institutional or waivered services care.

Any interest earned on the payments in this subsection is counted as unearned income as specified under WAC 388-450-0025.

(29) Payments from Susan Walker v. Bayer Corporation, et al., 96-c-5024 (N.D. Ill.) (May 8, 1997) settlement funds are excluded. Any interest earned on these payments is counted as unearned income as specified under WAC 388-450-0025.

(30) Cash received from the sale of an excluded resource is not counted when it is:

(a) Used to replace an excluded resource; or

(b) Invested in an excluded resource within the same month, unless specified differently under this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-511-1160.]

WAC 388-470-0045 Resources that are counted toward the resource limits for cash, food assistance and TANF/SFA-related medical programs. (1) The following resources are counted toward the resource limits for cash, food assistance and TANF/SFA-related medical programs:

(a) Liquid resources such as cash on hand, monies in checking or savings accounts; or

(b) Stocks or bonds minus any early withdrawal penalty.

(2) For TANF/SFA, GA, and TANF/SFA-related medical, the entire value of a motor home is counted as a resource when not used as a residence. For food assistance, a motor home is treated as a vehicle as described in WAC 388-470-0075.

(3) A resource owned with a person other than a spouse, contract vendor, mortgage or lien holder (jointly owned) is counted as follows:

(a) For cash assistance and TANF-related medical, the client's share of the equity value; or

(b) For food assistance, resources jointly owned by separate assistance units are considered available in their entirety to each assistance unit.

(4) A client may provide evidence that all or a portion of a jointly owned resource:

(a) Belongs to the other owner; and

(b) Is held for the benefit of the other owner.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0050 Resources that count. Unless otherwise specified the following resources count toward a cash or TANF-related medical assistance unit's resource limit:

(1) Burial insurance and term insurance: The cash surrender value in excess of fifteen hundred dollars.

(2) Child's irrevocable educational trust: Trust funds in excess of four thousand dollars per child.

(3) Life insurance: The cash surrender value of life insurance policies.

(4) Sales contracts, real estate mortgages, security interest: With the exception of sales contracts for the purposes of TANF-related medical, countable cash discount values.

(5) Savings accounts: For recipient's only, value in excess of three thousand dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0055 Resources that are counted for food assistance. The net value of the following resources are counted toward an assistance unit's resource limit:

(1) Excluded funds that are deposited in an account with countable funds (commingled) for more than six months from the date of deposit.

(2) Lump sums such as insurance settlements, refunded cleaning and damage deposits.

(3) Resources of ineligible household members, as described in WAC 388-408-0035(9).

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0055, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0060 Resources of an alien's sponsor. (1) Resources of a sponsor and the spouse who lives with the sponsor affects the eligibility of an alien for three years from the alien's date of entry into the U.S.

(2) A sponsor is any person or organization that signed an affidavit of support on behalf of the alien to allow the alien entry for permanent residence.

(3) The sponsor's countable resources are determined by:

(a) Totaling the countable resources of the sponsor and the sponsor's spouse (if they are living together); and

(b) Subtracting fifteen hundred dollars.

(4) Subsection (3) above does not apply when:

(a) The alien is receiving cash or food assistance as a member of the sponsor's assistance unit;

(b) An alien is sponsored by an organization; or

(c) An alien is not required to have a sponsor.

(5) The sponsor's countable resources are counted towards the alien's resource limit until:

(a) The three year time period expires; or

(b) The sponsor dies.

(6) For medical programs, the resources of the sponsor are excluded resources unless:

(a) The sponsor is a member of the alien's assistance unit; or

(b) The sponsor actually contributes resources to the alien's assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0060, filed 7/31/98, effective 9/1/98. Formerly WAC 388-510-1030.]

WAC 388-470-0065 Individual development accounts for TANF recipients. (1) A TANF recipient's individual development account (IDA) established under RCW 74.08A.220 is excluded when determining TANF eligibility.

(2) When a TANF recipient withdraws funds from an IDA, for a purpose other than specified in RCW 74.08A.220, the funds are a countable resource, as specified under WAC 388-470-0015(2).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0070 How vehicles are counted toward the resource limit for cash assistance and TANF/SFA-related medical. (1) A vehicle is any device for carrying persons and objects by land, water, or air.

(2) The entire value of a licensed vehicle needed to transport a physically disabled assistance unit member is excluded.

(3) The equity value of one vehicle up to five thousand dollars is excluded when the vehicle is used by the assistance unit or household as a means of transportation. Each separate medical assistance unit is allowed this exclusion.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610.]

WAC 388-470-0075 How vehicles are counted for food assistance. (1) The entire value of a licensed vehicle even during periods of temporary unemployment is excluded if the vehicle is:

(a) Used over fifty percent of the time for income-producing purposes. An excluded vehicle used by a self-employed farmer or fisher retains its exclusion for one year from the date the household member ends this self-employment.

(b) Used to produce income annually that is consistent with its fair market value (FMV).

(c) Necessary for long-distance travel that is essential to the employment of an assistance unit member whose resources are considered available to the assistance unit. Vehicles needed for daily commuting are not excluded under this provision.

(d) Necessary for hunting or fishing to support the household.

(e) Used as the assistance unit's home.

(f) Used to carry fuel for heating or water for home use when this is the primary source of fuel or water for the assistance unit.

(g) Needed to transport a physically disabled household member.

(2) The FMV in excess of four thousand six hundred fifty dollars is counted toward the assistance unit's resource limit for the following licensed vehicles if not excluded in subsection (1) above:

(a) One per assistance unit regardless of use;

(b) Used for transportation to and from work, training, or education; or

(c) Used for seeking employment.

(3) For all other licensed vehicles, the larger value of the following is counted toward the assistance unit's resource limit:

(a) FMV in excess of four thousand six hundred fifty dollars; or

(b) Equity value.

(4) Unlicensed vehicles driven by tribal members on the reservation are treated like a licensed vehicle.

(5) For unlicensed vehicles the equity value is counted towards the assistance unit's resource limit unless the vehicle is:

(a) Used to produce income annually that is consistent with its FMV even if used on a seasonal basis; or

(b) Work-related equipment necessary for employment or self-employment of an assistance unit member.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0075, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0075, filed 7/31/98, effective 9/1/98.]

Chapter 388-472 WAC
RIGHTS AND RESPONSIBILITIES

WAC

WAC 388-472-0005 Client rights and responsibilities. Unless specifically stated, the following rules apply to cash, food and medical assistance programs.

(1) A person who applies for or receives public assistance has the right to:

(a) Be treated politely and fairly without regard to race, color, creed, political affiliation, national origin, religion, age, gender, disability or birthplace;

(b) File an application on the same day, during regular business hours, that the person contacts the department. A client has the right to get a receipt when leaving an application or other materials with the department;

(c) Have an application promptly accepted and promptly acted upon;

(d) Ask that the application be processed without delay if the person is pregnant, in need of immediate medical care, experiencing an emergency such as having no money for food, or facing an eviction. If a pregnant client requests an interview, she has the right to have one within five working days;

(e) Get a written decision in most cases within thirty days.

(i) Medical and some disability cases may take forty-five to sixty days. Pregnancy medical will be authorized within fifteen working days.

(ii) Food stamps will be authorized within thirty days if the person is eligible. If the person is eligible and has little or no money, food stamps will be authorized within five days;

(f) Be fully informed, in writing, of all legal rights and responsibilities in connection with public assistance;

(g) Have information kept private. The department may share some facts with other agencies for efficient management of federal and state programs;

(h) For cash and medical assistance programs, ask the department not to collect child support if the absent parent may harm the person or person's child;

(i) For cash assistance programs, ask for extra money to help in an emergency, such as an eviction or a utility shutoff;

(j) Get a written notice, in most cases, at least ten days before the department makes changes to lower or stop benefits;

(k) Ask for a fair hearing if the person does not agree with the department about a decision. Without affecting the right to a fair hearing, the person can also ask a supervisor or administrator to review an employee decision or action;

(l) Have interpreter or translator services at no cost or undue delay;

(m) Refuse to speak to a fraud early detection (FRED) investigator from the division of fraud investigations. The person does not have to let an investigator into the home. The person may ask the investigator to come back at another time. Such a request will not affect the person's eligibility for benefits;

(n) For medical assistance programs only: A person applying for or receiving medical assistance, limited casualty

programs, medical care services, or children's health services has the same rights as cash assistance clients; and

(o) Receive help from the department to register to vote.

(2) A client is responsible for:

(a) Reporting any changes to the department within ten days for all cash and food assistance programs and twenty days for all medical assistance programs;

(b) Giving all the facts needed to determine eligibility;

(c) Giving the department proof of any facts for which proof is needed;

(d) For most cash or medical assistance programs related to children, cooperating with the department to get child support or medical care support unless it can be shown that harm to the person or child may occur;

(e) For cash or medical assistance programs, applying for and taking any benefits from other programs, if eligible;

(f) Completing reports and reviews when asked to do so;

(g) Seeking and taking a job or training if required; and

(h) For medical assistance programs only, showing the medical identification card or other adequate department generated notification of eligibility to the medical care provider.

(3) Clients will be screened and provided with necessary supplemental accommodation as specified under WAC 388-200-1300.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-472-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-472-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0430, 388-504-0440, 388-504-0450 and 388-505-0560.]

Chapter 388-473 WAC
ONGOING ADDITIONAL REQUIREMENTS

WAC

WAC 388-473-0010 General provisions for ongoing additional requirements. For the purposes of this chapter, "we" and "us" refers to the department of social and health services. "You" refers to the applicant or recipient. An "ongoing additional requirement" is a continuing need that you have for which you require additional financial benefits in order to continue living independently.

(1) We may authorize ongoing additional requirement benefits if you are:

(a) Eligible for temporary assistance for needy families (TANF), Tribal TANF, state family assistance (SFA), refugee or general assistance cash, or SSI payments; and

(b) Aged: You are age sixty-five or older;

(c) Blind: You have central visual acuity of 20/200 or less in the better eye with the use of a correcting lens or limited fields of vision so the widest diameter of the visual field subtends an angle of no greater than twenty degrees; or

(d) Disabled: You are unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment that:

(i) Can be expected to result in death; or

(ii) Has lasted or can be expected to last for a continuous period of not less than twelve months..

(2) You may apply for ongoing additional requirement benefits by asking for it from staff that maintain your cash or medical assistance.

(3) We authorize ongoing additional requirement benefits only when we determine the item is essential to you. In deciding if you are eligible for ongoing additional requirement benefits, we consider and verify:

(a) The circumstances that created the need; and

(b) Your health, safety and ability to continue to live independently.

(4) When we determine ongoing additional requirement benefits are needed, we:

(a) Increase your cash assistance benefit to provide the additional benefits by monthly payment;

(b) Periodically review whether you continue to need the additional benefits. We conduct this review at least:

(i) Twice a year for TANF and refugee cash assistance recipients;

(ii) Yearly for general assistance or SSI recipients when we decide the need is not likely to change; or

(iii) More frequently if we expect your circumstances to change.

(5) Monthly payment standards for ongoing additional requirements are described under WAC 388-478-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 01-01-070, § 388-473-0010, filed 12/12/00, effective 2/1/01; 00-15-053, § 388-473-0010, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0020 Restaurant meals as an ongoing additional requirement. We authorize benefits for restaurant meals when we decide you are:

(1) Physically or mentally unable to prepare meals;

(2) A roomer and meals are not provided or your housing arrangement does not provide for or allow cooking: or

(3) Homeless.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0020, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0030 Home-delivered meals as an ongoing additional requirement. We authorize benefits for home-delivered meals, such as meals on wheels, when we decide the following conditions are all true:

(1) You cannot prepare all of your meals, and home-delivered meals are available;

(2) You require help in preparing meals and getting home-delivered meals would ensure your nutrition or health;

(3) Help in preparing meals is not available without cost to you; and

(4) Board (or board and room) is not available to you or would cost you more than home-delivered meals.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0030, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0040 Food for service animals as an ongoing additional requirement. (1) A "service animal" is one that has been trained at a recognized school or training facility to provide you with assistance that is necessary for your health and safety, and that supports your ability to continue to live independently.

(2) We authorize benefits for food for a service animal if we decide the animal assists you in your daily living as described in WAC 388-473-0040(1).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0040, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0050 Telephone services as an ongoing additional requirement. We authorize benefits for telephone services when we decide:

(1) Without a telephone, your life would be endangered, you could not live independently, or you would require a more expensive type of personal care; and

(2) You have applied for the Washington telephone assistance program (WTAP) through your local telephone company.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0050, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0060 Laundry as an ongoing additional requirement. We authorize benefits for laundry when we decide:

(1) You are not physically able to do your own laundry; or

(2) You do not have laundry facilities that are accessible to you due to your physical limitations.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0060, filed 7/17/00, effective 9/1/00.]

Chapter 388-474 WAC
SUPPLEMENTAL SECURITY INCOME

WAC

WAC 388-474-0001 General information—Supplemental Security Income. (1) Persons with limited income and resources who are aged, blind, or disabled may qualify for federal cash benefits under the Supplemental Security Income program (SSI) administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

(2) The SSI program replaced state programs for aged, blind and disabled persons beginning in January, 1974. Persons who received state assistance in December, 1973, as aged, blind or disabled or were needed in the home to care for an eligible person, automatically became eligible for SSI in January, 1974.

(3) The spouse of an SSI recipient who does not qualify for SSI in their own right may be included in the state supplement payment but is not considered an SSI recipient for purposes of medical assistance eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0005 Medical coverage. (1) An SSI recipient qualifies for categorically needy (CN) medical coverage without a medical determination, except when the SSI recipient:

(a) Refuses to provide private medical insurance information or to assign the right to recover insurance funds to the department;

(b) Disposes of resources for less than fair market value and then applies for Medicaid coverage of nursing home care within thirty months of the date of transfer; or

(c) Has a Medicaid qualifying trust.

(2) A person designated as an essential person in January, 1974, qualifies for CN medical coverage as long as they continue to reside with the SSI recipient.

(3) The spouse of an SSI recipient designated as an ineligible spouse must have medical eligibility separately determined when:

(a) They do not automatically qualify for medical coverage in subsection (2) above; or

(b) They are not eligible for SSI in their own right.

(4) Persons who are not receiving SSI, but are SSI-related and qualify for CN medical assistance are described in WAC 388-505-0110.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0010 Eligibility for other programs. (1) The spouse of an SSI recipient is not eligible for the state supplement for an ineligible spouse when they are authorized for TANF.

(2) The spouse of an eligible SSI recipient qualifies for inclusion in the SSI grant and is not eligible for general assistance benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0015 Termination of SSI. (1) A person terminated from SSI cash assistance will have CN medical coverage continued when:

(a) Countable income exceeds the SSI income standard due solely to the annual cost-of-living adjustment (COLA); or

(b) A timely request for a hearing has been filed. Categorically needy medical coverage is continued until SSA makes a final decision on the hearing request and on any subsequent timely appeals.

(2) A person terminated from SSI is eligible for continued CN medical coverage for a period of up to one hundred twenty days from the date of termination of SSI cash benefits while eligibility for other cash or medical programs is being determined.

(3) A terminated SSI or SSI-related client will have their disability redetermined under certain conditions. These conditions are:

(a) The person presents new medical evidence;

(b) The person's medical condition changes significantly; or

(c) The termination from SSI was not based on a review of current medical evidence.

(4) Children terminated from SSI due to loss of status as a disabled person may be eligible for medical benefits under WAC 388-505-0210.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-524-2405.]

WAC 388-474-0020 Duplicate assistance and overpayments. (1) Persons receiving cash benefits under the general assistance program who receive advance, emergency or retroactive SSI cash assistance for the same time period are considered to have received duplicate assistance. The amount of general assistance paid during this time period must be repaid to the department.

(2) Applicants for general assistance-unemployable (GA-U) are required to sign DSHS 18-235(X), interim assistance reimbursement agreement (IARA) as a condition of eligibility for assistance.

(3) GA-U funds cannot be used to replace money deducted from a person's SSI check by SSA to repay an overpayment of SSI benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-476 WAC
SOCIAL SECURITY NUMBER

WAC

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) A newborn may receive benefits for up to six months from the date of birth if the household is unable to provide proof of application for an SSN at the time of birth.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

(a) The consolidated emergency assistance program;

(b) The refugee cash and medical assistance program;

(c) The medically indigent program;

(d) The alien emergency medical program;

(e) The state-funded pregnant woman program;

(f) The children's health program; and

(g) Detoxification services.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-476-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-476-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0530.]

Chapter 388-478 WAC
STANDARDS FOR PAYMENTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-478-0025 TANF payment standards for recent arrivals to Washington state. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0025, filed 7/31/98, effective 9/1/98.] Repealed by 99-16-024, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-478-0005 Cash assistance need and payment standards and grant maximum. (1) Need standards for cash assistance programs represent the amount of income required by individuals and families to maintain a minimum and adequate standard of living. Need standards are based on assistance unit size and include basic requirements for food, clothing, shelter, energy costs, transportation, household maintenance and operations, personal maintenance, and necessary incidentals.

(2) Payment standards for assistance units in medical institutions and other facilities are based on the need for

clothing, personal maintenance, and necessary incidentals (see WAC 388-478-0040 and 388-478-0045).

(3) Need and payment standards for persons and families who do not reside in medical institutions and other facilities are based on their obligation to pay for shelter.

(a) Eligibility and benefit levels for persons and families who meet the requirements in WAC 388-478-0010 are determined using standards for assistance units with an obligation to pay shelter costs.

(b) Eligibility and benefit levels for all other persons and families are determined using standards for assistance units who have shelter provided at no cost.

(c) For recent arrivals to Washington state who apply for temporary assistance for needy families (TANF), see WAC 388-478-0025.

(4) The monthly grant for an assistance unit containing eight or more persons cannot exceed the grant maximum of one thousand seventy-five dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0010 Households with obligations to pay shelter costs. The monthly need and payment standards for cash assistance are based on a determination of assistance unit size and whether the assistance unit has an obligation to pay shelter costs.

Eligibility and benefit level is determined using standards for assistance unit with obligations to pay shelter costs. An assistance unit has an obligation to pay shelter costs if one of the members:

(1) Owns, purchases or rents their place of residence, even if costs are limited to property taxes, fire insurance, sewer, water, or garbage;

(2) Resides in a lower income housing project which is funded under the United States Housing Act of 1937 or Section 236 of the National Housing Act, if the household either pays rent or makes a utility payment instead of a rental payment; or

(3) Is homeless. Homeless households include persons or families who:

(a) Lack a fixed, regular, and adequate nighttime residence; or

(b) Reside in a public or privately operated shelter designed to provide temporary living accommodations; or

(c) Live in temporary lodging provided through a public or privately funded emergency shelter program.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0010, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0015 Need standards for cash assistance. The need standards and one hundred eighty-five percent of the need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard	185% of Need
1	$ 797	$ 1,474
2	1,008	1,864
3	1,247	2,307
4	1,467	2,714
5	1,690	3,127
6	1,918	3,549
7	2,215	4,098
8	2,452	4,536
9	2,693	4,982
10 or more	2,926	5,413

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard	185% of Need
1	$ 480	$ 888
2	607	1,122
3	752	1,391
4	884	1,635
5	1,019	1,885
6	1,156	2,138
7	1,335	2,469
8	1,478	2,469
9	1,623	3,002
10 or more	1,764	3,263

[Statutory Authority: RCW 74.04.200. 99-04-056, § 388-478-0015, filed 1/29/99, effective 3/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0020 Payment standards for TANF, SFA, GA-S, GA-H and RCA. (1) The payment standards for temporary assistance for needy families (TANF), state family assistance (SFA), general assistance for pregnant women (GA-S), general assistance for children (GA-H) and refugee cash assistance (RCA) assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	$349	6	$ 841
2	440	7	971
3	546	8	1,075
4	642	9	1,180
5	740	10 or more	1,283

(2) The payment standards for TANF, SFA, GA-S, GA-H and RCA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	$212	6	$ 511
2	268	7	591
3	332	8	654
4	391	9	718
5	451	10 or more	780

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710.]

WAC 388-478-0026 Excluded resources for family medical programs. "Continuously eligible" means, for the

purposes of this chapter, eligible without a period of ineligibility of a calendar month or more since the date of receipt of any resources that would cause the client to exceed the resource limit of a family medical program.

(1) The department does not count any increase in a client's resources when the increase is received while a client:

(a) Is eligible for and receiving coverage under the family medical program; and

(b) Remains continuously eligible for a family medical program.

(2) The department will not count the resource increase for a client:

(a) Who meets the requirement of subsection (1)(a) of this section;

(b) Whose family medical program is terminated; and

(c) Who is subsequently determined eligible for all months since the termination, which may include a retroactive period of up to three months.

(3) The department counts the resource when the client is ineligible for a family medical program for a full calendar month or more except as described in subsection (2) of this section.

(4) For the purposes of this section, family medical programs include the medical extension benefits as described in WAC 388-523-0100.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530 and 2000 c 218. 00-21-063, § 388-478-0026, filed 10/16/00, effective 12/1/00.]

WAC 388-478-0030 Payment standards for GA-U and ADATSA. (1) The payment standards for general assistance - unemployable (GA-U) and alcohol and drug addiction treatment and support act (ADATSA) program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	$ 339
2	428

(2) The payment standards for GA-U and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$ 206
2	261

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0035 Maximum earned income limits for TANF and SFA. To be eligible for temporary assistance for needy families (TANF) or state family assistance (SFA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Earned Income Level
1	$ 698	6	$1,682
2	880	7	1,942
3	1,092	8	2,150
4	1,284	9	2,360
5	1,480	10 or more	2,566

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0040 Payment standard for persons in medical institutions. (1) "Medical institutions" include skilled nursing homes, public nursing homes, general hospitals, tuberculosis hospitals, intermediate care facilities, and psychiatric hospitals approved by the joint commission on accreditation of hospitals (JCAH).

(2) The monthly payment standard for eligible persons in medical institutions is forty-one dollars and sixty-two cents. The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0045 Payment standard for persons in certain group living facilities. (1) A monthly grant payment of thirty-eight dollars and eighty-four cents will be made to eligible persons in the following facilities:

(a) Congregate care facilities (CCF);

(b) Adult residential rehabilitation centers/adult residential treatment facilities (AARC/ARTF); and

(c) Division of developmental disabilities (DDD) group home facilities.

(2) The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0050 Payment standards for ongoing additional requirements. An **"ongoing additional requirement"** is a continuing need that you have for which you require additional financial benefits in order to continue living independently. The **"payment standard"** for ongoing additional requirement benefits is the amount of money needed to pay for these items or services. We use the following payment standards for ongoing additional requirements approved under WAC 388-473-0020 through 388-473-0060:

(1) Restaurant meals: $187.09 per month (or $6.04 per day with the payment rounded down to the nearest dollar amount);

(2) Laundry: $11.13 per month;

(3) Service animal food: $33.66 per month;

(4) Home delivered meals: The amount charged by the agency providing the meals;

(5) Telephone: The local telephone flat rate for the area; or the Washington telephone assistance program (WTAP) rate, whichever is less.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-052, § 388-478-0050, filed 7/17/00, effective 9/1/00; 98-16-044, § 388-478-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

WAC 388-478-0055 SSI standards. (1) Supplemental Security Income (SSI) is a cash assistance program for needy individuals and couples who meet federal disability guidelines as aged, blind or disabled. Since the SSI program began

in January 1974, the state of Washington has supplemented the federal benefit level with state funds, known as the SSI state supplement. Persons found eligible for SSI receive cash assistance based on the combined federal and state supplement benefit levels, minus countable income.

(2) Effective[,] November 1 through December 31, 2000, the federal, state and combined benefit levels for an eligible individual and couple are:

(a) Living alone area 1: King, Pierce, Snohomish, Thurston, and Kitsap Counties.

LIVING ALONE - Own household or alternate care, except nursing homes or medical institutions	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
Individual	$ 512.00	$ 22.90	$ 534.90
Individual with: One essential person	$ 769.00	$ 21.00	$ 790.00
Individual with: Multiple essential persons	$512 for the eligible individual plus $257 for each essential person (no state supplement)		
Individual with an ineligible spouse	$ 512.00	$ 167.20	$ 679.20
Couple	$ 769.00	$ 21.00	$ 790.00
Couple with one or more essential persons	$ 769 for eligible couple plus $257 for each essential person (no state supplement)		

(b) Living alone area 2: All other counties.

LIVING ALONE - Own household or alternate care, except nursing homes or medical institutions	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
Individual	$ 512.00	$ 2.45	$ 514.45
Individual with: One essential person	$ 769.00	$ 0.00	$ 769.00
Individual with: Multiple essential persons	$512 for the eligible individual plus $257 for each essential person (no state supplement)		
Individual with an ineligible spouse	$ 512.00	$ 137.25	$ 649.25
Couple	$ 769.00	$ 0.00	$ 769.00
Couple with one or more essential persons	$ 769 for eligible couple plus $257 for each essential person (no state supplement)		

(c) Shared living for both Area 1 and 2.

SHARED LIVING	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
Individual	$ 341.34	$ 4.81	$ 346.15
Individual with: One essential person	$ 512.00	$ 5.30	$ 517.30
Individual with: Multiple essential persons	$341.34 for the eligible individual plus $170.67 for each essential person (no state supplement)		
Individual with an ineligible spouse	$ 341.34	$ 102.76	$ 444.10
Couple	$ 512.67	$ 5.30	$ 517.97
Couple with one or more essential persons	$512.67 for eligible couple plus $170.67 for each essential person (no state supplement)		

(d) Residing in a medical institution: Area 1 and 2

MEDICAL INSTITUTION	Federal Benefit Level	State Supplement Benefit Level	Combined Benefit Level
Individual	$ 30.00	$ 11.62	$ 41.62

(e) Mandatory income level (MIL) for grandfathered claimant. "Grandfathered" refers to a person who qualified for assistance from the state as aged, blind, or disabled, was converted from the state to federal disability assistance under SSI in January 1974, and has remained continuously eligible for SSI since that date.

The combined federal/state SSI benefit level for MIL clients is the higher of the following:

(i) The state assistance standard they received in December 1973, except for those converted in a "D" living arrangement (residing in a medical institution at the time of conversion), plus the federal cost-of-living adjustments (COLA) since then; or

(ii) The current standard.

[Statutory Authority: RCW 74.08.090. 00-20-054, § 388-478-0055, filed 9/29/00, effective 11/1/00. Statutory Authority: RCW 74.08.090, 74.04.057. 00-11-130, § 388-478-0055, filed 5/22/00, effective 7/1/00;99-18-063, § 388-478-0055, filed 8/30/99, effective 10/1/99. Statutory Authority: RCW 74.08.090 and 74.04.630. 99-04-103, § 388-478-0055, filed 2/3/99, effective 3/6/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and

74.08.090. 98-16-044, § 388-478-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1115.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-478-0056 SSI state supplement standards. (1) Supplemental Security Income (SSI) is a cash assistance program for needy individuals and couples who meet federal disability guidelines as aged, blind or disabled. Since the SSI program began in January 1974, the state of Washington has supplemented the federal benefit level with state funds, known as the SSI state supplement. Persons found eligible for SSI receive cash assistance based on the combined federal and state supplement benefit levels, minus countable income.

(2) Effective January 1, 2001, the following state supplement amounts for eligible individuals and couples replace the state supplement amounts in WAC 388-478-0055:

(a) Living alone area 1: King, Pierce, Snohomish, Thurston, and Kitsap Counties.

Living Alone - In their own household or alternate care, except nursing homes or medical institutions	**State Supplement Benefit Level**
Individual	$25.90
Individual with one essential person	$19.90
Individual with multiple essential persons	$0.00
Individual with an ineligible spouse	$166.10
Couple	$19.90
Couple with one or more essential persons	$0.00

(b) Living alone area 2: All other counties.

Living alone - In their own household or alternate care, except nursing homes or medical institutions	**State Supplement Benefit Level**
Individual	$5.45
Individual with one essential person	$0.00
Individual with multiple essential persons	$0.00
Individual with an ineligible spouse	$136.15
Couple	$0.00
Couple with one or more essential persons	$0.00

(c) Shared living for both Area 1 and 2.

Shared Living	**State Supplement Benefit Level**
Individual	$3.71
Individual with one essential person	$4.20
Individual with multiple essential persons	$0.00
Individual with an ineligible spouse	$101.66
Couple	$4.20
Couple with one or more essential persons	$0.00

(d) Residing in a medical institution: Area 1 and 2.

Medical Institution	**State Supplement Benefit Level**
Individual	$11.62

(e) For a grandfathered claimant, see WAC 388-478-0055 (2)(e).

[Statutory Authority: RCW 74.04.620, 74.04.630. 00-24-056, § 388-478-0056, filed 11/30/00, effective 1/1/01.]

WAC 388-478-0060 What are my income limits for food assistance? So long as your assistance unit (AU) meets other eligibility requirements for food assistance benefits, your AU must have income at or below the limits in column (B) and (C) to get food assistance, unless you meet one of the exceptions listed below:

EFFECTIVE 10-1-2000

Column A Household Size	Column B Maximum Gross Monthly Income	Column C Maximum Net Monthly Income	Column D Maximum Allotment	Column E 165% of Poverty Level
1	$ 905	$ 696	$ 130	$ 1,149
2	1,219	938	238	1,547
3	1,533	1,180	341	1,946
4	1,848	1,421	434	2,345
5	2,162	1,663	515	2,744
6	2,476	1,905	618	3,142
7	2,790	2,146	683	3,541
8	3,104	2,388	781	3,940
9	3,419	2,630	879	4,339
10	3,734	2,872	977	4,738
Each Additional Member	+315	+242	+98	+399

Exceptions:

(1) If your AU is categorically eligible as defined in WAC 388-414-0001, your income will not have to be below the gross or net income standards in columns (B) and (C) to decide if you are eligible. However, we will budget the AU's income to decide the amount of food assistance your AU will receive.

(2) If your AU includes a member who is sixty years of age or older or has a disability, your income must be at or below the limit in column (C) only.

(3) If you are sixty years of age or older and are unable to purchase and prepare your own meals because of a permanent disability, we will use column (E) to determine if you can be a separate food assistance unit.

(4) If your AU has zero income you will receive the maximum allotment amount, based on your household size in column (D).

[Statutory Authority: RCW 74.04.510, 74.08.090. 00-23-013, § 388-478-0060, filed 11/3/00, effective 12/4/00. Statutory Authority: RCW 74.04.510. 99-24-053, § 388-478-0060, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0060, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.500, 74.04.510, 74.08.090. 99-05-074, § 388-478-0060, filed 2/17/99, effective 3/20/99. Statutory Authority: RCW 74.04.050, 74.04.055,

74.04.057 and 74.08.090. 98-16-044, § 388-478-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0065 TANF/SFA-related categorically needy income level (CNIL) and resource standards. (1) The categorically needy income level (CNIL) standard for TANF-related medical is the same as the grant payment standards for the TANF cash program as stated in WAC 388-478-0020.

(2) The countable resource standards for TANF/SFA-related categorically needy (CN) medical are the same as those of the TANF/SFA cash program as stated in WAC 388-470-0005.

(3) For all medical programs an unborn child is counted as a household member when determining household size.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0065, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710 and 388-508-0820.]

WAC 388-478-0070 Monthly income and countable resource standards for medically needy (MN) and medically indigent (MI) programs. (1) Beginning January 1, 2000, the medically needy income level (MNIL) and MI monthly income standards are as follows:

(a) One person	$539
(b) Two persons	$592
(c) Three persons	$667
(d) Four persons	$742
(e) Five persons	$858
(f) Six persons	$975
(g) Seven persons	$1,125
(h) Eight persons	$1,242
(i) Nine persons	$1,358
(j) Ten persons and more	$1,483

(2) The MNIL standard for a person who meets institutional status requirements is in WAC 388-513-1305(3).

(3) Countable resource standards for the MN and MI programs are:

(a) One person	$2,000
(b) Two persons	$3,000
(c) For each additional family member add	$50

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. 00-10-095, § 388-478-0070, filed 5/2/00, effective 5/2/00; 99-11-054, § 388-478-0070, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710, 388-507-0720, 388-511-1115, 388-518-1820, 388-518-1830, 388-518-1840 and 388-518-1850.]

WAC 388-478-0075 Medical programs—Monthly income standards based on the federal poverty level (FPL). (1) The department bases the income standard upon the Federal Poverty Level (FPL) for the following medical programs:

(a) Children's health program up to one hundred percent of FPL;

(b) Pregnant women's program up to one hundred eighty-five percent of FPL;

Federal Poverty Level (FPL). Beginning April 1, 2000, the

(c) Children's categorically needy program up to two hundred percent of FPL; and

(d) The children's health insurance program (CHIP) is over two hundred percent of FPL but under two hundred fifty percent of FPL.

(2) Beginning April 1, 2000, the monthly FPL standards are:

FAMILY SIZE	100% FPL	185% FPL	200% FPL	250% FPL
1	$ 696	$ 1288	$ 1392	$ 1740
2	$ 938	$ 1735	$ 1875	$ 2344
3	$ 1180	$ 2182	$ 2359	$ 2948
4	$ 1421	$ 2629	$ 2842	$ 3553
5	$ 1663	$ 3076	$ 3325	$ 4157
6	$ 1905	$ 3523	$ 3809	$ 4761
7	$ 2146	$ 3970	$ 4292	$ 5365
8	$ 2388	$ 4417	$ 4775	$ 5969
9	$ 2630	$ 4864	$ 5259	$ 6573
10	$ 2871	$ 5312	$ 5742	$ 7178
Add to the ten person standard for each person over ten:				
	$ 242	$ 448	$ 484	$ 605

(3) There are no resource limits for the programs under this section.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530 and the poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under authority of Section 673(2) of the Omnibus Budget Reconciliation Act (42 U.S.C. 9902(2)). 00-17-085, § 388-478-0075, filed 8/14/00, effective 9/14/00; 99-19-005, § 388-478-0075, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0075, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0805, 388-508-0810, 388-509-0910, 388-509-0920, 388-509-0940 and 388-509-0960.]

WAC 388-478-0080 SSI-related categorically needy income level (CNIL) and countable resource standards. (1) The SSI-related CNIL standard is the same as the SSI monthly payment standard based upon the area of the state where the person lives. Area 1 is defined as the following counties: King, Pierce, Snohomish, Thurston, and Kitsap. Area 2 is all other counties. Beginning January 1, 2000, the CNIL monthly income standards are as follows:

	Area 1	Area 2
(a) Single person	$539.00	$518.55
(b) A legally married couple who are both eligible	$790.00	$769.00

(2) The countable resource standards for the SSI-related CN medical program are:

(a) One person	$2,000
(b) A legally married couple	$3,000

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. 00-10-095, § 388-478-0080, filed 5/2/00, effective 5/2/00; 99-11-054, § 388-478-0080, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0080, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

WAC 388-478-0085 Medicare cost sharing programs—Monthly income and countable resources standards. (1) The qualified Medicare beneficiary (QMB) program income standard is up to one hundred percent of the QMB program's income standards are:

(a) One person	$ 696
(b) Two persons	$ 938

(2) The special low-income Medicare beneficiary (SLMB) program income standard is over one hundred percent of FPL, but under one hundred twenty percent of FPL. Beginning April 1, 2000, the SLMB program's income standards are:

	Minimum	Maximum
(a) One person	$ 696.01	$ 835
(b) Two persons	$ 938.01	$ 1125

(3) The expanded special low-income Medicare beneficiary (ESLMB) program income standard is over one hundred twenty percent of FPL, but under one hundred thirty-five percent of FPL. Beginning April 1, 2000, the ESLMB program's income standards are:

	Minimum	Maximum
(a) One person	$ 835.01	$ 940
(b) Two persons	$ 1125.01	$ 1266

(4) The qualified disabled working individual (QDWI) program income standard is up to two hundred percent of FPL. Beginning April 1, 2000, the QDWI program's income standards are:

(a) One person	$ 1392
(b) Two persons	$ 1875

(5) The qualified individual (QI) program income standard is over one hundred thirty-five percent of FPL, but under one hundred seventy-five percent of FPL. Beginning April 1, 2000, the QI program's income standards are:

	Minimum	Maximum
(a) One person	$ 940.01	$ 1218
(b) Two persons	$ 1266.01	$ 1641

(6) The resource standard for the Medicare cost sharing programs in this section is:

(a) One person	$ 4000
(b) Two persons	$ 6000

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530 and the poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under authority of Section 673(2) of the Omnibus Budget Reconciliation Act (42 U.S.C. 9902(2)). 00-17-085, § 388-478-0085, filed 8/14/00, effective 9/14/00; 99-19-005, § 388-478-0085, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0085, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1715, 388-517-1730, 388-517-1750 and 388-517-1770.]

Chapter 388-480 WAC
STRIKERS

WAC

WAC 388-480-0001 How being on strike effects food assistance benefits. (1) A strike is a work stoppage, slowdown or other interruption of work caused by employees. You are not considered to be on strike if you are:

(a) Locked out by your employer;

(b) Unable to work because work is not available as a result of striking employees;

(c) Not a member of the bargaining unit on strike and you fear someone may physically hurt you if you cross a picket line; or

(d) Exempt from work registration the day before the strike for any reason other than being employed over thirty hours per week.

(2) If you apply for food assistance, you will not be eligible if you are on strike unless:

(a) Your household met all income and resource eligibility standards the day before the strike; and

(b) You are otherwise eligible at the time you apply.

(3) You will not receive an increase in your food assistance benefits solely due to receiving less income as a direct result of being on strike.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-480-0001, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-480-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-482 WAC
STUDENT STATUS

WAC

WAC 388-482-0005 Student status for food assistance. (1) A food assistance client is considered a student when the client is:

(a) Aged eighteen through forty-nine years;

(b) Physically and mentally able to work; and

(c) Enrolled in an institution of higher education at least half-time as defined by the institution.

(2) An institution of higher education is:

(a) Any educational institution requiring a high school diploma or general education development certificate (GED);

(b) Business, trade or vocational schools requiring a high school diploma or GED; or

(c) A two-year or four-year college or university offering a degree but not requiring a high school diploma or GED.

(3) To be eligible for food assistance, a student as defined in subsection (1) of this section must meet at least one of the following requirements:

(a) Be employed for a minimum of twenty hours per week.

(b) Work and receive money from a federal or state work study program;

(c) Be responsible for the care of a dependent household member age five or younger;

(d) Be responsible for the care of a dependent household member six through eleven years of age and the department has determined that there is not adequate child care available during the school year to allow the student to:

(i) Attend class and satisfy the twenty hour work requirement; or

(ii) Take part in a work study program.

(e) Be a single parent responsible for the care of a dependent household member eleven years old or younger even if child care is available;

(f) Be an adult who has parental control of a child eleven years of age or younger and neither the adult's spouse nor the child's parents reside in the home;

(g) Participate in the WorkFirst program as required under WAC 388-310-400;

(h) Receive benefits from TANF or SFA;

(i) Attend an institution of higher education through:

(i) The job training partnership act (JTPA);

(ii) Food assistance employment and training program (FS E&T);

(iii) An approved state or local employment and training program; or

(iv) Section 236 of the Trade Act of 1974.

(4) Student status:

(a) Begins the first day of the school term; and

(b) Continues through vacations. Vacations include the summer when the student plans to return to school for the next term.

(5) If the only reason a student is eligible for food assistance is the participation in work study, the student becomes ineligible during the summer months if the student is not working and receiving money from work study. Consider other student eligibility criteria during the summer months.

(6) Student status ends when a student:

(a) Graduates;

(b) Is suspended or expelled;

(c) Drops out; or

(d) Does not intend to register for the next school term other than summer.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-482-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-482-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-484 WAC
TANF/SFA FIVE YEAR TIME LIMIT

WAC

WAC 388-484-0005 Five year (sixty-month) time limit for TANF, SFA and GA-S cash benefits. (1) **What is the sixty-month time limit?**

The sixty-month time limit is a lifetime limit of cash benefits for TANF, SFA, and GA-S. The time limit applies to any combination of these cash benefits.

(2) **When does the sixty-month time limit start?**

The sixty-month time limit starts August 1, 1997 for TANF and SFA and May 1, 1999 for GA-S.

(3) **Who does this time limit apply to?**

The sixty-month time limit applies to any needy caretaker relative(s) as defined in WAC 388-454-0010.

(4) **Are there any exceptions to the time limit?**

A month does not count towards the sixty-month time limit when:

(a) Unmarried pregnant or parenting minors live in a department approved living arrangement as defined by WAC 388-486-0005.

(b) Living in Indian country, as defined under 18 U.S.C. 1151, or an Alaskan Native village, if during the months the needy caretaker relative(s) received TANF, SFA, or GA-S cash benefits at least fifty percent of the adults living on the reservation or in the village were unemployed.

(5) **What happens if a member of my assistance unit has received sixty months of TANF, SFA, and GA-S cash benefits?**

The entire assistance unit becomes ineligible for TANF, SFA, or GA-S cash benefits once any member has received sixty months of these benefits.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-08-050, § 388-484-0005, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-484-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-486 WAC
TEEN PARENTS

WAC

WAC 388-486-0005 Unmarried pregnant or parenting minors—Required living arrangement. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) The following definitions apply to terms used in this section:

(a) "Unmarried" means a person who have never been married or whose marriage has been annulled. It does not include a person who has been divorced or widowed.

(b) "Minor" means a person younger than eighteen years of age.

(c) "Legal guardian" means a court-appointed legal guardian or court-appointed permanent custodian.

(d) "Relative" is a person who related to the pregnant or parenting minor as defined under RCW 74.15.020(4).

(3) An unmarried pregnant or parenting minor is not eligible for TANF, SFA or GA-S unless the person:

(a) Has been emancipated by a court; or

(b) Lives in a home approved by the department and has a protective payee.

(4) The home of a minor's parent, legal guardian, or adult relative may be approved unless:

(a) The minor has no living parent, legal guardian, or adult relative that can be located or those persons do not want the minor to live with them;

(b) The minor or the minor's child is being or has been seriously harmed either physically, emotionally or sexually in the home of the parent, legal guardian, or adult relative;

(c) Substantial evidence exists of an act or failure to act by the parent, legal guardian, or adult relative that presents imminent or serious harm to the minor or the minor's child if they lived there; or

(d) The department determines that it is in the best interest of the minor or the minor's child to waive the requirement

of living in the home of a parent, legal guardian, or adult relative.

(5) If the home of a minor's parent, legal guardian, or adult relative is not available or suitable, one of the following alternatives may be approved:

(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;

(b) A maternity home;

(c) Other adult-supervised living arrangement; or

(d) The minor's current or proposed living arrangement, if the department determines it is appropriate.

(6) A home that includes the other natural parent of the minor's child or unborn child is never approved if:

(a) The minor is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for rape of a child as set forth in RCW 9A.44.073, 9A.44.076, and 9A.44.079.

(7) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-486-0010 Unmarried pregnant or parenting minors—Required school attendance. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) To be eligible for TANF or SFA, an unmarried pregnant or parenting minor who has not completed high school or a general education development (GED) certificate program must participate in educational activities leading to the attainment of a high school diploma or GED.

(3) The minor must meet the standard for satisfactory attendance set by the school or program in which the minor is enrolled.

(4) An unmarried minor is exempt from this rule if the minor has:

(a) Been emancipated by a court; or

(b) A child who is less than twelve weeks old.

(5) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-488 WAC
TRANSFER OF PROPERTY

WAC

WAC 388-488-0005 Transfer of property to qualify for cash assistance. This rule applies to cash assistance programs only and does not affect Medicaid eligibility for a person who is not institutionalized. For transfer of property for institutional medical see WAC 388-513-1365.

(1) An assistance unit is disqualified from receiving benefits when it transferred or transfers real or personal property for less than its market value in an attempt to qualify for benefits:

(a) Two years prior to the date of application;

(b) During the application process; or

(c) Anytime while receiving benefits.

(2) When an assistance unit transferred property for less than its fair market value in an attempt to qualify for benefits, the disqualification period:

(a) For applicants, begins the first day of the month the property was transferred.

(b) For recipients, begins the first day of the month after the month the property was transferred.

(3) To determine the number of months an assistance unit will be disqualified, divide the uncompensated resource value of the transferred property by the state gross median income. The uncompensated resource value is the equity value minus the amount the client received when transferring a resource.

(4) An assistance unit can provide evidence to clarify the reasons for transferring the property when the department presumes that the assistance unit transferred the property in an attempt to qualify for benefits.

(5) The benefits received by an assistance unit are not affected by the transfer of separate property of a spouse who is not a member of the assistance unit.

(6) An assistance unit's disqualification period is reduced when the client:

(a) Verifies undue hardship will exist if the benefits are denied such as an eviction;

(b) Secures a return of some or all of the transferred property or the equivalent value of the transferred property;

(c) Verifies an unforeseen change in circumstances such as extensive hospitalization; or

(d) Is responsible for and can verify medical expenses.

(7) When a disqualification period has been adjusted and the client is otherwise eligible, benefits will be authorized. Any benefits authorized because of the reason(s) in subsection (6) of this section, are not considered an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-518-1820.]

WAC 388-488-0010 Transfer of property to qualify for food assistance. (1) An assistance unit is disqualified from the program when it transfers a resource to qualify or attempt to qualify for benefits:

(a) Three months prior to the month of application; or

(b) Beginning the month the household is approved for benefits.

(2) The length of disqualification depends on the dollar amount the household is over the resource limit. The countable resources transferred are added to the assistance unit's other countable resources. This total is compared to the resource limit. The amount in excess of the resource limit is located on the chart below to determine the length of the disqualification period.

Amount Over the Resource Limit	Disqualification Period
$ 0 - $ 249.99	1 month
250 - 999.99	3 months
1,000 - 2,999.99	6 months
3,000 - 4,999.99	9 months
5,000 and over	12 months

(3) The disqualification period begins:

(a) For applicants, the month of application; or

(b) For recipients, the first of the month after the advance notice period expires.

(4) An assistance unit will not be disqualified for transferring the following:

(a) Excluded resources that do not affect eligibility;

(b) Resources sold or traded at or near fair market value (FMV);

(c) Resources transferred between assistance unit members of the same household including ineligible household members; and

(d) Resources transferred for reasons other than to qualify for benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-490 WAC
VERIFICATION

WAC

388-490-0005 The department requires proof before authorizing benefits for cash, medical, and food assistance.

WAC 388-490-0005 The department requires proof before authorizing benefits for cash, medical, and food assistance. This rule applies to cash, medical, and food assistance.

(1) When you first apply for benefits, the department may require you to provide proof of things that help us decide your eligibility. This is also called "verification." The types of things that need to be proven are different for each program.

(2) After that, we will ask you to give us proof when:

(a) You report a change;

(b) We find out that your circumstances have changed; or

(c) The information we have is questionable or confusing.

(3) Whenever we ask for proof, we will give you a notice as described in WAC 388-458-0001.

(4) You must give us the proof within the time limits described in:

(a) WAC 388-406-0030 and 388-406-0035 if you are applying for benefits; and

(b) WAC 388-458-0001 if you currently receive benefits.

(5) We will accept any proof that you can easily get when it reasonably supports your statement or circumstances. The proof you give to us must:

(a) Clearly relate to what you are trying to prove;

(b) Be from a reliable source; and

(c) Be accurate, complete, and consistent.

(6) We cannot make you give us a specific type or form of proof.

(7) If the only type of proof that you can get costs money, we will pay for it.

(8) If the proof that you give to us is questionable or confusing, we may:

(a) Ask you to give us more proof or provide a collateral contact (a "collateral contact" is a statement from someone outside of your residence that knows your situation);

(b) Schedule a visit to come to your home and verify your circumstances; or

(c) Send an investigator from the division of fraud investigations (DFI) to make an unannounced visit to your home to verify your circumstances.

(9) By signing the application, eligibility review, or change of circumstances form, you give us permission to contact other people, agencies, or institutions.

(10) If you do not give us all of the proof that we have asked for, we will determine if you are eligible based on the information that we already have. If we cannot determine that you are eligible based on this information, we will deny or stop your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 00-08-091, § 388-490-0005, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-490-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0460.]

Chapter 388-500 WAC
MEDICAL DEFINITIONS

WAC

388-500-0005 Medical definitions.

WAC 388-500-0005 Medical definitions. Unless defined in this chapter or in other chapters of the *Washington Administrative Code*, use definitions found in the *Webster's New World Dictionary*. This section contains definitions of words and phrases the department uses in rules for medical programs. Definitions of words used for both medical and financial programs are defined under WAC 388-22-030.

"Assignment of rights" means the client gives the state the right to payment and support for medical care from a third party.

"Base period" means the time period used in the limited casualty program which corresponds with the months considered for eligibility.

"Beneficiary" means an eligible person who receives:

*A federal cash Title XVI benefit; and/or

*State supplement under Title XVI; or

*Benefits under Title XVIII of the Social Security Act.

"Benefit period" means the time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of

benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for Medicare payments.

"Cabulance" means a vehicle for hire designed and used to transport a physically restricted person.

"Carrier" means:

*An organization contracting with the federal government to process claims under Part B of Medicare; or

*A health insurance plan contracting with the department.

"Categorical assistance unit (CAU)" means one or more family members whose eligibility for medical care is determined separately or together based on categorical relatedness.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-503-0310, chapter 388-517 WAC and WAC 388-523-2305.

"Children's health program" means a state-funded medical program for children under age eighteen:

*Whose family income does not exceed one hundred percent of the federal poverty level; and

*Who are not otherwise eligible under Title XIX of the Social Security Act.

"Coinsurance-Medicare" means the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges.

"Community services office (CSO)" means an office of the department which administers social and health services at the community level.

"Couple" means, for the purposes of an SSI-related client, an SSI-related client living with a person of the opposite sex and both presenting themselves to the community as husband and wife. The department shall consider the income and resources of such couple as if the couple were married except when determining institutional eligibility.

"Deductible-Medicare" means an initial specified amount that is the responsibility of the client.

***"Part A of Medicare-inpatient hospital deductible"** means an initial amount of the medical care cost in each benefit period which Medicare does not pay.

***"Part B of Medicare-physician deductible"** means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.

"Delayed certification" means department approval of a person's eligibility for medicaid made after the established application processing time limits.

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

"Early and periodic screening, diagnosis and treatment (EPSDT)" also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.

"Electronic fund transfers (EFT)" means automatic bank deposits to a client's or provider's account.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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.

"Emergency medical expense requirement" means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

"Essential spouse" see **"spouse."**

"Extended care patient" means a recently hospitalized Medicare patient needing relatively short-term skilled nursing and rehabilitative care in a skilled nursing facility.

"Garnishment" means withholding an amount from earned or unearned income to satisfy a debt or legal obligation.

"Grandfathered client" means:

*A noninstitutionalized person who meets all current requirements for Medicaid eligibility except the criteria for blindness or disability; and

*Was eligible for Medicaid in December 1973 as blind or disabled whether or not the person was receiving cash assistance in December 1973; and

*Continues to meet the criteria for blindness or disability and other conditions of eligibility used under the Medicaid plan in December 1973; and

*An institutionalized person who was eligible for Medicaid in December 1973 or any part of that month, as an inpatient of a medical institution or resident of an intermediate care facility that was participating in the Medicaid program and for each consecutive month after December 1973 who:

*Continues to meet the requirements for Medicaid eligibility that were in effect under the state's plan in December 1973 for institutionalized persons; and

*Remains institutionalized.

"Health maintenance organization (HMO)" means an entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.

"Healthy kids," see **"EPSDT."**

"Home health agency" means an agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"Hospital" means an institution licensed as a hospital by the department of health.

"Income for an SSI-related client," means the receipt by an individual of any property or service which the client can apply either directly, by sale, or conversion to meet the client's basic needs for food, clothing, and shelter.

***"Earned income"** means gross wages for services rendered and/or net earnings from self-employment.

***"Unearned income"** means all other income.

"Institution" means an establishment which furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally retarded.

*__"Institution-public"__ means an institution, including a correctional institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

*__"Institution for mental diseases"__ means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.

*__"Institution for the mentally retarded or a person with related conditions"__ means an institution that:

*Is primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or a person with related conditions; and

*Provides, in a protected residential setting, on-going care, twenty-four hour supervision, evaluation, and planning to help each person function at the greatest ability.

*__"Institution for tuberculosis"__ means an institution for the diagnosis, treatment, and care of a person with tuberculosis.

*__"Medical institution"__ means an institution:

*Organized to provide medical care, including nursing and convalescent care;

*With the necessary professional personnel, equipment and facilities to manage the health needs of the patient on a continuing basis in accordance with acceptable standards;

*Authorized under state law to provide medical care; and

*Staffed by professional personnel. Services include adequate physician and nursing care.

"Intermediary" means an organization having an agreement with the federal government to process Medicare claims under Part A.

"Legal dependent" means a person for whom another person is required by law to provide support.

"Limited casualty program (LCP)" means a medical care program for medically needy, as defined under WAC 388-503-0320 and for medically indigent, as defined under WAC 388-503-0370.

"Medicaid" means the federal aid Title XIX program under which medical care is provided to persons eligible for:

*Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or

*Medically needy program as defined in WAC 388-503-0320.

"Medical assistance." See **"Medicaid."**

"Medical assistance administration (MAA)" means the unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs.

"Medical assistance unit (MAU)" means one or more family members whose eligibility for medical care is determined separately or together based on financial responsibility.

"Medical care services" means the limited scope of care financed by state funds and provided to general assistance (GAU) and ADATSA clients.

"Medical consultant" means a physician employed by the department.

"Medical facility" see **"Institution."**

"Medically indigent (MI)" means a state-funded medical program for a person who has an emergency medical condition requiring hospital-based services.

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Medically needy (MN)" is the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"Medicare" means the federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

*__"Part A"__ covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

*__"Part B"__ is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

"Medicare assignment" means the method by which the provider receives payment for services under Part B of Medicare.

"Month of application" means the calendar month a person files the application for medical care. When the application is for the medically needy program, at the person's request and if the application is filed in the last ten days of that month, the month of application may be the following month.

"Nursing facility" means any institution or facility the department [of health] licenses as a nursing facility, or a nursing facility unit of a licensed hospital, that the:

*Department certifies; and

*Facility and the department agree the facility may provide skilled nursing facility care.

"Outpatient" means a nonhospitalized patient receiving care in a hospital outpatient or hospital emergency department, or away from a hospital such as in a physician's office, the patient's own home, or a nursing facility.

"Patient transportation" means client transportation to and from covered medical services under the federal Medicaid and state medical care programs.

"Physician" means a doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Professional activity study (PAS)" means a compilation of inpatient hospital data, conducted by the commission of professional and hospital activities, to determine the average length of hospital stay for patients.

"Professional review organization for Washington (PRO-W)" means the state level organization responsible for determining whether health care activities:

*Are medically necessary;

*Meet professionally acceptable standards of health care; and

*Are appropriately provided in an outpatient or institutional setting for beneficiaries of Medicare and clients of Medicaid and maternal and child health.

"Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to:

*Artificially replace a missing portion of the body;

*Prevent or correct physical deformity or malfunction; or

*Support a weak or deformed portion of the body.

"Provider" or **"provider of service"** means an institution, agency, or person:

*Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and

*Is eligible to receive payment from the department.

"Resources for an SSI-related client," means cash or other liquid assets or any real or personal property that an individual or spouse, if any, owns and could convert to cash to be used for support or maintenance.

*If an individual can reduce a liquid asset to cash, it is a resource.

*If an individual cannot reduce an asset to cash, it is not considered an available resource.

*Liquid means properties that are in cash or are financial instruments which are convertible to cash such as, but not limited to, cash, savings, checking accounts, stocks, mutual fund shares, mortgage, or a promissory note.

*Nonliquid means all other property both real and personal evaluated at the price the item can reasonably be expected to sell for on the open market.

"Retroactive period" means the three calendar months before the month of application.

"Spell of illness" see **"benefit period."**

"Spenddown" means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department.

"Spouse" means:

***"Community spouse"** means a person living in the community and married to an institutionalized person or to a person receiving services from a home and community-based waivered program as described under chapter 388-515 WAC.

***"Eligible spouse"** means an aged, blind or disabled husband or wife of an SSI-eligible person, with whom such a person lives.

***"Essential spouse"** means, a husband or wife whose needs were taken into account in determining old age assistance (OAA), aid to the blind (AB), or disability assistance (DA) client for December 1973, who continues to live in the home and to be the spouse of such client.

***"Ineligible spouse"** means the husband or wife of an SSI-eligible person, who lives with the SSI-eligible person and who has not applied or is not eligible to receive SSI.

***"Institutionalized spouse"** means a married person in an institution or receiving services from a home or community-based waivered program.

***"Nonapplying spouse"** means an SSI-eligible person's husband or wife, who has not applied for assistance.

"SSI-related" means an aged, blind or disabled person not receiving an SSI cash grant.

"Supplemental security income (SSI) program, Title XVI" means the federal grant program for aged, blind, and disabled established by section 301 of the Social Security amendments of 1972, and subsequent amendments, and administered by the Social Security Administration (SSA).

"Supplementary payment (SSP)" means the state money payment to persons receiving benefits under Title XVI, or who would, but for the person's income, be eligible for such benefits, as assistance based on need in supplementation of SSI benefits. This payment includes:

***"Mandatory state supplement"** means the state money payment to a person who, for December 1973, was a client receiving cash assistance under the department's former programs of old age assistance, aid to the blind and disability assistance; and

***"Optional state supplement"** means the elective state money payment to a person eligible for SSI benefits or who, except for the level of the person's income, would be eligible for SSI benefits.

"Third party" means any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

"Title XIX" is the portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

"Transfer" means any act or omission to act when title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person; including delivery of personal property, bills of sale, deeds, mortgages, pledges, or any other instrument conveying or relinquishing an interest in property. Transfer of title to a resource occurs by:

*An intentional act or transfer; or

*Failure to act to preserve title to the resource.

"Value-fair market for an SSI-related person" means the current value of a resource at the price for which the resource can reasonably be expected to sell on the open market.

"Value of compensation received" means, for SSI-related medical eligibility, the gross amount paid or agreed to be paid by the purchaser of a resource.

"Value-uncompensated" means, for SSI-related medical eligibility, the fair market value of a resource, minus the amount of compensation received in exchange for the resource.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-500-0005, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-500-0005, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-500-0005, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-80-005, 388-82-006, 388-92-005 and 388-93-005.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-501-0105 Applicability. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0105, filed 5/3/94, effective 6/3/94. Formerly WAC 388-80-002.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-501-0110 Purpose of the medical care program. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0110, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-81-005, 388-81-025, 388-99-005 and 388-100-005.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.

388-501-0130 Administrative controls. [Statutory Authority: RCW 74.08.090 and 74.09.290. 96-06-041 (Order 3949), § 388-501-0130, filed 3/1/96, effective 4/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-015.] Repealed by 00-23-014, filed 11/3/00, effective 12/4/00. Statutory Authority: RCW 74.08.090, 43.20B.675.

388-501-0140 Fraud. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0140, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-446-0001.

388-501-0150 Confidential records. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-035.] Repealed by 00-14-047, filed 6/30/00, effective 7/31/00.

388-501-0170 Third party resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0170, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-010 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0540.

388-501-0190 Maternity care distressed area. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0190, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-070.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-501-0050 Medical services requiring approval. All medical services that are provided to clients of medical care programs are subject to review and approval for reimbursement by the medical assistance administration (MAA).

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0050, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0100 Subrogation. (1) For the purpose of this section, **"liable third party"** means:

(a) The tort-feasor or insurer of the tort-feasor, or both; and

(b) Any person who is liable to provide coverage for the illness or injuries for which the medical assistance administration (MAA) is providing assistance or residential care. That liability must be based on any contract or insurance purchased by the client or any other person.

(2) As a condition of medical care eligibility, a client must assign to the state any right the client may have to receive payment from any other third party. An eligible client who receives health care items or services from the state under medical care programs under chapter 74.09 RCW and who has a right to payment from any other third party for those items or services, subrogates that right of payment to the state. This applies except as provided in subsection (3) of this section.

(3) To the extent authorized by a contract executed under RCW 74.09.522, a managed health care plan has the rights and remedies of the department as provided in RCW 43.20B.060 and 70.09.180.

(4) MAA is not responsible to pay for medical care for a client whose personal injuries are caused by the negligence or wrongdoing of another. However, MAA may provide the medical care required as a result of an injury to the client if both of the following apply:

(a) The client is otherwise eligible for medical care; and

(b) No other liable third party has been identified at the time the claim is filed.

(5) The department may pursue its right to recover the value of medical care provided to an eligible client from any liable third party as a subrogee, assignee, or by enforcement of its public assistance lien as provided under RCW 43.20B.040 through 43.20B.070.

(6) Recovery pursuant to the subrogation rights, assignment, or enforcement of the lien granted to the department is not reduced, prorated, or applied to only a portion of a judgment, award, or settlement. The secretary of the department or the secretary's designee must consent in writing to any dis-

charge or compromise of any settlement or judgment of a lien created under RCW 42.20B.060. The department considers the compromise or discharge of a medical care lien only as authorized by federal regulation at 42 CFR 433.139.

(7) The doctrine of equitable subrogation does not apply to defeat, reduce, or prorate any recovery made by the department that is based on its assignment, lien, or subrogation rights.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0100, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0125 Advance directives. In this section "advance directive" means a written instruction, recognized under state law, relating to the provision of health care when an individual is incapacitated.

(1) All agencies, health maintenance organizations (HMOs), and facilities including hospitals, critical access hospitals, skilled nursing and nursing facilities, and providers of in-home care services that serve medical assistance clients eighteen years of age or older must have written policies and procedures concerning advance directives.

(2) The agencies, HMOs, and facilities must give the following information to each adult client, in writing and orally, and in a language the client understands:

(a) A statement about the client's right to:

(i) Make decisions concerning the client's medical care;

(ii) Accept or refuse surgical or medical treatment;

(iii) Execute an advance directive;

(iv) Revoke an advance directive at any time;

(b) The written policies of the agency, HMO, or facility concerning advance directives, including any policy that would preclude it from honoring the client's advance directive; and

(c) The client's rights under state law.

(3) The agencies, HMOs, and facilities must provide the information described in subsection (2) of this section to adult clients as follows:

(a) Hospitals at the time the client is admitted as an inpatient;

(b) Nursing facilities at the time the client is admitted as a resident;

(c) Providers of in-home care services before the client comes under the care of the provider or at the time of the first home visit so long as it is provided prior to care being rendered;

(d) Hospice programs at the time the client initially receives hospice care from the program; and

(e) HMOs at the time the client enrolls with the organization.

(4) If the client is incapacitated at the time of admittance or enrollment and is unable to receive information or articulate whether or not the client has executed an advance directive, the agencies, HMOs, and facilities:

(a) May give information about advance directives to the person authorized by RCW 7.70.065 to make decisions regarding the client's health care;

(b) Must document in the client's file that the client was unable to communicate whether an advance directive exists if no one comes forward with a previously executed advance directive; and

(c) Must give the information described in subsection (2) to the client once the client is no longer incapacitated.

(5) The agencies, HMOs, and facilities must:

(a) Review each client's medical record prior to admittance or enrollment to determine if the client has an advance directive;

(b) Honor the directive or follow the process explained in subsection (6); and

(c) Not refuse, put conditions on care, or otherwise discriminate against a client based on whether or not the client has executed an advance directive.

(6) If an agency, HMO, or facility has a policy or practice that would keep it from honoring a client's advance directive, the facility or organization must:

(a) Tell the client prior to admission or enrollment or when the client executes the directive;

(b) Provide the client with a statement clarifying the differences between institution-wide conscience objections and those that may be raised by individual physicians and explaining the range of medical conditions or procedures affected;

(c) Prepare and keep a written plan of intended actions according to the requirements in RCW 70.122.060 if the client still chooses to retain the facility or organization; and

(d) Make a good faith effort to transfer the client to another health care practitioner who will honor the directive if the client chooses not to retain the facility or organization.

(7) A health care practitioner may refuse to implement a directive, and may not be discriminated against by the facility or organization for refusing to withhold or withdraw life-sustaining treatment.

(8) The agencies, HMOs, and facilities must document, in a prominent place in each client's medical record, whether or not the client has executed an advance directive.

(9) The agencies, HMOs, and facilities must educate staff and the community on issues concerning advance directives.

(10) The agencies, HMOs, and facilities must comply with state and federal laws and regulations concerning advance directives, including but not limited to: 42 USC 1396a, subsection (w); 42 CFR 417.436; 42 CFR 489 Subpart I; and chapter 70.122 RCW.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-19-050, § 388-501-0125, filed 9/14/00, effective 10/15/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0125, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-017.]

WAC 388-501-0135 Patient requiring regulation. (1) Patient requiring regulation (PRR) is a health and safety program for clients needing help in the appropriate use of medical services. A client in PRR is restricted to one primary care provider (PCP) and one pharmacy. Enrollment in the PRR program is for twenty-four months.

(2) Any client of the department's medical programs is reviewed for assignment to PRR if:

(a) The client has:

(i) Made repeated and documented efforts to seek medically unnecessary health services; and

(ii) Been counseled at least once by a health care provider or managed care plan representative about the appropriate use of health care services; or

(b) Any three of the following conditions have been met or exceeded in a ninety-day period. The client:

(i) Received services from four different physicians; or

(ii) Had prescriptions filled by four different pharmacies; or

(iii) Received ten prescriptions; or

(iv) Had prescriptions filled by four different prescribers; or

(v) Used two emergency room (ER) visits.

(3) If subsections (2)(a) or (b) of this section apply, then the client's use of medical services is reviewed by the department. The review considers the client's diagnoses, history of services provided, or other medical information supplied by the health care provider or managed care plan. The review is done by a nurse consultant, physician, or other qualified medical staff according to established medical review guidelines.

(4) If the medical review finds that the client uses inappropriate or medically unnecessary services the client receives written notice which:

(a) Asks the client to select a primary care provider and one pharmacy; and

(b) Notifies the client of their right to request a fair hearing within ninety days (see subsection (6) of this section); and

(c) Requires the client to respond within twenty days by:

(i) Selecting a primary care provider and pharmacy; or

(ii) Submitting additional medical information, which justifies the client's use of medical services; or

(iii) Writing or calling the PRR representative, who is identified in the PRR notice, requesting assistance; or

(iv) Requesting a fair hearing (see subsection (6) of this section).

(5) A client who does not respond to the notice within twenty days is assigned to the PRR program. The department assigns the client to a PCP and pharmacy. The client may change the assigned PCP and pharmacy once within the initial sixty days. The assigned providers will be:

(a) Located in the client's local geographic area; and

(b) Reasonably accessible to the client.

(6) A client has ninety days to request a fair hearing. A client who requests a fair hearing within twenty days from the date they receive notice under subsection (4) of this section will not be assigned to the PRR program until a fair hearing decision is made. A client who requests a fair hearing after twenty days may have been assigned a PCP and pharmacist. An assigned client will remain in PRR until a fair hearing decision is made.

(7) When a PRR client chooses or the department assigns a PCP and pharmacy, the PCP and pharmacy requirements are:

(a) A PCP supervises and coordinates medical care for the client. The PCP makes referrals for specialist care and provides continuity of care. A PCP must be:

(i) A physician who meets the criteria under WAC 388-502-0020 and 388-502-0030; or

(ii) An advanced registered nurse practitioner (ARNP) who meets criteria under WAC 388-502-0020 and 388-502-0030; or

(iii) A licensed physician assistant, practicing with a sponsoring supervising physician.

(b) A single pharmacy fills all prescriptions for the client. For fee for service clients the pharmacy must be contracted with MAA.

(c) For clients enrolled in a managed care plan, the pharmacy and PCP must be contracted with the client's managed care plan.

(8) The PRR client's medical assistance identification card (MAID) will be marked in the "restricted" column.

(9) A client in PRR cannot change their PCP or pharmacy for twelve months unless the:

(a) Client changes to a residence outside the provider's geographic area; or

(b) PCP or pharmacy moves out of the client's geographical area; or

(c) PCP or pharmacy refuses to continue as the client's provider; or

(d) Client was assigned providers. The client may change the assigned providers once within sixty days of the initial assignment.

(10) A PRR client enrolled in a managed care plan must select a PCP and pharmacy from those identified as available within their plan. In addition to the reasons given in subsection (9) of this section, the client may change a provider if the:

(a) Chosen or assigned PCP or pharmacy no longer participates with their plan. The client may:

(i) Select a new PCP from the list of available PCPs provided by the plan; or

(ii) Transfer enrollment of all family members to the new department-contracted plan which the established PCP has joined.

(b) Client chooses a new plan during the managed care program's open enrollment period, which occurs during the twenty-four-month PRR enrollment period as defined in subsection (1) of this section.

(11) After twenty-four months, a PRR client's use of services is reviewed. A client is removed from PRR if:

(a) The billing records show the care received was reasonable and appropriate; or

(b) The PCP reports the services requested and received were reasonable and appropriate.

(12) If the client is not removed from PRR under subsection (11) of this section, the client continues to be in PRR for an additional twelve months. After that twelve-period, the client is reviewed again according to subsection (11)(a) and (b) of this section.

(13) Under the PRR program, MAA or the client's managed care plan will pay for only:

(a) Those services authorized by the PCP, the PCP-referred specialist, or the pharmacist; or

(b) Emergencies services; or

(c) Family planning services; or

(d) Women's health care services. A client enrolled with a managed care plan must self-refer to providers within the plan's network.

The client may be responsible for payment of services not covered by the PRR program.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-501-0135, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-501-0135, filed 7/31/98, effective 9/1/98. 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.]

WAC 388-501-0160 Exception to rule—Request for a noncovered medical or dental service, or related equipment. A client and/or their provider may request prior authorization for MAA to pay for a noncovered medical or dental service, or related equipment. This is called an exception to rule.

(1) MAA cannot approve an exception to rule if the exception violates state or federal law or federal regulation.

(2) For MAA to consider the request, sufficient client-specific information and documentation must be submitted for the MAA medical director or designee to determine if:

(a) The client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s); and

(b) The requested service or equipment will result in lower overall costs of care for the client.

(3) The MAA medical director or designee evaluates and considers requests on a case-by-case basis according to the information and documentation submitted from the provider.

(4) Within fifteen working days of MAA's receipt of the request, MAA notifies the provider and the client, in writing, of MAA's decision to grant or deny the exception to rule.

(5) Clients do not have a right to a fair hearing on exception to rule decisions.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035. 00-03-035, § 388-501-0160, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-030.]

WAC 388-501-0165 Determination process for coverage of medical equipment and medical or dental services. This section applies to fee for service (FFS) requests for medical equipment and medical or dental services that require prior authorization.

(1) MAA evaluates requests on an individual basis, and bases the decision to approve or deny on submitted and obtainable evidence.

(2) MAA denies a request when MAA determines the service or equipment is not:

(a) Medically/dentally necessary;

(b) Covered; or

(c) Generally considered as acceptable treatment by the medical/dental profession based on the medical/dental standard of practice, or is investigative or experimental in nature. However, MAA may approve such a request if the provider submits sufficient objective clinical evidence demonstrating that a client's particular circumstances make the request medically/dentally necessary.

(3) Requests for covered services and equipment are approved when MAA determines that the service or equipment is medically necessary as defined in WAC 388-500-0005 or dentally necessary as defined in WAC 388-535-1050.

(4) The examining physician/dentist responsible for the client's diagnosis and/or treatment must submit specific evidence sufficient to determine if the covered service or equipment is medically/dentally necessary. Such evidence may include, but is not limited to:

(a) A client-specific physiological description of the disease, injury, impairment, or other ailment;

(b) Pertinent laboratory findings;

(c) X-ray and/or imaging reports;

(d) Individual patient records pertinent to the case or request;

(e) Photographs and/or videos when requested by MAA;

(f) Dental x-rays; and

(g) Objective medical/dental information, including but not limited to medically/dentally acceptable clinical findings and diagnoses resulting from physical or mental examinations.

(5) MAA gives substantial weight to objective medical/dental information and resulting conclusions from an examining physician/dentist responsible for the client's diagnosis and/or treatment.

(a) MAA accepts the examining physician's/dentist's uncontradicted and adequately substantiated conclusion with respect to medical/dental necessity, unless MAA presents specific detailed reasons for rejecting that conclusion. MAA's reasons will be consistent with sound medical/dental practice and supported by objective medical/dental information in the client's file.

(b) If two or more examining physicians/dentists provide conflicting medical/dental information or conclusions about medical/dental necessity for the request under review, MAA will use all information submitted to reach a decision. If MAA concludes the request is not medically/dentally necessary, MAA will enumerate specific reasons, supported by objective medical/dental information in the client's file, for that decision.

(6) Within fifteen calendar days of receiving a request:

(a) MAA approves or denies the request; or

(b) Requests additional justifying information from the prescribing physician, dentist, specialty therapist, and/or service vendor if the documentation submitted is insufficient to reasonably determine medical or dental necessity. Examples of information that MAA may request are shown in subsection (4) of this section. MAA sends a copy of the request to the client at the same time.

(i) If MAA does not receive the information within thirty days of the date requested, MAA denies the original request within the next five working days on the basis of insufficient justification of medical/dental necessity;

(ii) If MAA receives the information within thirty days, MAA makes a final determination on the request within five working days of the receipt of that additional information.

(7) When MAA denies all or part of a request for a covered service(s) or equipment, MAA sends the client and the provider written notice of the denial within five working days of the decision. The notice includes:

(a) The WAC reference(s) used as a basis for the decision;

(b) A summary statement of the specific facts MAA relied upon for the decision;

(c) An explanation of the reasons for the denial, including the reasons why the specific facts relied upon did not meet the requirements for approval;

(d) When required by subsection (5) of this section, a specific statement of the reasons and supporting facts for rejecting any medical/dental information or conclusions of an examining physician/dentist;

(e) Notice of the client's right to a fair hearing and filing deadlines;

(f) Instructions about how to request the hearing;

(g) A statement that the client may be represented at the hearing by legal counsel or other representative; and

(h) Upon the client's request, the name and address of the nearest legal services office.

(8) When MAA receives a request for a noncovered service(s) or equipment, MAA may:

(a) Approve the request as an exception to rule according to WAC 388-501-0160; or

(b) Deny the request as a noncovered service, and send the client and the provider written notice of the denial within five working days of the decision. The notice includes:

(i) The WAC reference(s) used as a basis for the decision;

(ii) The reason for the denial;

(iii) Notice of the client's right to a fair hearing and filing deadlines;

(iv) Instructions about how to request the hearing;

(v) A statement that the client may be represented at the hearing by legal counsel or other representative; and

(vi) Upon the client's request, the name and address of the nearest legal services office.

(9) If a fair hearing is requested, MAA or the client may request an independent medical/dental assessment. MAA will pay for the independent assessment if MAA agrees that it is necessary, or a fair hearing judge determines that the assessment is necessary.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035. 00-03-035, § 388-501-0165, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0165, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-038.]

WAC 388-501-0175 Medical care provided in bordering cities. (1) An eligible Washington state resident may receive medical care in a recognized out-of-state bordering city on the same basis as in-state care.

(2) The only recognized bordering cities are:

(a) Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho; and

(b) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0175, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0175, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-130.]

WAC 388-501-0180 Out-of-state medical care. (1) The department of social and health services (DSHS) considers cities bordering Washington state and listed in WAC 388-501-0175 the same as in-state cities for:

(a) Medical care coverage under all medical programs administered by the medical assistance administration (MAA); and

(b) Reimbursement purposes.

(2) The department does not cover out-of-state medical care for clients under the following state-administered (Washington state medical care only) medical programs:

(a) General assistance-unemployable (GA-U);

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

(c) Medically indigent program (MIP).

(3) Subject to the exceptions and limitations in this section, the department covers out-of-state medical care provided to eligible clients when the services are:

(a) Within the scope of the client's medical care program as specified under chapter 388-529 WAC; and

(b) Medically necessary as defined in WAC 388-500-0005.

(4) If the client travels out-of-state expressly to obtain medical care, the medical services must have prior authorization through the department's determination process described in WAC 388-501-0165.

(5) See WAC 388-501-0165 for the department's determination process for requests for:

(a) Any service that is listed in any Washington Administrative Code section as noncovered;

(b) A service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550; and

(c) A covered service that is subject to the department's limitations or other restrictions and the request for the service exceeds those limitations or restrictions.

(6) The department determines out-of-state coverage for transportation services, including ambulance services, according to chapter 388-546 WAC.

(7) The department reimburses an out-of-state provider for medical care provided to an eligible client if the provider:

(a) Meets the licensing requirements of the state in which care is provided;

(b) Contracts with the department to be an enrolled provider; and

(c) Meets the same criteria for payment as in-state providers.

[Statutory Authority: RCW 74.08.090 and 74.09.035. 01-01-011, § 388-501-0180, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0180, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-135 and 388-92-015.]

WAC 388-501-0200 Third-party resources. (1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the EPSDT program.

(3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.

(5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:

(a) Third-party payment when the payment is less than MAA's maximum allowable rate; or

(b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.

(6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

[Statutory Authority: RCW 74.04.050, 74.08.090. 00-11-141, § 388-501-0200, filed 5/23/00, effective 6/23/00; 00-01-088, § 388-501-0200, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0213 Case management services. (1) The department shall provide case management services to medical assistance recipients:

(a) By contract with providers of case management services.

(b) Limited to target groups of clients as determined by the contract.

(c) Limited to services as determined by the contract.

(2) Case management services are services which will assist clients in gaining access to needed medical, social, educational, and other services.

[00-23-067, recodified as § 388-501-0213, filed 11/15/00, effective 11/15/00. Statutory Authority: RCW 74.08.090. 87-22-094 (Order 2555), § 388-86-017, filed 11/4/87.]

WAC 388-501-0300 Limits on scope of medical program services. (1) The medical assistance administration (MAA) shall pay only for equipment, supplies, and services that are listed as covered in MAA published issuances, including Washington Administrative Code (WAC), billing instructions, numbered memoranda, and bulletins, and when the items or services are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary;

(c) Within accepted medical, dental, or psychiatric practice standards and are:

(i) Consistent with a diagnosis; and

(ii) Reasonable in amount and duration of care, treatment, or service.

(d) Not listed under subsection (2) of this section; and

(e) Billed according to the conditions of payment under WAC 388-87-010.

(2) Unless required under EPSDT/healthy kids program; included as part of a managed care plan service package; included in a waivered program; or part of one of the Medicare programs for the qualified Medicare beneficiaries, the MAA shall specifically exclude from the scope of covered services:

(a) Nonmedical equipment, supplies, personal or comfort items and/or services, including, but not limited to:

(i) Air conditioners or air cleaner devices, dehumidifiers, other environmental control devices, heating pads;

(ii) Enuresis (bed wetting) training equipment;

(iii) Recliner and/or geri-chairs;

(iv) Exercise equipment;

(v) Whirlpool baths;

(vi) Telephones, radio, television;

(vii) Any services connected to the telephone, television, or radio;

(viii) Homemaker services;

(ix) Utility bills; or

(x) Meals delivered to the home.

(b) Services, procedures, treatment, devices, drugs, or application of associated services which the department or HCFA consider investigative or experimental on the date the services are provided;

(c) Physical examinations or routine checkups;

(d) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness;

(e) Routine foot care that includes, but not limited to:

(i) Medically unnecessary treatment of mycotic disease;

(ii) Removal of warts, corns, or calluses;

(iii) Trimming of nails and other hygiene care; or

(iv) Treatment of asymptomatic flat feet.

(f) More costly services when less costly equally effective services as determined by the department are available;

(g) Procedures, treatment, prosthetics, or supplies related to gender dysphoria surgery except when recommended after a multidisciplinary evaluation including but not limited to urology, endocrinology, and psychiatry;

(h) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for sterilization reversals and donor ovum, sperm, or womb;

(i) Acupuncture, massage, or massage therapy;

(j) Orthoptic eye training therapy;

(k) Weight reduction and control services not provided in conjunction with a MAA medically approved program. This includes food supplements and educational products;

(l) Parts of the body, including organs tissues, bones, and blood;

(m) Blood and eye bank charges;

(n) Domiciliary or custodial care, excluding nursing facility care;

(o) Hair pieces, wigs, or hair transplantation;

(p) Biofeedback or other self-help care;

(q) Marital counseling or sex therapy;

(r) Any service specifically excluded by statute; and

(s) Home births, except when provided as an approved service under MAA's planned home birth pilot project.

(3) Clients shall be responsible for payment as described under WAC 388-87-010 for services not covered under the client's medical care program.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, amended and recodified as § 388-501-0300, filed 11/13/00, effective 12/14/00. Statutory Authority: RCW 74.08.090. 93-16-037 (Order 3599), § 388-86-200, filed 7/28/93, effective 8/28/93; 93-11-086 (Order 3536), § 388-86-200, filed 5/19/93, effective 6/19/93.]

Chapter 388-502 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—PROVIDERS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-502-0205 Civil rights. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0205, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-010 (part).] Repealed by 00-15-050, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530.

388-502-0250 Interest penalties—Providers. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.] Amended and decodified by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090. Later promulgation, see WAC 388-502-0130.

WAC 388-502-0010 Payment—Eligible providers defined. The department reimburses enrolled providers for covered medical services, equipment and supplies they provide to eligible clients.

(1) To be eligible for enrollment, a provider must:

(a) Be licensed, certified, accredited, or registered according to Washington state laws and rules; and

(b) Meet the conditions in this chapter and chapters regulating the specific type of provider, program, and/or service.

(2) To enroll, an eligible provider must sign a core provider agreement or a contract with the department and receive a unique provider number.

(3) Eligible providers listed in this subsection may request enrollment. Out-of-state providers listed in this subsection are subject to conditions in WAC 388-502-0120.

(a) Professionals:

(i) Advanced registered nurse practitioners;

(ii) Anesthesiologists;

(iii) Audiologists;

(iv) Chiropractors;

(v) Dentists;

(vi) Dental hygienists;

(vii) Denturists;

(viii) Dietitians or nutritionists;

(xiv) Maternity case managers;

(x) Midwives;

(xi) Occupational therapists;

(xii) Ophthalmologists;

(xiii) Opticians;

(xiv) Optometrists;

(xv) Orthodontists;

(xvi) Osteopaths;

(xvii) Podiatric physicians;

(xviii) Physicians;

(xix) Physical therapists;

(xx) Psychiatrists;

(xxi) Psychologists;

(xxii) Registered nurse delegators;

(xxiii) Registered nurse first assistants;

(xxiv)Respiratory therapists;

(xxv) Speech/language pathologists;

(xxvi) Radiologists; and

(xvii) Radiology technicians (technical only);

(b) Agencies, centers and facilities:

(i) Adult day health centers;

(ii) Ambulatory services (ground and air);

(iii) Ambulatory surgery centers (Medicare-certified);

(iv) Birthing centers (licensed by the department of health);

(v) Blood banks;

(vi) Chemical dependency treatment facilities certified by the department of social and health services (DSHS) divi-

sion of alcohol and substance abuse (DASA), and contracted through either:

(A) A county under chapter 388-810 WAC; or

(B) DASA to provide chemical dependency treatment services;

(vii) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by DASA);

(viii) Community AIDS services alternative agencies;

(ix) Community mental health centers;

(x) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;

(xi) Family planning clinics;

(xii) Federally qualified health care centers (designated by the Federal Health Care Financing Administration);

(xiii) Genetic counseling agencies;

(xiv) Health departments;

(xv) HIV/AIDS case management;

(xvi) Home health agencies;

(xvii) Hospice agencies;

(xviii) Hospitals;

(xix) Indian Health Service;

(xx) Tribal or urban Indian clinics;

(xxi) Inpatient psychiatric facilities;

(xxii) Intermediate care facilities for the mentally retarded (ICF-MR);

(xxiii) Kidney centers;

(xxiv) Laboratories (CLIA certified);

(xxv) Maternity support services agencies;

(xxvi) Neuromuscular and neurodevelopmental centers;

(xxvii) Nursing facilities (approved by DSHS Aging and Adult Services);

(xxviii) Pharmacies;

(xxix) Private duty nursing agencies;

(xxx) Rural health clinics (Medicare-certified);

(xxxi) Tribal mental health services (contracted through the DSHS mental health division); and

(xxxii) Washington state school districts and educational service districts.

(c) Suppliers of:

(i) Durable and nondurable medical equipment and supplies;

(ii) Infusion therapy equipment and supplies;

(iii) Prosthetics/orthotics;

(iv) Hearing aids; and

(v) Oxygen equipment and supplies;

(d) Contractors of:

(i) Transportation brokers;

(ii) Interpreter services agencies; and

(iii) Eyeglass and contact lens providers.

(4) Nothing in this chapter precludes the department from entering into other forms of written agreements to provide services to eligible clients.

(5) The department does not enroll licensed or unlicensed practitioners who are not specifically addressed in subsection (3) of this section, including, but not limited to:

(a) Acupuncturists;

(b) Counselors;

(c) Sanipractors;

(d) Naturopaths;

(e) Homeopaths;

(f) Herbalists;

(g) Massage therapists;

(h) Social workers; or

(i) Christian Science practitioners or theological healers.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0010, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0020 General requirements for providers. (1) Enrolled providers must:

(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

(i) Patient's name and date of birth;

(ii) Dates of services;

(iii) Name and title of person performing the service, if other than the billing practitioner;

(iv) Chief complaint or reason for each visit;

(v) Pertinent medical history;

(vi) Pertinent findings on examination;

(vii) Medications, equipment, and/or supplies prescribed or provided;

(viii) Description of treatment (when applicable);

(ix) Recommendations for additional treatments, procedures, or consultations;

(x) X-rays, tests, and results;

(xi) Dental photographs and teeth models;

(xii) Plan of treatment and/or care, and outcome; and

(xiii) Specific claims and payments received for services.

(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;

(c) Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation;

(d) Bill the department according to department rules and billing instructions;

(e) Include and sign the following statement with each bill submitted to the department for reimbursement: "I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the state of Washington; the claim is just and due; that no part of the same has been paid and I am authorized to sign for the payee; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, sex, religion, national origin, marital status, or the presence of any sensory, mental or physical handicap."

(f) Accept the payment from the department as payment in full;

(g) Follow the requirements in WAC 388-502-0160 and 388-538-095 about billing clients;

(h) Fully disclose ownership and control information requested by the department;

(i) Not pay a third party biller a percentage of amounts collected, or discount client accounts to a third party biller;

(j) Provide all services without discriminating on the grounds of race, creed, color, age, sex, religion, national origin, marital status, or the presence of any sensory, mental or physical handicap; and

(k) Provide all services according to federal and state laws and rules, and billing instructions issued by the department.

(2) A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the department's programs.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0020, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0030 Denying, suspending, and terminating a provider's enrollment. (1) The department terminates enrollment or does not enroll or reenroll a provider if, in the department's judgement, it may be a danger to the health or safety of clients.

(2) Except as noted in subsection (3) of this section, the department does not enroll or reenroll a provider to whom any of the following apply:

(a) Has a restricted professional license;

(b) Has been terminated, excluded, or suspended from Medicare/Medicaid; or

(c) Has been terminated by the department for quality of care issues or inappropriate billing practices.

(3) The department may choose to enroll or reenroll a provider who meets the conditions in subsection (2) of this section if all of the following apply:

(a) The department determines the provider is not likely to repeat the violation that led to the restriction or sanction;

(b) The provider has not been convicted of other offenses related to the delivery of professional or other medical services in addition to those considered in the previous sanction; and

(c) If the United States Department of Health and Human Services (DHHS) or Medicare suspended the provider from Medicare, DHHS or Medicare notifies the department that the provider may be reinstated.

(4) The department gives thirty days written notice before suspending or terminating a provider's enrollment. However, the department suspends or terminates enrollment immediately if any one of the following situations apply:

(a) The provider is convicted of a criminal offense related to participation in the Medicare/Medicaid program;

(b) The provider's license, certification, accreditation, or registration is suspended or revoked;

(c) Federal funding is revoked;

(d) By investigation, the department documents a violation of law or contract;

(e) The MAA medical director or designee determines the quality of care provided endangers the health and safety of one or more clients; or

(f) The department determines the provider has intentionally used inappropriate billing practices.

(5) The department may terminate a provider's number if:

(a) The provider does not disclose ownership or control information;

(b) The provider does not submit a claim to the department for twenty-four consecutive months;

(c) The provider's address on file with the department is incorrect;

(d) The provider requests a new provider number (e.g., change in tax identification number or ownership); or

(e) The provider voluntarily withdraws from participation in the medical assistance program.

(6) Nothing in this chapter obligates the department to enroll all eligible providers who request enrollment.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0030, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0100 General conditions of payment. (1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

(a) The service is within the scope of care of the client's medical assistance program;

(b) The service is medically or dentally necessary;

(c) The service is properly authorized;

(d) The provider bills within the timeframe set in WAC 388-502-0150;

(e) The provider bills according to department rules and billing instructions; and

(f) The provider follows third-party payment procedures.

(2) The department is the payer of last resort, unless the other payer is:

(a) An Indian health service;

(b) A crime victims program through the department of labor and industries; or

(c) A school district for health services provided under the Individuals with Disabilities Education Act.

(3) The provider must accept Medicare assignment for claims involving clients eligible for both Medicare and medical assistance before MAA makes any payment.

(4) The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.

(5) The department may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:

(a) The department considered the person eligible at the time of service;

(b) The service was not otherwise paid for; and

(c) The provider submits a request for payment to the department.

(6) The department does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.

(7) Information about medical care for jail inmates is found in RCW 70.48.130.

(8) The department pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0100, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0110 Conditions of payment—Medicare deductible and coinsurance. (1) The department pays the deductible and coinsurance amounts for a client participating in Parts A and/or B of Medicare (Title XVIII of the Social Security Act) when the:

(a) Total reimbursement to the provider from Medicare and the department does not exceed the rate in the department's fee schedule; and

(b) Provider accepts assignment for Medicare payment.

(2) The department pays the deductible and coinsurance amounts for a client who has Part A of Medicare. If the client:

(a) Has not exhausted lifetime reserve days, the department considers the Medicare diagnostic related group (DRG) as payment in full; or

(b) Has exhausted lifetime reserve days during an inpatient hospital stay, the department considers the Medicare DRG as payment in full until the Medicaid outlier threshold is reached. After the Medicaid outlier threshold is reached, the department pays an amount based on the policy described in the Title XIX state plan.

(3) If Medicare and Medicaid cover the service, the department pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less. If only Medicare and not Medicaid covers the service, the department pays only the deductible and/or coinsurance up to Medicare's allowed amount.

(4) The department bases its outlier policy on the methodology described in the department's Title XIX state plan, methods, and standards used for establishing payment rates for hospital inpatient services.

(5) The department pays, according to department rules and billing instructions, for Medicaid covered services when the client exhausts Medicare benefits.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0110, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0120 Payment for medical care outside the state of Washington. (1) The medical assistance administration (MAA) pays the provider of service in designated bordering cities as if the care were provided within the state of Washington (see WAC 388-501-0175). MAA requires providers to meet the licensing requirements of the state in which care is rendered.

(2) MAA does not authorize payment for out-of-state medical care furnished to clients in state-only funded medical programs.

(3) MAA applies the three-month retroactive coverage as defined under WAC 388-500-0005 to covered medical services that are furnished to eligible clients by out-of-state providers.

(4) MAA requires out-of-state providers to obtain a valid provider number in order to be reimbursed.

(a) MAA requires a completed core provider agreement, and furnishes the necessary billing forms, instructions, and a core provider agreement to providers.

(b) MAA issues a provider number after receiving the signed core provider agreement.

(c) The billing requirements of WAC 388-502-0100 and 388-502-0150 apply to out-of-state providers.

(5) For Medicare-eligible clients, providers must submit Medicare claims, on the appropriate Medicare billing form, to the intermediary or carrier in the provider's state. If the provider checks the Medicare billing form to show the state of Washington as being responsible for medical billing, the intermediary or carrier may either:

(a) Forward the claim to MAA on behalf of the provider; or

(b) Return the claim to the provider, who then submits it to MAA.

(6) For covered services for eligible clients, MAA reimburses approved out-of-state nursing facilities at the lower of:

(a) The billed amount; or

(b) The adjusted statewide average reimbursement rate for in-state nursing facility care.

(7) For covered services for eligible clients, MAA reimburses approved out-of-state hospitals at the lower of:

(a) The billed amount; or

(b) The adjusted statewide average reimbursement rate for in-state hospitals.

(8) For covered services for eligible clients, MAA reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX Medicaid program.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-502-0120, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-502-0120, filed 12/14/99, effective 1/14/00.]

WAC 388-502-0130 Interest penalties—Providers. (1) Providers who are enrolled as contractors with the department's medical care programs may be assessed interest on excess benefits or other inappropriate payments. Nursing home providers are governed by WAC 388-96-310 and are not subject to this section.

(2) The department assesses interest when:

(a) The excess benefits or other inappropriate payments were not the result of department error; and

(b) A provider is found liable for receipt of excess benefits or other payments under RCW 74.09.220; or

(c) A provider is notified by the department that repayment of excess benefits or other payments is due under RCW 74.09.220.

(3) The department assesses interest at the rate of one percent for each month the overpayment is not satisfied. Daily interest calculations and assessments are made for partial months.

(4) Interest is calculated beginning from the date the department receives payment from the provider. Interest ceases to be calculated and collected from the provider once the overpayment amount is received by the department.

(5) The department calculates interest and amounts, which are identified on all department collection notices and statements.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, recodified as § 388-502-0130, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.]

WAC 388-502-0150 Time limits for providers to bill MAA. Providers may bill the **medical assistance administration (MAA)** for covered services provided to eligible clients.

(1) MAA requires providers to submit initial claims and adjust prior claims in a timely manner. MAA has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims, see subsections (7) and (8) of this section; and

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section.

(2) The provider must submit claims to MAA as described in MAA's billing instructions.

(3) Providers must submit their claim to MAA and have an internal control number (ICN) assigned by MAA within three hundred sixty-five days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders MAA to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) MAA may grant exceptions to the three hundred sixty-five-day time limit for initial claims when billing delays are caused by either of the following:

(a) The department's certification of a client for a retroactive period; or

(b) The provider proves to MAA's satisfaction that there are other extenuating circumstances.

(5) MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to MAA's billing limits.

(6) When a client is covered by both Medicare and MAA, the provider must bill Medicare for the service before billing Medicaid. If Medicare:

(a) Pays the claim the provider must bill MAA within six months of the date Medicare processes the claim; or

(b) Denies payment of the claim, MAA requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) MAA allows providers to resubmit, modify, or adjust any claim, other than a prescription drug claim, with a timely ICN within thirty-six months of the date the service was provided to the client. This applies to any claim, other than a prescription drug claim, that met the time limits for an initial claim, whether paid or denied. MAA does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(8) The thirty-six-month period described in subsection (7) of this section does not apply to overpayments that a provider must refund to the department. After thirty-six months, MAA does not allow a provider to refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(9) MAA allows providers to resubmit, modify, or adjust any prescription drug claim with a timely ICN within fifteen months of the date the service was provided to the client. After fifteen months, MAA does not accept any prescription drug claim for resubmission, modification or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the department. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) MAA does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements of this section, resulting in the claim not being paid by MAA.

[Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.45. 00-14-067, § 388-502-0150, filed 7/5/00, effective 8/5/00.]

WAC 388-502-0160 Billing a client. (1) A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay for the service because the provider failed to satisfy the conditions of payment in MAA billing instructions, this chapter, and other chapters regulating the specific type of service provided.

(2) The provider is responsible to verify whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

(3) A provider may bill a client only if one of the following situations apply:

(a) The client is enrolled in a managed care plan and the client and provider comply with the requirements in WAC 388-538-095;

(b) The client is enrolled in a program other than managed care, and the client and provider sign an agreement. It must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for department review upon request. The agreement must include each of the following elements to be valid:

(i) The specific service to be provided;

(ii) The service is not covered;

(iii) The client chooses to receive and pay for the specific service; and

(iv) The client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider for the service because the provider did not satisfy MAA's billing requirements;

(c) The client or the client's legal guardian was reimbursed for the service directly by a third party;

(d) The provider has documentation that the client represented himself/herself as a private pay patient and not receiving medical assistance. The documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the patient's file for department review upon request. If the patient later becomes eligible for the service due to delayed or retroactive eligibility, the provider must comply with subsection (4) of this section;

(e) The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. Medical Assistance is not insurance; or

(f) The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA.

(4) If a client becomes eligible for a service that has already been provided due to:

(a) Delayed eligibility, the provider must:

(i) Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and

(ii) Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service.

(b) Retroactive eligibility, the provider:

(i) Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and

(ii) May refund any payment received from the client or anyone on the client's behalf, and then bill MAA for the service.

(5) Hospitals may not bill, demand, collect, or accept payment from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown.

(6) A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(a) Medical charts;

(b) Radiological or imaging films; and

(c) Laboratory or other diagnostic test results.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 00-14-069, § 388-502-0160, filed 7/5/00, effective 8/5/00.]

WAC 388-502-0210 Statistical data-provider reports. (1) At the request of the medical assistance administration (MAA), all providers enrolled with MAA programs must submit full reports, as specified by MAA, of goods and services furnished to eligible medical assistance clients. MAA furnishes the provider with a standardized format to report these data.

(2) MAA analyzes the data collected from the providers' reports to secure statistics on costs of goods and services furnished and makes a report of the analysis available to MAA's advisory committee, the state welfare medical care committee, representative organizations of provider groups enrolled with MAA, and any other interested organizations or individuals.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-15-049, § 388-502-0210, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-020.]

WAC 388-502-0220 Administrative appeal contractor/provider rate reimbursement. (1) Any enrolled contractor/provider of medical services has a right to an administrative appeal when the contractor/provider disagrees with the medical assistance administration's (MAA) reimbursement rate. The exception to this is nursing facilities governed by WAC 388-96-904.

(2) The first level of appeal. A contractor/provider who wants to contest a reimbursement rate must file a written appeal with MAA.

(a) The appeal must include all of the following:

(i) A statement of the specific issue being appealed;

(ii) Supporting documentation; and

(iii) A request for MAA to recalculate the rate.

(b) When a contractor/provider appeals a portion of a rate, MAA may review all components of the reimbursement rate.

(c) In order to complete a review of the appeal, MAA may do one or both of the following:

(i) Request additional information; and/or

(ii) Conduct an audit of the documentation provided.

(d) MAA issues a decision or requests additional information within sixty calendar days of receiving the rate appeal request.

(i) When MAA requests additional information, the contractor/provider has forty-five calendar days from the date of MAA's request to submit the additional information.

(ii) MAA issues a decision within thirty calendar days of receipt of the completed information.

(e) MAA may adjust rates retroactively to the effective date of a new rate or a rate change. In order for a rate increase to be retroactive, the contractor/provider must file the appeal within sixty calendar days of the date of the rate notification letter from MAA. MAA does not consider any appeal filed after the sixty day period to be eligible for retroactive adjustment.

(f) MAA may grant a time extension for the appeal period if the contractor/provider makes such a request within the sixty-day period referenced under (e) of this subsection.

(g) Any rate increase resulting from an appeal filed within the sixty-day period described in subsection (2)(e) of this section is effective retroactively to the rate effective date in the notification letter.

(h) Any rate increase resulting from an appeal filed after the sixty-day period described in subsection (2)(e) of this section is effective on the date the rate appeal is received by the department.

(i) Any rate decrease resulting from an appeal is effective on the date specified in the appeal decision letter.

(j) Any rate change that MAA grants that is the result of fraudulent practices on the part of the contractor/provider as described under RCW 74.09.210 is exempt from the appeal provisions in this chapter.

(3) The second level of appeal. When the contractor/provider disagrees with a rate review decision, it may file a request for a dispute conference with MAA. For this section "dispute conference" means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with a department action as described under subsection (1) of this section, and not agreed upon at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) If a contractor/provider files a request for a dispute conference, it must submit the request to MAA within thirty calendar days after the contractor/provider receives the rate review decision. MAA does not consider dispute conference requests submitted after the thirty-day period for the first level decision.

(b) MAA conducts the dispute conference within ninety calendar days of receiving the request.

(c) A department-appointed conference chairperson issues the final decision within thirty calendar days of the conference. Extensions of time for extenuating circumstances may be granted if all parties agree.

(d) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(e) The dispute conference is the final level of administrative appeal within the department and precede judicial action.

(4) MAA considers that a contractor/provider who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-502-0220, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-043.]

WAC 388-502-0230 Provider review and appeal. (1) As authorized by chapter 74.09 RCW, the medical assistance administration (MAA) monitors and reviews all providers who furnish medical, dental, or other services to eligible medical assistance clients. MAA determines whether the providers are complying with the rules and regulations of the program(s) and providing appropriate quality of care, and recovers any identified overpayments. Examples of provider reviews are:

(a) A review of all billing/medical/dental/service records for medical assistance clients;

(b) A statistical sampling of billing/medical/dental/service records for medical assistance clients, extrapolated per WAC 388-502-0240 (9), (10), and (11); and

(c) A review focused on selected billing/medical/dental/service records for medical assistance clients.

(2) The Washington State Health Professions Quality Assurance Commissions serve in an advisory capacity to MAA in conducting provider reviews and monitoring.

(3) MAA may determine that a provider's billing does not comply with program regulations or the provider is not meeting quality of care practices. MAA may do, but is not limited to, any of the following:

(a) Conduct pre-pay reviews of all claims the provider submits to MAA;

(b) Refer the provider to MAA's auditors (see WAC 388-502-0240);

(c) Refer the provider to Medicaid's Fraud Control Unit;

(d) Refer the provider to the appropriate state health professions quality assurance commission;

(e) Impose provisional stipulations for the provider to continue participation in medical assistance programs;

(f) Terminate the provider's participation in medical assistance programs;

(g) Assess a civil penalty against the provider, per RCW 74.09.210; and

(h) Recover any monies that the provider received as a result of inappropriate payments.

(4) When any part of the time period that is reviewed or monitored falls on or before June 30, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request an administrative review hearing to dispute the action(s).

(a) The request for an administrative review hearing must be in writing and:

(i) Be sent within twenty-eight days of the date of the notice of action(s);

(ii) State the reason(s) why the provider thinks the action(s) are incorrect;

(iii) Be sent by certified mail (return receipt) or other means that provides proof of delivery to:

The Medical Assistance Administration
Attn: Deputy Assistant Secretary
P.O. Box 45500
Olympia WA 98504-5500

(b) The administrative review hearing consists of a review by MAA's deputy assistant secretary of all documents submitted by the provider and MAA. At the deputy assistant secretary's discretion, the administrative review hearing may be conducted in person, as a telephone conference, in written submissions, or a combination thereof.

(c) When a final decision is issued, the office of financial recovery collects any amount the provider is ordered to repay.

(d) The administrative review hearing referenced in this subsection is the final level of administrative review.

(5) When the entire time period that is reviewed or monitored falls on or after July 1, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request a hearing to dispute the action(s).

(a) The request for hearing must be in writing and;

(i) Be sent within twenty-eight days of the date of the notice of action(s), by certified mail (return receipt) or other means that provides proof of delivery to:

The Office of Financial Recovery
P.O. Box 9501
Olympia, WA 98507-5501; and

(ii) State the reason(s) why the provider thinks the action(s) are incorrect.

(b) The office of administrative hearings schedules and conducts the hearing under the Administrative Procedure Act, chapter 34.05 RCW. MAA offers a pre-hearing/alternative dispute conference prior to the hearing.

(c) The office of financial recovery collects any amount the provider is ordered to repay.

(6) A provider who disagrees with a department action regarding termination may appeal the action per WAC 388-502-0260. The provider may request a dispute conference; the request must be:

(a) In writing;

(b) Sent within thirty days of the date the provider received the termination notice;

(c) Include a statement of the action(s) appealed and supporting justification; and

(d) Sent to:

DSHS Central Contract Services

P.O. Box 45811

Olympia, WA 98504-5811

(7) See WAC 388-502-0220 for rate reimbursement appeals. See WAC 388-502-0240 for appeals of audit findings. See WAC 388-502-0260 for appeals related to contracts other than MAA's core provider agreements.

[Statutory Authority: RCW 74.08.090, 74.09.520, 34.05.020, 34.05.220. 00-22-017, § 388-502-0230, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-042.]

WAC 388-502-0240 Audits and the audit appeal process for contractors/providers. (1) This section applies to all contractor/providers except the following:

(a) Nursing homes as described in chapters 388-96, 388-97, and 388-98 WAC; and

(b) Managed care contractors as described in chapter 388-538 WAC.

(2) Subject to the limitations in subsection (1) of this section, the following definitions apply to this section:

(a) **"Contractor/provider"** means any person or organization that has a signed core provider agreement with the medical assistance administration (MAA) to provide services to eligible clients.

(b) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(c) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(3) MAA may audit an MAA contractor/provider who furnishes medical or other covered services to eligible clients. See WAC 388-502-0220 for rate appeals. See WAC 388-502-0230 for dispute appeals involving provider review, termination and appeal. See WAC 388-502-0260 for contract appeals, other than those contained in core provider.

(4) MAA conducts audits as necessary to identify benefits or payments to which contractor/providers are not entitled.

(5) The Washington state health professions quality assurance commissions serve in an advisory capacity to MAA in conducting audits.

(6) An MAA audit includes the following:

(a) An examination of provider records, by either an on-site or desk audit. See subsections (7) and (8) of this section;

(b) A draft audit report, which contains preliminary findings and recommendations. See subsection (13) of this section;

(c) A dispute conference, if the contractor/provider requests it. See subsection (14) of this section;

(d) A final audit report. See subsection (15) of this section; and

(e) The right to an administrative appeal, if the contractor/provider requests it. See subsections (15) and (16) of this section.

(7) MAA audits providers who furnish medical and other services as authorized by chapter 74.09 RCW. An audit:

(a) Determines whether providers are:

(i) Complying with the rules and regulations of the program;

(ii) Meeting the community standard of practice; and

(iii) Billing allowable costs; or

(b) Investigates any of the following:

(i) Complaints/allegations;

(ii) Actions taken regarding Medicare or medical assistance; or

(iii) Actions taken by the health profession's quality assurance commissions.

(8) As part of the audit:

(a) MAA examines provider records.

(i) MAA examines those records, or portion thereof, that were reimbursed by MAA.

(ii) MAA examines records as necessary to verify usual and customary charges and payable and receivable accounts to verify third party liability.

(iii) MAA may remove copies of, but not original, records from the provider's premises.

(b) MAA gives a provider twenty days advance notice that it is going to audit paid claims or patient medical records for compliance with program rules, standards, or the community standard of practice. See subsection (16) of this section to request an extension of this notification period. This notice does not:

(i) Apply to providers who are suspected of fraudulent or abusive practices;

(ii) Apply to providers whose practices MAA considers may present a risk of imminent danger to medical assistance clients;

(iii) Include names of patient files that MAA will review; and

(iv) Apply to medical assistance provider business and financial records and patient financial records when they are reviewed as part of a third-party liability compliance audit.

(c) Whenever possible, MAA works with the provider to minimize inconvenience and disruption of health care delivery during the audit.

(d) MAA destroys all copies of identified client medical records made during an audit, after all appeal rights are exhausted.

(9) MAA may audit on a claim-by-claim basis, or using a probability sample.

(10) When MAA conducts a probability sample audit, all of the following apply:

(a) The sample claims are selected on the basis of recognized and generally accepted sampling methods;

(b) The sample claims are examined for compliance with relevant federal and state laws and regulations, department billing instructions, and numbered memoranda; and

(c) When projecting the overpayment, MAA uses a sample that is sufficient to ensure a minimum ninety-five percent confidence level.

(11) MAA uses probability sampling as described in subsection (10) of this section.

(a) If the audit findings demonstrate that MAA has made an overpayment to a Washington state Title XIX or other medical program provider(s), MAA recovers those statistically calculated overpayments.

(b) When calculating the amount to be recovered, MAA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(c) MAA does not consider nonbilled services or supplies when calculating underpayments or overpayments.

(12) When MAA uses the results of a probability sample to extrapolate the amount to be recovered as described in subsection (11) of this section, the provider may request a description of all of the following:

(a) The universe from which MAA drew the sample;

(b) The sample size and method that MAA used to select the sample; and

(c) The formulas and calculation procedures MAA used to determine the amount to be recovered.

(13) Upon completion of the audit, MAA identifies for the contractor/provider those files or records that are necessary for the audit, but were not located at the time of the audit.

(a) MAA allows the contractor/provider thirty calendar days from the date of completion of the on-site audit to locate and provide the missing files or records. Undocumented services will be considered as program overpayments; and

(b) At the end of this thirty day period, MAA issues the draft audit report. At this time:

(i) The contractor/provider may review, comment, and provide any additional information related to the draft audit report, that the contractor/provider wants considered. This information must be submitted within forty-five days of the date the contractor/provider received the draft audit report. See subsection (16) of this section to request an extension of this time period;

(ii) MAA works with the contractor/provider to resolve areas of disagreement; and

(iii) If necessary, MAA issues a revised draft audit report.

(14) A contractor/provider who wants to dispute draft audit findings must request a dispute conference.

(a) The contractor/provider must submit a written request for a dispute conference within forty-five calendar days of the date the draft audit report was received by the contractor/provider. MAA may grant an additional thirty day extension of the forty-five day limit as long as the contractor/provider requests the time extension in writing within the forty-five day limit and states the reason for the request.

(b) The dispute request must:

(i) Specify which finding(s) the contractor/provider is disputing; and

(ii) Supply documentation to support the contractor/provider's position.

(c) MAA acknowledges each request for a dispute conference.

(d) MAA responds to each disputed item in writing.

(e) If MAA and the contractor/provider reach an agreement during the dispute conference process, MAA issues the final audit report and the recommendations are binding.

(f) If MAA and the contractor/provider cannot reach an agreement during the dispute conference process, and the contractor/provider has had the opportunity to raise all concerns related to the audit findings, MAA may close the dispute conference process and issue a final audit report. After MAA issues the final audit report, the contractor/provider may request an audit appeal hearing per subsection (15) of this section.

(15) After MAA issues the final audit report, the contractor/provider may appeal findings in the report and request an audit appeal hearing. When the contractor/provider requests an audit appeal hearing, and when any part of the audited time period falls on or before June 30, 1998, the following process applies. This hearing is not governed by the Administrative Procedure Act (chapter 34.05 RCW).

(a) The request for an audit appeal hearing must meet all of the following:

(i) Be in writing;

(ii) Be submitted within twenty-eight calendar days of the date of delivery of the final audit report, by certified mail. (Contact the office of financial recovery to request an extension of this time period.) Send the request to:

Office of Financial Recovery/DSHS
POB 45862
Olympia, WA 98504-5862

(iii) Include a copy of the final audit report cover letter;

(iv) State the contractor/provider's name, address, and contract number (DSHS contract number or core provider agreement number);

(v) State the audit time period's beginning and ending dates; and

(vi) Provide additional documentation, limited to the issues identified in the audit, that the contractor/provider requests to be considered within the hearing.

(b) The audit appeal hearing consists of an administrative review of all documents submitted for consideration by the contractor/provider and MAA. DSHS appoints a hearing officer to conduct such a review. At the hearing officer's discretion, the review may be conducted as a telephone conference, as an in-person meeting in Olympia, Washington, or as a combination thereof.

(c) The decision made by the hearing officer serves as the final agency action and is binding.

(d) The office of financial recovery collects any amount the provider is ordered to repay.

(16) A contractor/provider may request an extension of the time periods in this section by sending a request to MAA that contains all of the following. The request must:

(a) Be in writing;

(b) Be received by MAA before the applicable time period has elapsed;

(c) Include the reason(s) for the request; and

(d) Include the date the contractor/provider expects to submit or respond to requested information.

(17) When a contractor/provider requests an audit appeal hearing, and the entire audit period falls on or after July 1,

1998, the audit hearing is governed by the process in RCW 43.20B.675.

(18) MAA considers that a contractor/provider has abandoned the dispute, if the provider fails to identify and attempt to resolve disputed audit findings as provided in this section, has abandoned the dispute. MAA proceeds with issuing and/or implementing the final audit report.

(19) Based on the findings of an audit, MAA may order the provider to repay excess benefits or payments received, as follows:

(a) MAA may assess civil penalties as provided for in chapter 74.09 RCW;

(b) The amount of civil penalties may not exceed three times the amount of excess benefits or payments the provider received; and

(c) The repayment includes interest on the amount of excess benefits or payments, per RCW 43.20B.695.

(20) When MAA imposes a civil penalty or suspends or terminates a provider from the program, written notice of the action taken is given to the appropriate licensing agency, disciplinary commission, and/or other entity requiring a report.

(21) When an audit shows that a provider has demonstrated a significant noncompliance with the provisions of the medical care program, MAA may refer that provider to the appropriate disciplinary commission.

(22) Where MAA finds evidence of or has reason to suspect fraud, those contractors/providers are referred to the appropriate prosecuting authority for possible criminal action.

[Statutory Authority: RCW 74.08.090, 43.20B.675. 00-23-014, § 388-502-0240, filed 11/3/00, effective 12/4/00.]

WAC 388-502-0260 Appeals and dispute resolution for providers with contracts other than core provider agreements. (1) Providers of medical services who have a contract, other than a core provider agreement, with a dispute resolution provision must follow the dispute resolution process described in the contract.

(2) See WAC 388-502-0220 for disputes involving rates. See WAC 388-502-0240 for disputes involving audits. See WAC 388-502-0230 for disputes involving provider reviews and termination.

[Statutory Authority: RCW 74.08.090, 74.09.290. 00-22-016, § 388-502-0260, filed 10/20/00, effective 11/20/00.]

Chapter 388-503 WAC
PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-503-0305 Program priorities. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-503-0305, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.

388-503-0310 Categorically needy eligible persons. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-503-0310, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-036, § 388-503-0310, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090 and SPA 95-11. 96-12-001 (Order 3981), § 388-503-0310, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-17-036 (Order 3769), § 388-503-0310, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-503-0310, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-010 and 388-82-115.] Repealed by 99-19-091, filed 9/17/99, effective 10/18/99. Statutory Authority: RCW 74.08.090.

388-503-0320 Medically needy eligible persons. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-503-0320, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-503-0320, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-005 and 388-99-010.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0100.

388-503-0350 Medical care services—GAU/ADATSA. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-503-0350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-126 and 388-83-006.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110 and 388-529-0100.

388-503-0370 Medically indigent eligible persons. [Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-503-0370, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-503-0370, filed 5/3/94, effective 6/3/94. Formerly WAC 388-100-005 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110, 388-519-0300 and 388-438-0100.

WAC 388-503-0505 General eligibility requirements for medical programs. (1) Persons applying for benefits under the medical coverage programs established under chapter 74.09 RCW must meet the eligibility criteria established by the department in chapters 388-400 through 388-555 WAC.

(2) Persons applying for medical coverage are considered first for federally funded or federally matched programs. State-funded programs are considered after federally funded programs are not available to the client except for brief periods when the state-funded programs offer a broad scope of care which meet a specific client need.

(3) Unless otherwise specified in program specific WAC, the eligibility criteria for each medical program are as follows:

(a) Verifiable of age and identity (chapters 388-404, 388-406, and 388-490 WAC); and

(b) Residence in Washington state (chapter 388-468 WAC); and

(c) Citizenship or immigration status in the United States (chapter 388-424 WAC); and

(d) Possession of a valid Social Security Account Number (chapter 388-474 WAC); and

(e) Assignment of medical support rights to the state of Washington (WAC 388-505-0540); and

(f) Cooperation in securing medical support (chapter 388-422 WAC); and

(g) Countable resources which are within program limits (chapters 388-470 and 388-478 WAC); and

(h) Countable income which are within program limits (chapters 388-450 and 388-478 WAC).

(4) In addition to the general eligibility requirements in subsection (3) of this section, each program has specific eligibility requirements as described in applicable WAC.

(5) Persons living in correctional institutions are not eligible for the department's medical coverage programs.

(6) Persons terminated from SSI or TANF cash grants and those who lose eligibility for categorically needy (CN) medical coverage have their CN coverage extended while their eligibility for other medical programs is redetermined. This extension of medical coverage is described in chapter 388-434 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0505, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0110, 388-503-0305 and 388-505-0501.]

WAC 388-503-0510 How a client is determined "related to" a categorical program. (1) A person is related to the Supplemental Security Income (SSI) program if they are:

(a) Aged, blind, or disabled as defined in WAC 388-511-1105(1); or

(b) Considered as eligible for SSI under WAC 388-511-1105(5); or

(c) Children meeting the requirements of WAC 388-505-0210(6).

(2) A person or family is considered to be related to the temporary assistance for needy families (TANF) program or the state-funded assistance (SFA) program if they meet:

(a) The program requirements for the TANF or the SFA cash assistance programs or the requirements of WAC 388-505-0220, 388-505-0210 (3) or (4), or 388-503-0310 (17)(b); or

(b) Would meet such requirements except that:

(i) The assistance unit's countable income exceeds the TANF or the SFA program standards in chapter 388-478 WAC; or

(ii) The assistance unit's countable resources exceed the cash program standards in chapter 388-470 WAC.

(3) Persons related to SSI or to TANF are eligible for categorically needy (CN) or medically needy (MN) medical coverage if they meet the other eligibility criteria for these medical programs. See chapters 388-505 and 388-519 WAC for these eligibility criteria.

(4) Persons related to SSI or to TANF and who receive the related CN medical coverage have redetermination rights as described in WAC 388-503-0505(6).

(5) Persons related to SFA are eligible for state-funded medical coverage as long as they meet the other eligibility criteria for the medical program. The state-funded medical coverage has the same scope of coverage as CN or MN coverage described in subsection (3) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0510, filed 7/31/98, effective 9/1/98.]

WAC 388-503-0515 Medical coverage resulting from a cash grant. (1) Families or individuals eligible for SSI, SSI state supplement or TANF cash grants are automatically eligible for categorically needy (CN) medical coverage. These clients receive medical coverage benefits without making a separate application. Certification for CN medical coverage parallels that for the cash benefits.

(2) Upon termination of cash benefits as described in subsection (1) of this section, medical coverage continues until the client's eligibility for other medical coverage can be completed. Continuing medical coverage is terminated if the client does not cooperate with the eligibility re-determination process.

(3) Families or individuals eligible for or related to state financial assistance (SFA) cash grants are eligible for state-funded medical coverage. For this program, the term "related-to" is defined parallel to WAC 388-503-0510(2). The scope of medical coverage parallels that for the federally funded CN program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0515, filed 7/31/98, effective 9/1/98.]

Chapter 388-505 WAC
FAMILY MEDICAL

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-505-0501 Eligibility—General. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0501, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.

388-505-0505 Age. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-505-0510 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.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-468-0010.

388-505-0520 Citizenship. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-505-0520, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 96-13-002 (Order 3983), § 388-505-0520, filed 6/6/96, effective 7/7/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-24-016 (Order 3923), § 388-505-0520, filed 11/22/95, effective 12/23/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0520, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-015.] Repealed by 98-16-050, filed

7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-424-0005 and 388-424-0010.

388-505-0530 Social Security number. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-017.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-476-0005.

388-505-0560 Cooperation in securing medical support. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0560, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-013.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-472-0005, 388-505-0540, 388-422-0005, 388-422-0010 and 388-422-0020.

388-505-0570 Good cause for noncooperation—Medical care support. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0570, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-014.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-422-0020(4)(c).

388-505-0580 Resources. [Statutory Authority: RCW 74.08.090. 96-01-005 (Order 3932, # 100268), § 388-505-0580, filed 12/6/95, effective 1/6/96; 95-02-026 (Order 3817), § 388-505-0580, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-505-0580, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-026.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0015, 388-470-0020, 388-470-0040, 388-488-0005 and 388-450-0210.

388-505-0590 Income. [Statutory Authority: RCW 74.08.090. 95-17-031 (Order 3878), § 388-505-0590, filed 8/9/95, effective 9/9/95; 95-04-047 (Order 3827), § 388-505-0590, filed 1/25/95, effective 2/25/95; 94-10-065 (Order 3732), § 388-505-0590, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-041.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0005, 388-450-0015, 388-450-0210 and 388-450-0215.

WAC 388-505-0110 Medical assistance coverage for adults not covered under family medical programs. (1) An adult who does not meet the institutional status requirements as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for categorically needy (CN) coverage under this chapter. Persons excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for CN coverage when the person:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has CN countable income and resources that do not exceed the income and resource standards in WAC 388-478-0080; and

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

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

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

(i) Was a concurrent beneficiary of Title II and Supplemental Security Income (SSI) benefits;

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

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

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

(B) All Title II COLA increases received during the time period in subsection (1)(d)(iii)(A) of this section by the client's spouse or other financially responsible family member living in the same household.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Is at least eighteen years old;

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

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

(f) Is a client who:

(i) In August 1972, received:

(A) Old age assistance (OAA);

(B) Aid to blind (AB);

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

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

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

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

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

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has MN countable income that does not exceed the income standards in WAC 388-478-0070, or meets the excess income spenddown requirements in WAC 388-519-0110; and

(c) Meets the countable resource standards in WAC 388-478-0070; and

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

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

(5) An adult may be eligible for the alien emergency medical program as described in WAC 388-438-0110.

(6) An adult is eligible for the state-funded general assistance - expedited Medicaid disability (GA-X) program when they:

(a) Meet the requirements of the cash program in WAC 388-400-0025 and 388-478-0030; or

(b) Meet the SSI-related disability standards but cannot get the SSI cash grant due to immigration status or sponsor deeming issues.

Clients may be eligible for GA cash benefits and CN medical coverage due to different sponsor deeming requirements.

(7) An adult is eligible for the state-funded medical care services (MCS) program when the person is eligible for GAU or ADATSA program coverage as described in WAC 388-478-0030.

(8) An adult is eligible for the state-funded medical indigent (MI) program when the person meets the requirements listed in WAC 388-438-0100.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0350 and 388-503-0370.]

WAC 388-505-0210 Children's medical eligibility. (1) A child under the age of one is eligible for categorically needy (CN) medical assistance when:

(a) The child's mother was eligible for and receiving coverage under a medical program at the time of the child's birth; and

(b) The child remains with the mother and resides in the state.

(2) Children under the age of nineteen are eligible for CN medical assistance when they meet the requirements for:

(a) Citizenship or U.S. national status as described in WAC 388-424-0005(1) or immigrant status as described in WAC 388-424-0010 (1) or (2);

(b) State residence as described in chapter 388-468 WAC;

(c) A social security number as described in chapter 388-476 WAC; and

(d) Family income levels as described in WAC 388-478-0075 (1)(c).

(3) Upon implementation of the children's health insurance program (CHIP) as described in chapter 388-542, WAC, children under the age of nineteen are eligible for CHIP when:

(a) They meet the requirements of subsection (2)(a) and (b) of this section;

(b) They do not have other creditable health insurance coverage; and

(c) Family income exceeds two hundred percent of the federal poverty level (FPL), but does not exceed two hundred fifty FPL as described in WAC 388-478-0075 (1)(c) and (d).

(4) Children under the age of nineteen who first physically entered the U.S. after August 21, 1996 are eligible for state-funded CN scope of care when they meet the:

(a) Eligibility requirements in subsection (2)(b), (c), and (d) of this section; and

(b) Qualified alien requirements for lawful permanent residents, parolees, conditional entrants, or domestic violence victims as described in WAC 388-424-0005 (3)(a), (c), (f), or (i).

(5) Children under the age of twenty-one are eligible for CN medical assistance when they:

(a) Meet citizenship or immigrant status, state residence, and social security number requirements as described in subsection (2)(a), (b), and (c) of this section;

(b) Meet income levels described in WAC 388-478-0075 when income is counted according to WAC 388-408-0055 (1)(c); and

(c) Meet one of the following criteria:

(i) Reside in a medical hospital, intermediate care facility for mentally retarded (ICF/MR), or nursing facility for more than thirty days;

(ii) Reside in a psychiatric or chemical dependency facility;

(iii) Are in foster care; or

(iv) Receive subsidized adoption services.

(6) Children are eligible for CN medical assistance if they:

(a) Receive Supplemental Security Income (SSI) payments based upon their own disability; or

(b) Received SSI payments for August 1996, and except for the passage of amendments to federal disability definitions, would be eligible for SSI payments.

(7) Children under the age of nineteen are eligible for Medically Needy (MN) medical assistance when they:

(a) Meet citizenship or immigrant status, state residence, and social security number requirements as described in subsection (2)(a), (b), and (c); and

(b) Have income at or above the income levels described in WAC 388-478-0075 (1)(c).

(8) A child is eligible for SSI-related MN when the child:

(a) Meets the conditions in subsection (6)(a);

(b) Meets the blind and/or disability criteria of the federal SSI program; and

(c) Has family income above the level described in WAC 388-478-0070(1).

(9) Nonimmigrant children, including visitors or students from another country and undocumented children, under the age of eighteen are eligible for the state-funded children's health program, if:

(a) The department determines the child ineligible for any CN or MN scope of care medical program;

(b) They meet family income levels described in WAC 388-478-0075 (1)(a); and

(c) They meet state residency requirements as described in chapter 388-468 WAC.

(10) There are no resource standards for the children's CN or the state-funded CN scope of care, or the children's health programs.

(11) Children may also be eligible for:

(a) Temporary assistance for needy families (TANF) or state family assistance (SFA)-related medical as described in WAC 388-505-0220; and

(b) TANF/SFA-related medical extensions as described in WAC 388-523-0100.

(12) Except for a client described in subsection (4)(c) and (d), an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for CN or MN medical coverage.

[Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-505-0210, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0905, 388-509-0910 and 388-509-0920.]

WAC 388-505-0220 Family medical eligibility. (1) A person is eligible for categorically needy (CN) medical coverage when they are:

(a) Receiving temporary assistance for needy families (TANF) cash benefits; or

(b) Receiving cash diversion assistance described in chapter 388-222 WAC; or

(c) Eligible for TANF but chooses not to receive cash benefits; or

(d) Not eligible for or receiving TANF cash assistance, but meets the eligibility criteria for aid to families with dependent children (AFDC) that were in effect on July 16, 1996 except:

(i) Earned income is treated as described in WAC 388-450-0210; and

(ii) Resources are treated as described in WAC 388-470-0005 for applicants and 388-470-0050 for recipients.

(2) A person is eligible for CN medical coverage when they are not eligible for or receiving cash benefits solely for one of the following reasons:

(a) Received sixty months of TANF cash benefits or is a member of an assistance unit which has received sixty months of TANF cash benefits; or

(b) Failed to meet the school attendance requirement in chapter 388-400 WAC; or

(c) Is an unmarried minor parent not in a department-approved living situation; or

(d) Is a parent or caretaker relative who fails to notify the department within five days of the date the child leaves the home and the child's absence will exceed ninety days; or

(e) Is a fleeing felon or fleeing to avoid prosecution for a felony charge, or a probation and parole violator; or

(f) Was convicted of a drug related felony; or

(g) Was convicted of receiving benefits unlawfully; or

(h) Was convicted of misrepresenting residence to obtain assistance in two or more states; or

(i) Has gross earnings exceeding the TANF gross income level; or

(j) Does not meet work quarter requirements; or

(k) Does not meet the unemployment requirement; or

(l) Is not cooperating with WorkFirst requirements.

(3) A person is eligible for SFA medical when:

(a) Eligible for or receiving SFA cash benefits; or

(b) Receiving SFA cash diversion assistance described in chapter 388-222 WAC; or

(c) Is not eligible for or receiving SFA solely due to factors described in subsection (2) of this section; or

(d) Meets the criteria of (1)(d) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0220, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0740 and 388-522-2210.]

WAC 388-505-0540 Assignment of rights and cooperation. (1) When a person becomes eligible for any of the department's medical programs, they make assignment of certain rights to the state of Washington. This assignment includes all rights to any type of coverage or payment for medical care which results from:

(a) A court order;

(b) An administrative agency order; or

(c) Any third-party benefits or payment obligations for medical care which are the result of **subrogation** or contract (see WAC 388-501-0100).

(2) **Subrogation** is a legal term which describes the method by which the state acquires the rights of a client for whom or to whom the state has paid benefits. The subrogation rights of the state are limited to the recovery of its own costs.

(3) The person who signs the application makes the assignment of rights to the state. Assignment is made on their own behalf and on behalf of any eligible person for whom they can legally make such assignment.

(4) A person must cooperate with the department in the identification, use or collection of third-party benefits. Failure to cooperate results in a termination of eligibility for the responsible person. Other obligations for cooperation are located in chapters 388-14A and 388-422 WAC. The follow-

ing clients are exempt from termination of eligibility for medical coverage as a result of noncooperation:

(a) A pregnant woman, and

(b) Minor children, and

(c) A person who has been determined to have "good cause" for noncooperation (see WAC 388-422-0015).

(5) A person will not lose eligibility for medical assistance programs due solely to the noncooperation of any third party.

(6) A person will be responsible for the costs of otherwise covered medical services if:

(a) The person received and kept the third-party payment for those services; or

(b) The person refused to provide to the provider of care their legal signature on insurance forms.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-505-0540, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0540, filed 7/31/98, effective 9/1/98. 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, 388-501-0170 and 388-505-0560.]

WAC 388-505-0595 Trusts. (1) For the purposes of this section, the department shall ensure a trust includes any legal instrument similar to a trust.

(2) The department shall ensure this section shall not apply to any trust or initial trust decree established:

(a) On or before April 6, 1986; and

(b) Solely for the benefit of a client who lives in an intermediate care facility for the mentally retarded (ICFMR).

(3) For trusts established on or before August 10, 1993, the department shall:

(a) Determine if the trust is established by the client, client's spouse, or the legal guardian for a client under which:

(i) The client may be the beneficiary of all or part of the payments from the trust;

(ii) The distribution of such payments is determined by one or more of the trustees; and

(iii) The trustees are permitted to use discretion with respect to the distribution of payments to the client;

(b) Consider available to the client the greatest amount of payments permitted to be distributed under the terms of the trust when the conditions defined under (a) of this subsection exist;

(c) Apply (b) of this subsection whether or not:

(i) The trust:

(A) Is irrevocable; or

(B) Is established for purposes other than to establish eligibility for medical assistance;

(ii) The trustees actually use the discretion permitted by the trust.

(d) For an irrevocable trust not meeting the description under (a) of this subsection, consider:

(i) The trust as an unavailable resource when the client establishes the trust for a beneficiary other than the client or the client's spouse;

(ii) As an available resource the amount of the trust's assets:

(A) The client may access; or

(B) The trustee of the trust distributes as actual payments to the client.

(iii) Referencing WAC 388-513-1365 for regulations concerning the transfer of assets;

(e) For a revocable trust, consider:

(i) The full amount of the trust as an available resource of the client when the trust is established by:

(A) The client;

(B) The client's spouse and the client lives with the spouse;

(C) A person other than the client or the client's spouse only to the extent the client has access to the assets of the trust.

(ii) Only the amounts paid to the client from the trust as an available resource when the trust is established by:

(A) The client's spouse and the client does not live with the spouse; or

(B) A person other than the client or the client's spouse and payments are distributed by a trustee of the trust.

(f) Not consider client withdrawal of funds from a trust as described under (e) of this subsection as income;

(g) Waive the requirements of this subsection (3) if undue hardship exists. Undue hardship includes but is not limited to situations in which:

(i) The trustee refused to disburse the funds from the trust and the client has filed and is actively pursuing litigation to require the trustee to disburse said funds; or

(ii) The client would be forced to go without life sustaining services because trust funds are not made available to pay for the services.

(4) For trusts established on or after August 11, 1993, the department shall follow subsection (3) of this section to determine eligibility for medical services received on or before September 30, 1993.

(5) For trusts established on or after August 11, 1993, the department shall follow subsections (6) through (14) of this section to determine eligibility for medical services received on or after October 1, 1993.

(6) The department shall consider a trust established by the client when:

(a) All or part of the assets, as defined under WAC 388-513-1365, of the trust were from the client; and

(b) The trust was established, other than by will, by:

(i) The client or the client's spouse;

(ii) A person, including a 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, including a court or administrative body, acting at the direction of or upon the request of the client or the client's spouse.

(7) The department shall consider available to the client only the assets contributed to the trust by the client when part of the trust assets were contributed by any other person.

(8) The department shall not consider:

(a) The purposes for which a trust is established;

(b) Whether the trustees have or exercise any discretion under the terms of the trust;

(c) Restrictions on when or whether distributions may be made from the trust; or

(d) Restrictions on the use of distributions from the trust.

(9) For a revocable trust established as described under subsection (6) of this section, the department shall consider:

(a) The full amount of a revocable trust as an available resource of the client;

(b) Payments from the trust to or for the benefit of the client as income of the client; and

(c) Any payments from the trust other than payments described under (b) of this subsection as a transfer of client assets.

(10) For an irrevocable trust established as described under subsection (6) of this section, the department shall consider:

(a) As an available resource to the client, the portions of a trust or the income from the trust from which payment can be made to or for the benefit of the client. When payment is made from such irrevocable trust, the department shall consider such payments as:

(i) Income to the client when payment is to or for the client's benefit; or

(ii) The transfer of an asset when payment is made to any person for any purpose other than the client's benefit;

(b) As a transfer of assets, a trust from which a payment cannot be made to or for the client's benefit. For such trust the department shall find:

(i) The transfer of assets is effective the date:

(A) Of the establishment of the trust; or

(B) On which payment to the client is precluded, if later;

(ii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(11) For a revocable or irrevocable trust established by persons or with funds other than as described under subsection (6) of this section, the department shall consider such trust under subsection (3)(e) of this section.

(12) The department shall not follow subsections (6) through (11) of this section for a trust containing the assets of a person:

(a) Sixty-four years of age and younger who is disabled as defined by SSI criterion and the trust:

(i) Is established for the benefit of such person by such person's parent, grandparent, legal guardian, or a court; and

(ii) Stipulates that the state will receive all amounts remaining in the trust upon the death of the client up to the amount of Medicaid expended on the client's behalf.

(b) Regardless of age, who is disabled as defined by SSI criteria and the trust:

(i) Is managed by a nonprofit association which:

(A) Maintains separate accounts for each trust beneficiary; and

(B) May pool such separate accounts only for investment and fund management purposes.

(ii) Stipulates that the state will receive all amounts remaining in the client's trust account upon the death of the client up to the amount of Medicaid expended on the client's behalf.

(13) The department shall waive the application of this section if the client establishes undue hardship exists. Undue hardship includes, but is not limited to, situations where the client would be forced to go without life sustaining services.

(14) See WAC 388-513-1365 for trusts the department determines is a transfer of assets under this section.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0595, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-041.]

Chapter 388-506 WAC
MEDICAL FINANCIAL RESPONSIBILITY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-506-0610 AFDC-related medical programs. [Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. 95-19-007 (Order 3895), § 388-506-0610, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. 95-10-025 (Order 3847), § 388-506-0610, filed 4/26/95, effective 5/27/95; 94-17-034 (Order 3767), § 388-506-0610, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-506-0610, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-046 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055, 388-450-0005 and 388-470-0070.

388-506-0630 SSI-related income deeming. [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.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055 and 388-450-0150.

WAC 388-506-0620 SSI-related medical clients. (1) The department shall consider income and resources for an institutionalized:

(a) Child as described under WAC 388-513-1315(6); or

(b) Spouse as described under WAC 388-513-1330 and 388-513-1350.

(2) The department shall consider the income and resources of spouses as available to each other through the month in which the spouses stopped living together. See WAC 388-513-1330 and 388-513-1350 when a spouse is institutionalized.

(3) The department shall follow WAC 388-515-1505, 388-515-1510, or 388-515-1530 when one or both spouses are receiving community options program entry system (COPES), community alternatives program (CAP), outward bound residential alternatives (OBRA), or coordinated community aids service alternatives (CASA) waivered service program.

(4) The department shall allow a community spouse applying for medically needy a spousal deduction equal to the one-person medically needy income level (MNIL) less the spouse's income when:

(a) The community spouse is living in the same household as the spouse; and

(b) The spouse is receiving home-based and community-based services.

(5) The department shall consider income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a congregate care facility (CCF), adult family home (AFH), adult residential rehabilitation

center/adult residential treatment facility (ARRC/ARTF), or division of developmental disability-group home (DDD-GH) facility when:

(a) Only one spouse enters the facility;

(b) Both spouses enter the same facility but have separate rooms; or

(c) Both spouses enter separate facilities.

(6) The department shall consider income and resources jointly when spouses are placed in a CCF, AFH, ARRC/ARTF, or DDD-GH facility and share a room.

(7) See Wac 388-408-0055 for rules on medical assistance units that include SSI-related persons.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-506-0620, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0620, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-025.]

Chapter 388-510 WAC
ALIEN MEDICAL ELIGIBILITY

WAC

388-510-1005 Definitions—Aliens.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-510-1020 Alien—Eligibility.[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530. and RCW 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-510-1020, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-510-1020, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. Later promulgation, see WAC 388-424-0005.

388-510-1030 Alien—Deeming.[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-510-1030, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. Later promulgation, see WAC 388-470-0060(6).

WAC 388-510-1005 Definitions—Aliens. "Legal immigrant" means an alien residing in the United States who is lawfully present with intent to remain. A legal immigrant includes, but is not limited to, an alien meeting PRUCOL criteria.

"Nonimmigrant" means an alien legally residing in the country but without an intent to remain permanently or who is not lawfully present.

"PRUCOL" means a person permanently residing under color of law.

"Qualified alien" means an alien:

(1) Who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 12, Sec. 101 (a)(20));

(2) Who is a refugee admitted to the United States under section 207 of such Act;

(3) Who is granted asylum under section 208 of Act;

(4) Whose deportation is being withheld under section 243(h) of such Act;

(5) Who is paroled into the United States under section 212 (d)(5) of such Act for a period of at least one year;

(6) Who is granted conditional entry under section 203 (a)(7) of such Act as in effect prior to April 1, 1980;

(7) Who is a victim of domestic violence or an immigrant child that has been battered or subjected to extreme cruelty when:

(a) The immigrant petitions for legal status under section 204(a) of the INA or a petition for suspension of deportation under section 244(a) of the INA; and

(b) The person responsible for the battery no longer resides with the immigrant.

(8) Who is a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or

(9) Who is an Amerasian immigrant as defined in the Balanced Budget Agreement of 1997.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-510-1005, filed 7/13/98, effective 7/30/98.]

Chapter 388-511 WAC
SSI-RELATED MEDICAL ELIGIBILITY

WAC

388-511-1105 SSI-related eligibility requirements.

388-511-1130 SSI-related income availability.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-511-1110 SSI-related resource standards. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1110, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-050.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0050 and 388-478-0080.

388-511-1115 SSI-related income standards. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1115, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0070 and 388-478-0055.

388-511-1140 SSI-related income exemptions. [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.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020 and 388-450-0040.

388-511-1150 SSI-related resource availability. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-040.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see chapter 388-470 WAC.

388-511-1160 SSI-related resource exemptions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 42 CFR 435.601 and Section 4735 of the Federal Balanced Budget Act of 1997 (Public Law 105-33 (H.R. 2015)). 98-

04-031, § 388-511-1160, filed 1/29/98, effective 3/1/98. 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.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0040.

388-511-1170 SSI—State data exchange. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1170, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

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 categorically needy. Such ineligible spouse may be eligible for noninstitutional medically needy.

(4) The client shall be resource eligible under WAC 388-478-0080 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 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-511-1105, filed 9/1/98, effective 9/1/98. 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:

(1) Considers client checks received in advance of the month of normal receipt as income in the month of normal receipt;

(2) Considers electronically transferred client funds available as income in the month of normal receipt, regardless of the date the banking institution posted the funds to the client's bank account;

(3) Includes as countable income to the client any earned or unearned income amounts withheld due to garnishment under a court, administrative or agency order. See WAC 388-513-1380 (7)(a) for garnishment that affects an institutionalized client; and

(4) Requires a client, as a condition of eligibility, to take all necessary steps to obtain any of the following benefits to which the client is entitled unless the client can show good cause for not doing so:

(a) Annuity;

(b) Pension;

(c) Retirement;

(d) Disability; and

(e) Other benefits, including but not limited to:

(i) Unemployment compensation;

(ii) Veteran's compensation; or

(iii) Old age survivor's disability insurance (OASDI).

[Statutory Authority: RCW 74.04.050, 74.08.090. 00-22-029, § 388-511-1130, filed 10/23/00, effective 12/1/00. 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).]

Chapter 388-512 WAC
SSI-RELATED GRANDFATHERED RECIPIENTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-512-1280 Application following termination. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1280, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-080.] Repealed by 98-04-004, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510.

WAC 388-512-1210 Program description. The department shall provide medical assistance within limitations set forth in these rules and regulations to a person who is a grandfathered client.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-010.]

WAC 388-512-1215 General eligibility. (1) There is no requirement of citizenship as a condition of eligibility for benefits under the medical care program.

(2) Residence; see WAC 388-504-0470.

(3) Medical need. The grandfathered client must have a medical need to remain eligible for medical assistance under Title XIX of the Social Security Act. Disability shall not constitute a medical need; treatment of disability does.

(4) The grandfathered client shall be:

(a) Age sixty-five or older; or

(b) Disabled as defined in WAC 388-512-1225; or

(c) Blind as defined in WAC 388-512-1220 and not publicly soliciting alms by wearing, carrying or exhibiting signs denoting blindness, carrying receptacles for the reception of alms or doing the same by proxy or by begging. It shall be assumed that a person is not soliciting alms unless there is evidence to the contrary.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1215, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-015.]

WAC 388-512-1220 Eligibility—Blindness. "Blindness" is defined in terms of ophthalmic measurements as:

(1) Central visual acuity of 20/200 or less in the better eye with the best possible corrective glasses; or

(2) Contraction of the peripheral field of vision to within twenty degrees of the fixation point in all quadrants as determined by standard parametric testing; or

(3) Muscle function, measured in all parts of the motor field and charted upon 20 rectangles, 4 x 5 degrees in size, equal to 18/20 binocular or monocular.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-020.]

WAC 388-512-1225 Permanently and totally disabled. (1) In general, **"permanently and totally disabled"** means that a person has some permanent physical or mental impairment, disease or loss that substantially precludes a person from engaging in a useful occupation within a person's competence, such as holding a substantially gainful job or homemaking. The impairment may be physical or mental, organic or functional, and of such degree as to interfere with the person's faculties, such as senses, reasoning, or mobility. It may exist from birth, be acquired during the lifetime of the person, or result from an accident. It may be obvious, such as the loss of a limb, or it may be such that it can be revealed only by medical examination. It may exist singly or in combination.

(2) The term **"permanently disabled"** refers to the existence of a physiological, anatomical, emotional and/or mental impairment verified by medical findings, which is of major importance, and is a condition not likely to improve, but will continue throughout the lifetime of the person. Any condition which is considered by the medical reviewer as not likely to respond to any known therapeutic procedure shall be deemed to be a permanent impairment. Any condition which is considered as likely to remain static or to become worse unless certain therapeutic measures are carried out shall be deemed to be permanent so long as treatment is unavailable, inadvisable, or the person refuses treatment and his decision is reasonable. See WAC 388-512-1230.

(a) A decision that an impairment is permanent can be made even though recovery from the impairment is possible. The discovery of new drugs or other advances in medical treatment is always a potential which may change a permanent situation; pending the actual physical improvement, the classification is proper. Therefore, the term "permanent" need not be everlasting or unchangeable, but is used in the sense of continuing indefinitely as distinct from temporary or transient.

(b) A physician's medical report must be used to establish the existence of an impairment and its permanency.

(3) The term **"totally disabled"** refers to a person's ability to perform those activities necessary to carry out specified responsibilities such as those necessary to employment or homemaking. Totality involves considerations in addition to those verified through the medical findings such as age, training, skills, and work experience, and the person's functioning in a person's particular situation in light of the impairment. Such social data will describe the person's education and work history, the activities required of the person at home or at work, living conditions, interests, capacity and limitations, and the extent to which the person has adjusted to the impairment.

(a) Job training may enable a permanently and totally disabled person to acquire a new skill in spite of the impairment. The person continues to be totally disabled during a reasonable period of training and until job competence is acquired.

(b) The social summary must show how the person reacts in social situations in order to illustrate that the disability substantially precludes the person from engaging in employment or homemaking in the foreseeable future. The social worker carries the major responsibility for providing the state office review team with the recorded objective social information bearing on the totality factor.

(4) The term **"substantially precludes"** relates to the extent to which a person's permanent impairment has left a

person unable to engage in those activities necessary to carry on specified responsibilities such as employment and homemaking. If a person is able to perform such activities well enough and with sufficient regularity to receive substantial payment for such effort or to carry on homemaking responsibilities on a continuing basis, the person is not considered as precluded from engaging in "useful occupations" and cannot be found to be permanently and totally disabled.

(5) The term **"useful occupations"** means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value. The person whose impairment is so severe that it results in being unable to leave bed, leave home, or maintain body hygiene without the help of another person, and for whom the assumption would commonly be made that the person could not engage in any useful occupation, but in fact, through supreme effort the person does some work shall have ability to work evaluated in light of:

(a) The extent to which sympathy or compassion enters into the opportunity to engage in remunerative work. In other words, is the person able to do something because family, friends, or neighbors help more than is usual; for example, running errands, bringing materials, "engineering" the job, helping devise and create special tools, creating a market based more on sympathy than intrinsic value received, selling through church or other organization without charging the usual commission, etc.; and

(b) The extent to which the energy which must be discharged by the person is far beyond that which is ordinarily required for that activity. For example, does it take six or seven hours to do what most workers could do in an hour.

(c) If through careful consideration of such facts, in addition to the medical and social reports, it can be reasonably concluded that this person is doing more than can ordinarily be expected from persons with the impairments of similar severity, but activity is not substantially gainful, a finding of permanent and total disability may be reached.

(6) The term **"homemaking"** involves the ability to carry the home management and decision-making responsibilities and provide essential services within the home for at least one person in addition to oneself. This may be either a man or a woman. If homemaking is such that children are neglected or the other person receives practically no benefit from the homemaking efforts, these facts should be clearly shown in the social summary. If the homemaker must have the help of other persons to complete the essential household tasks, it may be shown that the person is not actually able to perform as a homemaker. The following activities are important to successful performance of the occupation of homemaking: Shopping for food and supplies; planning and preparing meals; washing dishes; cleaning house; making beds; washing and ironing clothes and, if the care of young children is within the homemaking responsibility, lifting and carrying infants; bathing and dressing young children; training and supervising children; accompanying children to community activities and to sources of medical care. A finding that a person is unable to perform the occupation of homemaking would require that the person is unable to perform a significant combination or grouping of these activities because of permanent impairment. When homemaking is the responsibility of the applicant, determination shall be made as to whether a permanent impairment prevents the client from totally meeting such responsibility.

(7) Special emotional problems.

(a) Alcoholism. For alcoholism to be considered permanently and totally disabling, at least one of the following criteria are required for approval of permanent and total disability:

(i) Evidence that a pathological or demonstrable organic damage has resulted from chronic alcoholism, such as neuritis or cirrhosis of the liver; or

(ii) Evidence that the alcoholism has reached the addiction state as shown by marked ethical deterioration, the obsessive character of the drinking, the approaching loss of alcohol tolerance, prolonged bouts, and a breakdown of the rationalization pattern; or

(iii) A history of several years of excessive drinking to the extent that it has adversely affected interpersonal relationships and social and economic functioning—loss of employment and inability to sustain employment because of excessive drinking.

(b) Personality inadequacy. Even though the medical report does not show a physical ailment which of itself is permanently disabling, a person may be found to be permanently and totally disabled if the medical or psychiatric report together with the social report supplemented with a psychological report, if indicated, shows an extended history of a combination of personality problems, character disorders or social inadequacies including unusual behavior, which prevents the person from making the adjustment required for an employable person or homemaker.

(i) This would include the person whose responses to the environment are habitually inadequate and who seems to have limited or no voluntary control over reactions. The symptoms of this emotionally unstable personality usually are demonstrated in antisocial or unconventional behavior; for example, drug addiction or alcoholism. The person does not get along with other people and may break many of society's rules. Most of these persons have had one difficulty after another since childhood with the typical lack of awareness and lack of remorse that is associated with this kind of behavior. The repetitive nature of their problems coupled with lack of motivation for change produces a person whose pattern provides a serious permanent impairment that can be totally disabling. Examples of this kind of personality might be:

(A) A patient returning from a mental hospital who is no longer psychotic but whose behavior would be unacceptable to a prospective employer or to family;

(B) The person who has never been able to hold a job due to a pattern of emotional instability, or other unusual behavior which shows that the person is unable, for an extended period, to substantially engage in any gainful occupation or homemaking;

(C) Drug addiction over an extended period of time.

(ii) In all cases of personality inadequacy, the reports specified in (b) of this subsection are required.

[Statutory Authority: RCW 74.08.090. 95-02-025 (Order 3816), § 388-512-1225, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-512-1225, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-025.]

WAC 388-512-1230 Refusal to accept medical treatment. (1) A disabled client who refuses without good cause to accept available medical treatment which can reasonably be expected to render the client able to work or do homemaking shall become ineligible.

(2) **"Available medical treatment"** shall mean medical, surgical or psychiatric therapy, or any combination of these treatments.

(3) **"Reasonably be expected to render the client able to work or do homemaking"** shall mean that, in the opinion of the state review team, the recommended medical, surgical, or psychiatric therapy is of such a nature and prognosis that, in the specific instance of the person involved, medical experience indicates that the recommended treatment will restore or substantially improve the person's ability to work for pay in a regular and predictable manner or to engage in homemaking.

(4) A client has good cause to refuse recommended medical treatment when, according to the best objective judgment of the state office review team, such refusal is based upon one or more of the following conditions:

(a) The person is genuinely fearful of undergoing recommended treatment. Such fear may appear to be unrealistic, or entirely emotional in origin, or irrational; however, fear exists in such a degree that treatment would be adversely affected and the doctor may therefore be dubious about undertaking to treat the person;

(b) The person could lose a faculty, or the remaining use of faculty the client now has, and refuses to accept the risk; or

(c) The person will not accept recommended medical treatment because of definitely stated religious scruples.

(5) The controlling principle in determining whether refusal was for or without good cause rests with the state office review team which will be guided by whether a reasonable, prudent person under similar circumstances would accept the recommended treatment. The determination will be made only after considering all social and medical evidence, including that furnished by the person, who will be provided with an opportunity to set forth in writing objective reasons for declining recommended treatment. A determination that a refusal to accept treatment without good cause is a decision which the client may appeal according to chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-512-1230, filed 12/29/00, effective 1/29/01; 94-10-065 (Order 3732), § 388-512-1230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-030.]

WAC 388-512-1235 Review for disability or blindness. (1) The grandfathered client's blindness or permanent and total disability shall be reviewed when a significant change has occurred.

(2) When a change in blindness occurs, an eye examination shall be secured from an ophthalmologist or optometrist and evaluated by the department's ophthalmological consultant. The ophthalmological consultant shall determine and certify whether legal blindness continues to exist.

(3) When a change in disability has occurred, a medical examination shall be secured. The medical reports shall be evaluated by the office of disability insurance to determine whether permanent and total disability continues to exist.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1235, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-035.]

WAC 388-512-1240 Computation of available income. (1) Income and net income shall be as defined in WAC 388-22-030. Total income of a beneficiary of supplementary security income is not considered an available resource except for institutionalized clients.

(2) To determine available income, deduct the following items from net income:

(a) Support payments being paid by the client under court order;

(b) Special nonmedical needs, such as payment to a wage earner's plan (specified by the court in a bankruptcy proceeding), or previously contracted major household repairs if failure to make payments would result in garnishment of wages or loss of employment;

(c) Tax rebates or special payments exempted by federal regulations and publicized by numbered memoranda from the state office.

(3) The exempt earned income shall be:

(a) For a former recipient of old age assistance or of disability assistance—the first twenty dollars plus one-half of the next sixty dollars;

(b) For a former recipient of aid to the blind—the first eighty-five dollars plus one-half of the amount over eighty-five dollars.

(4) Personal and nonpersonal work expense shall be deducted from earned income as follows:

(a) Mandatory deductions as required by law or as a condition of employment;

(b) Necessary cost of public transportation or eight cents a mile for private car to and from place of employment;

(c) Expenses of employment which are necessary to that employment such as tools, materials, union dues;

(d) Additional clothing costs. For a person doing clerical work, five dollars and seventy cents; for a person doing manual work, three dollars and sixty cents; for persons enrolled in remedial education or vocational training course, the actual cost of uniforms and/or special clothing;

(e) The cost of child care necessary to employment if not provided without cost or as departmental service. The actual expense shall be deducted but not to exceed standard in WAC 388-16-215.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1240, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-040.]

WAC 388-512-1245 Monthly maintenance standard—Own home. (1) The following monthly standards of available income for maintenance shall apply when determining financial eligibility:

FAMILY SIZE	STANDARD	FAMILY SIZE	STANDARD
1	$195	10	$591
2	$237	11	$635
3	$282	12	$679
4	$327	13	$723
5	$371	14	$768
6	$415	15	$812

7	$459	16	$856
8	$503	17	$900
9	$547	18	$944

(2) Forty-four dollars shall be added for each additional member.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1245, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-045.]

WAC 388-512-1250 Monthly maintenance standard—Person in institution. (1) The monthly standard for clothing and personal maintenance for a person in a skilled nursing facility or general hospital shall be twenty-five dollars.

(2) The monthly standards for clothing and personal maintenance for a person in an intermediate care facility shall be twenty-seven dollars and thirty cents.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-050.]

WAC 388-512-1255 Available income and nonexempt resources. (1) The person's available income determined according to WAC 388-512-1240 and nonexempt resources determined according to WAC 388-512-1260 and 388-512-1265 shall be allocated for the purposes and in the order specified in this section.

(2) Maintenance needs of the person living in his own home, or of legal dependents living in the family home if the individual is in an institution:

(a) Apply maintenance standards in WAC 388-512-1245; unless

(b) The legal dependents are applying for or receive public assistance, when the appropriate grant standards apply.

(3) Maintenance needs according to WAC 388-512-1250 for a person in an institution.

(4) Supplementary medical insurance premiums for an individual not in a nursing home who is eligible for medicare during the month of authorization and the month following if not withheld from the RSDI or RR benefit. See WAC 388-529-2960.

(5) Health and accident insurance premiums for policies continued in force from time of application.

(6) Costs not covered under this program for medical or remedial care as determined necessary by eligible providers according to WAC 388-87-005 (2)(a) and (h) initiated during a period of certification. See WAC 388-91-016 (1)(a).

(7) Participation in cost of care provided under this program except as provided in subsection (8) of this section; however, participation may not exceed:

(a) The excess regular income multiplied by six or the anticipated excess income that will be available within a six-month period, whichever is greater;

(b) The resources in excess of those listed in chapter 388-216 WAC. See WAC 388-512-1260;

(c) Additional cash resources that come into possession of the person during a period of certification.

(8) The twenty percent increase in Social Security benefits shall be considered exempt income when determining eligibility and participation for persons who in August 1972 received OAA, AFDC, AB or DA and also received RDSI benefits and who became ineligible for OAA, AFDC, AB or DA solely because of the twenty percent increase in Social Security benefits under Public Law 92-366.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1255, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-055.]

WAC 388-512-1260 Exempt resources. When determining the eligibility of the grandfathered client, the rules for exempt resources in chapter 388-216 WAC shall apply. When separate property is a consideration, see WAC 388-216-2100.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1260, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-060.]

WAC 388-512-1265 Nonexempt resources. (1) All resources not specifically exempted in WAC 388-512-1260 shall be considered available for medical and nonmedical needs following priorities set forth in WAC 388-512-1245 through 388-512-1255. Value shall be assigned resources according to WAC 388-216-2800.

(2) The possession of a nonexempt resource affects eligibility for medical care. Except for nonexempt real property, the value assigned to such resources shall be the "fair market value." The "fair market value" of the resource is considered available toward the cost of medical care. Such amount is considered at the time of each review for as long as the resource is possessed by the client.

(3) When assigning value to nonexempt real property, follow this sequence:

(a) First consideration shall be given to the sale of nonexempt real property based on the "quick sale value."

(b) When sale is not possible, rental or lease must be considered with the income derived from such rental or lease being considered available to meet the cost of medical care.

(c) If the property cannot be sold, rented, or leased and if the client has used reasonable diligence in seeking a purchaser, renter, or lessee, then no resource value for this property shall be considered to exist for the purpose of determining eligibility. The property shall remain on the market for as long as the client is certified for medical care.

(4) An application for medical assistance from a person who refuses to dispose of his property or refuses to attempt to dispose of his property shall be denied.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1265, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-065.]

WAC 388-512-1275 Continuing certification. (1) A grandfathered client who continues to meet requirements under this chapter is eligible for medical assistance.

(2) When a grandfathered client does not meet the requirements under this chapter, the department shall:

(a) Terminate the client's medical assistance; and

(b) Redetermine the client's eligibility under chapter 388-511 WAC.

[Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510. 98-04-004, § 388-512-1275, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1275, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-075.]

Chapter 388-513 WAC
CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-513-1300 Applicability of alternate living and institutional rules. [Statutory Authority: RCW 74.08.090. 95-06-025 (Order 3834), § 388-513-1300, filed 2/22/95, effective 3/25/95.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act.

388-513-1310 Resource standard—Institutional. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1310, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-390.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act.

WAC 388-513-1301 Definitions related to long-term care (LTC) services. This section defines the meaning of certain terms used in chapters 388-513 and 388-515 WAC. Within these chapters, institutional, waivered, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used. Definitions of terms used in certain rules that regulate LTC programs are as follows:

"Add-on hours" means additional hours the department purchases from providers to perform medically-oriented tasks for clients who require extra help because of a handicapping condition.

"Alternate living facility (ALF)" means one of the following that are contracted with the department to provide certain services:

(1) Adult family home (AFH) is a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care.

(2) Adult residential care facility (ARC) (formally know as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision.

(3) Adult residential rehabilitation center (ARRC) or Adult residential treatment facility (ARTF) is a licensed facility that provides its residents with twenty-four hour residential care for impairments related to mental illness.

(4) Assisted living facility (AL) is a licensed facility for aged and disabled low income persons with functional disabilities. COPES eligible clients are often placed in assisted living.

(5) Division of developmental disabilities (DDD) group home (GH) is a licensed facility that provides its residents with twenty-four hour supervision.

(6) Enhanced adult residential care facility (EARC) is a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs.

"Annuity" means a policy, certificate, or contract that is an agreement between two or more parties to purchase a right to receive periodic income of a specified amount for a specified period of time.

"Assets" means all the income and resources of the client and the client's spouse. This includes any income and resources they are entitled to but do not receive because of action by:

(1) The client or the spouse;

(2) An individual, court or administrative body, with legal authority to act in place of or on behalf of the client or the spouse; or

(3) An individual, court or administrative body, acting at the direction or upon the request of the client or the spouse.

"Clothing and personal incidentals (CPI)" means a standard allowance intended for clothing and other personal expenses for clients who live in a medical or alternate living facility. This allowance is sometimes referred to as the client's personal needs allowance (PNA).

"Community alternatives program (CAP)" means a Medicaid-waivered program that provides home and community-based services as an alternative to an institution for the mentally retarded (ICF-MR) to persons determined eligible for services from DDD.

"Community options program entry system (COPES)" means a Medicaid-waivered program that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility.

"Community spouse (CS)" means a person who does not receive institutional, waivered, or hospice services and is legally married to an institutionalized client.

"Comprehensive assessment (CA)" means the evaluation process used by a department designated social worker to determine the client's need for long-term care services.

"Coordinated community AIDS service alternative (CASA)" means a Medicaid-waivered program that provides a person with Acquired Immune Deficiency Syndrome (AIDS) or Disabled Class IV Human Immunodeficiency Virus (HIV) and at risk of hospitalization with the option to remain at home or in an alternate living facility.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the local market at the time of transfer or assignment. A transfer of assets for love and affection is not considered a transfer for FMV.

"Federal benefit rate (FBR)" means the basic benefit amount the Social Security Administration (SSA) pays to clients who are eligible for the Supplemental Security Income (SSI) program.

"Hospice" means a Medicaid program that provides a client with a terminal illness a variety of treatment alternatives that can be received either at home or in a nursing facility.

"Institutional services" means services paid for by Medicaid or state payment and provided in a nursing facility or equivalent care provided in a medical facility.

"Institutional status" means what is described in WAC 388-513-1320.

"Institutionalized client" means a client who has attained institutional status as described in WAC 388-513-1320.

"Institutionalized spouse" means a client who has attained institutional as described in WAC 388-513-1320 and is legally married to a person who is not an institutionalized client.

"Legally married" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"Life estate" means an ownership interest in property limited to the owner's lifetime or, in some cases, to a lesser period. Its duration depends upon the lifetime of the owner or on the occurrence of some specific event, such as remarriage of the owner. Ordinarily, the owner of a life estate has the right: of possession, to use the property, to sell interest in the life estate, and to any income produced by the life estate. A contract establishing the life estate may restrain one or more rights of the owner.

"Likely to reside" means there is a reasonable expectation the client will remain in a medical facility for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"Long-term care (LTC) services" means institutional, waivered, and hospice services.

"Look-back period" means the number of months prior to the month of application for LTC services.

"Maintenance needs amount" means a monthly income amount a client keeps or that is allocated to a spouse or dependent family member who lives in the client's home.

"Medical facility" means an establishment that provides food, shelter, and medical care to four or more persons unrelated to the proprietor. (This definition does not include correctional facilities.) Medical facilities are limited to the following:

(1) A private or public medical facility licensed as a hospital and certified for Medicaid.

(2) Institution for mental disease (IMD), which is a hospital, nursing facility, or other facility of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(3) Institution for the mentally retarded (IMR), which is an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with mental retardation and related conditions. It provides, in a protected residential setting, ongoing care, twenty-four hour supervision, evaluation, and planning to help each person function at his/her greatest ability. Includes intermediate care facilities for the mentally retarded (ICF-MR).

(4) Nursing facility (NF), which is an institution or part of an institution licensed as a nursing facility or hospital which has a contract with DSHS to provide care for Medicaid clients.

(5) Residential habilitation center (RHC), which is a state-operated facility certified to provide ICF-MR and/or nursing facility level of care for persons with developmental disabilities.

"Medically intensive children (MIC)" program means a Medicaid-waivered program that enables medically fragile children under age eighteen to live in the community. The program allows them to obtain medical and support services necessary for them to remain at home or in a home setting instead of in a hospital. Eligibility is included in the OBRA program described in WAC 388-515-1510.

"Noninstitutional medical assistance" means medical benefits provided by Medicaid or state-funded programs that do not include LTC services.

"Nursing facility turnaround document (TAD)" means the billing document nursing facilities use to request payment for institutionalized clients.

"Outward bound residential alternative (OBRA)" means a Medicaid-waivered program that provides a person approved for services from DDD with the option to remain at home or in an alternate living facility.

"Penalty period" means a period of time for which a client is not eligible to receive LTC services.

"Personal needs allowance (PNA)" means a standard allowance for clothing and other personal needs for clients who live in a medical or alternate living facility. This allowance is sometimes referred to as "CPI."

"Prouty benefits" means special "age seventy-two" Social Security benefits available to persons born before 1896 who are not otherwise eligible for Social Security.

"Short stay" means a person who has entered a medical facility but is not likely to remain institutionalized for thirty consecutive days.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program

that is three hundred percent of the SSI Federal Benefit Rate (FBR).

"SSI-related" means an aged, blind, or disabled client who meets the requirements described in WAC 388-503-0510(1).

"Swing bed" means a bed in a medical facility that is contracted as both a hospital and a nursing facility bed.

"Transfer of a resource or asset" means any act or failure to act, by a person or a nonapplying joint tenant, whereby title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means the person is not able to meet shelter, food, clothing, or health needs.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

(1) Aid and attendance for an individual needing regular help from another person with activities of daily living;

(2) Housebound for an individual who, when without assistance from another person, is confined to the home.

(3) Improved pension is the newest type of VA disability pension. It is available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount.

(4) Unusual medical expenses (UME) are determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both.

"Waivered programs/services" means programs for which the federal government authorizes exceptions to Medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under Medicaid. In Washington state, waivered programs are CAP, CASA, COPES, MIC, and OBRA.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1301, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1305 Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF). This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC 388-478-0045 for the personal needs allowance (PNA) amount that applies in this rule.

(1) Alternate living facilities include the following:

(a) An adult family home (AFH);

(b) An adult residential care facility (ARC);

(c) An adult residential rehabilitation center (ARRC);

(d) An adult residential treatment facility (ARTF);

(e) An assisted living facility (AL);

(f) A division of developmental disabilities (DDD) group home (GH); and

(g) An enhanced adult residential care facility (EARC).

(2) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program that cannot exceed the special income level (SIL) equals the following amounts. For a client who lives in:

(a) An ARC, an ARRC, an ARTF, an AL, a DDD GH, or an EARC, the department-contracted rate based on a thirty-one day month plus the PNA; or

(b) An AFH, the department-contracted rate based on a thirty-one day month plus the PNA plus the cost of any add-on hours authorized by the department.

(3) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility rate based on a thirty-one-day month plus the PNA.

(4) The monthly income standard for noninstitutional medical assistance under the general assistance (GA) program equals the GA grant standard described in WAC 388-478-0030.

(5) The department determines a client's nonexcluded resources as described in chapter 388-470 WAC and WAC 388-505-0595.

(6) The department determines a client's nonexcluded income as described in chapter 388-450 WAC, WAC 388-505-0595, 388-506-0620, and 388-511-1130.

(7) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who receives Supplemental Security Income (SSI) or who is SSI-related as described in WAC 388-503-0510(1), if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client's nonexcluded income described in subsection (6) does not exceed the CN standard described in subsection (2).

(8) The department approves MN noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client satisfies any spenddown liability as described in chapter 388-519 WAC.

(9) The department approves GA noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for a client determined eligible for the program as described in WAC 388-400-0025.

(10) The client described in subsections (7) and (9) keeps the PNA amount and pays remaining income to the facility for board and room.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1305, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1305, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1305, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-036 and 388-99-036.]

WAC 388-513-1315 Eligibility for long-term care (institutional, waivered, and hospice) services. This section describes how the department determines a client's eligibility for institutional, waivered, or hospice services under the categorically needy (CN) program and institutional or hospice services under the medically needy (MN) program. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (11) and emergency medical programs described in subsections (10) and (12).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a) through (f);

(b) Attain institutional status as described in WAC 388-513-1320; and

(c) Not be subject to a penalty period of ineligibility as described in WAC 388-513-1365 and 388-513-1366.

(2) To be eligible for institutional, waivered, or hospice services under the CN program, a client must either:

(a) Be related to the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1) or be approved for the general assistance expedited Medicaid disability (GA-X) program; and

(b) Meet the following financial requirements, by having:

(i) Gross nonexcluded income described in subsection (7)(a) that does not exceed the special income level (SIL); and

(ii) Nonexcluded resources described in subsection (6) that do not exceed the resource standard described in WAC 388-513-1350(1), unless subsection (3) applies; or

(c) Be eligible for the CN children's medical program as described in WAC 388-505-0210; or

(d) Be eligible for the temporary assistance for needy families (TANF) program or state family assistance (SFA) program as described in WAC 388-505-0220.

(3) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the SIL.

(4) To be eligible for waivered or hospice services, a client must also meet the program requirements described in:

(a) WAC 388-515-1505 for COPES services;

(b) WAC 388-515-1510 for CAP and OBRA services;

(c) WAC 388-515-1530 for CASA services; or

(d) Chapter 388-551 WAC for hospice services.

(5) To be eligible for institutional or hospice services under the MN program, a client must be:

(a) Eligible for the MN children's medical program as described in WAC 388-505-0210; or

(b) Related to the SSI program as described in WAC 388-503-0510(1) and meet all requirements described in WAC 388-513-1395.

(6) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers resources available as described in WAC 388-513-1350;

(b) Excludes resources described in WAC 388-513-1360, 388-513-1365, and 388-513-1366; and

(c) Compares the nonexcluded resources to the standard described in WAC 388-513-1350(1).

(7) To determine income eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;

(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;

(c) Disregards income for the MN program as described in WAC 388-513-1345; and

(d) Follows program rules for the MN program as described in WAC 388-513-1395.

(8) A client who meets the requirements of the CN program is approved for a period of up to twelve months for:

(a) Institutional services in a medical facility;

(b) Waivered services at home or in an alternate living facility; or

(c) Hospice services at home or in a medical facility.

(9) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395 (5)(a)(ii) for:

(a) Institutional services in a medical facility; or

(b) Hospice services at home or in a medical facility.

(10) The department determines eligibility for LTC services under the alien emergency medical (AEM) program described in WAC 388-438-0110 for a client who meets all other requirements for such services but does not meet citizenship requirements.

(11) The department determines eligibility for institutional services under the GA program described in WAC 388-448-0001 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (10).

(12) The department determines eligibility for institutional services under the medically indigent program described in WAC 388-438-0100 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (11).

(13) A client is eligible for Medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 388-513-1320; and

(b) Is less than twenty-one years old or is at least sixty-five years old.

(14) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

(15) The department considers the parents' income and resources available as described in WAC 388-405-0055

(1)(c) for a minor who is less than eighteen years old and is receiving or is expected to receive inpatient chemical dependency and/or inpatient mental health treatment.

(16) The department considers the parents' income and resources available only as contributed for a client who is less than twenty-one years old and has attained institutional status as described in WAC 388-513-1320

(17) The department determines a client's participation in the cost of care for LTC services as described in WAC 388-513-1380.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1315, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1315, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.08.090 and 42 CFR 435.1005. 98-04-003, § 388-513-1315, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 96-11-072 (Order 3980), § 388-513-1315, filed 5/10/96, effective 6/10/96. Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. 95-19-007 (Order 3895), § 388-513-1315, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1315, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1320 Determining institutional status for long-term care (LTC) services. Institutional status is an eligibility requirement for LTC services.

(1) To attain institutional status, a client must:

(a) Be approved for and receiving waivered or hospice services; or

(b) Reside or be likely to reside in a medical facility for a continuous period of:

(i) Ninety days for a child seventeen years of age or younger receiving inpatient chemical dependency and/or inpatient mental health treatment; or

(ii) Thirty days for:

(A) An SSI-related client;

(B) A child not described in subsection (1)(b)(i); or

(C) A client related to medical eligibility as described in WAC 388-513-1315 (10), (11), or (12).

(2) A client's institutional status is not affected by a:

(a) Transfer between medical facilities; or

(b) Change from one kind of long-term care services to another.

(3) A client loses institutional status when the client:

(a) Is absent from the medical facility for at least thirty consecutive days; or

(b) Does not receive waivered or hospice services for at least thirty consecutive days.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1320, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1320, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2). 97-15-025, § 388-513-1320, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090. 96-11-072 (Order 3980), § 388-513-1320, filed 5/10/96, effective 6/10/96; 94-10-065 (Order 3732), § 388-513-1320, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1325 Determining available income for a single client for long-term care (LTC) services. This section describes income the department considers available when determining a single client's eligibility for LTC services.

(1) Refer to WAC 388-513-1330 for rules related to available income for legally married couples.

(2) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 388-450-0005 (3) and (4), Income—Ownership and availability;

(b) WAC 388-450-0085, Self-employment income—Allowable expenses;

(c) WAC 388-450-0210 (4)(b), (e), and (h), Countable income for medical programs;

(d) WAC 388-506-0620, SSI-related medical clients;

(e) WAC 388-511-1130, SSI-related income availability; and

(f) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waivered, and hospice) services.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1325, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1330 Determining available income for legally married couples for long-term care (LTC) services. This section describes income the department considers available when determining a legally married client's eligibility for LTC services.

(1) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 388-450-0005 (3) and (4), Income—Ownership and availability;

(b) WAC 388-450-0085, Self-employment income—Allowable expenses;

(c) WAC 388-450-0210 (4)(b), (e), and (h), Countable income for medical programs;

(d) WAC 388-506-0620, SSI-related medical clients;

(e) WAC 388-511-1130, SSI-related income availability; and

(f) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waivered, and hospice) services.

(2) For an institutionalized client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available, unless subsection (4) applies:

(a) Income received in the client's name;

(b) Income paid to a representative on the client's behalf;

(c) One-half of the income received in the names of both spouses; and

(d) Income from a trust as provided by the trust.

(3) The department considers the following income unavailable to an institutionalized client:

(a) Separate or community income received in the name of the community spouse; and

(b) Income established as unavailable through a fair hearing.

(4) For the determination of eligibility only, if available income described in subsections (2)(a) through (d) minus

income exclusions described in WAC 388-513-1340 exceeds the special income level (SIL), then:

(a) The department follows community property law when determining ownership of income;

(b) Presumes all income received after marriage by either or both spouses to be community income; and

(c) Considers one-half of all community income available to the institutionalized client.

(5) If both spouses are either applying or approved for LTC services, then:

(a) The department allocates one-half of all community income described in subsection (4) to each spouse; and

(b) Adds the separate income of each spouse respectively to determine available income for each of them.

(6) The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.

(7) The department considers income not generated by a transferred resource available to the client, even when the client transfers or assigns the rights to the income to:

(a) The spouse; or

(b) A trust for the benefit of the spouse.

(8) The department evaluates the transfer of a resource described in subsection (6) according to WAC 388-513-1365 and 388-513-1366 to determine whether a penalty period of ineligibility is required.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1330, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1330, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-513-1330, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1330, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1330, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-335 and 388-95-340.]

WAC 388-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the department excludes when determining a client's eligibility and participation in the cost of care for LTC services with the exceptions described in subsections (30) and (33).

(1) Crime victim's compensation;

(2) Earned income tax credit (EITC);

(3) Native American benefits excluded by federal statute (refer to WAC 388-450-0040);

(4) Tax rebates or special payments excluded by other statutes;

(5) Any public agency's refund of taxes paid on real property and/or on food;

(6) Supplemental Security Income (SSI) and certain state public assistance based on financial need;

(7) The amount a representative payee charges to provide services when the services are a requirement for the client to receive the income;

(8) The amount of expenses necessary for a client to receive compensation, e.g., legal fees necessary to obtain settlement funds;

(9) Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution;

(10) Child support payments received from an absent parent for a minor child who is not institutionalized;

(11) The amount of expenses related to impairments of a permanently and totally disabled client that allow the client to work;

(12) The amount of expenses related to blindness that allow the client to work;

(13) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);

(14) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(15) Assistance (other than wages or salary) received under the Older Americans Act;

(16) Assistance (other than wages or salary) received under the foster grandparent program;

(17) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(18) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(19) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(20) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(21) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(22) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(23) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(24) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(25) Payments made from *Susan Walker v. Bayer Corporation, et, al.*, 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(26) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(27) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(28) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(29) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(30) Interest earned from payments described in subsections (24) through (29) is considered available and counted as nonexcluded income;

(31) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(32) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent;

(b) Unusual medical expenses, aid and attendance allowance, and housebound allowance, with the exception described in subsection (33);

(33) Benefits described in subsection (32)(b) for a client who resides in a state veterans' home and has no dependents are excluded when determining eligibility, but are considered available when determining participation in the cost of care.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-513-1340, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1340, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1340, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 388-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the department disregards when determining a client's eligibility for institutional or hospice services under the MN program. The department considers disregarded income available when determining a client's participation in the cost of care.

(1) The department disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a client is:

(i) Based on need; and

(ii) Totally or partially funded by the federal government or a private agency.

(2) For a client who is related to the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1), the first sixty-five dollars per month of earned income not excluded under WAC 388-513-1340, plus one-half of the remainder.

(3) For a TANF/SFA-related client, fifty percent of gross earned income.

(4) Department of Veterans Affairs benefits if:

(a) Those benefits are designated for:

(i) Unusual medical expenses;

(ii) Aid and attendance allowance; or

(iii) Housebound allowance; and

(b) The client:

(i) Resides in a state veterans' home; and

(ii) Has no dependents.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-513-1345, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1345, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1345, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 388-513-1350 Defining the resource standard and determining available resources for long-term care (LTC) services. This section describes how the department defines the resource standard and available resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and be resource eligible for program benefits.

(1) The resource standard used to determine eligibility for LTC services equals:

(a) Two thousand dollars for a single client; or

(b) Three thousand dollars for a legally married couple, unless subsection (2) applies.

(2) If the department has already established eligibility for one spouse, then it applies the standard described in subsection (1)(a) to each spouse, unless doing so would make one of the spouses ineligible.

(3) The department must apply the following rules when determining available resources for LTC services:

(a) WAC 388-470-0005, Resource eligibility and limits;

(b) WAC 388-470-0010, How to determine who owns a resource;

(c) WAC 388-470-0015, Availability of resources;

(d) WAC 388-470-0060(6), Resources of an alien's sponsor; and

(e) WAC 388-506-0620, SSI-related medical clients.

(4) The department determines a client's nonexcluded resources used to establish eligibility for LTC services in the following way:

(a) For an SSI-related client, the department reduces available resources by excluding resources described in WAC 388-513-1360;

(b) For an SSI-related client who has a community spouse, the department:

(i) Excludes resources described in WAC 388-513-1360; and

(ii) Adds together the available resources of both spouses according to subsection (5)(a) or (b) as appropriate;

(c) For a client not described in subsection (4)(a) or (b), the department applies the resource rules of the program used to relate the client to medical eligibility.

(5) A change in federal law that took effect on October 1, 1989 affects the way the department determines available resources of a legally married client. If the client's current period of institutional status began:

(a) On or after that date, the department adds together the total amount of nonexcluded resources held in the name of:

(i) Either spouse; or

(ii) Both spouses.

(b) Before that date, the department adds together one-half the total amount of nonexcluded resources held in the name of:

(i) The institutionalized spouse; or

(ii) Both spouses;

(6) If subsection (5)(a) applies, the department allocates the maximum amount of resources ordinarily allowed by law

to the community spouse before determining nonexcluded resources used to establish eligibility for the institutionalized spouse. The maximum allocation amount is eighty-four thousand, one hundred and twenty dollars effective January 1, 2000.

(7) The amount of allocated resources described in subsection (6) can be increased, only if:

(a) A court transfers additional resources to the community spouse; or

(b) An administrative law judge establishes in a fair hearing described in chapter 388-08 WAC that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(8) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsections (9)(a), (b), or (c) apply.

(9) A redetermination of the couples' resources as described in subsections (4)(b) or (c) is required, if:

(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;

(b) The institutionalized spouse's nonexcluded resources exceed the standard described in subsection (1)(a), if subsection (5)(a) applies; or

(c) The institutionalized spouse does not transfer the amount described in subsections (6) or (7) to the community spouse or to another person for the sole benefit of the community spouse as described in WAC 388-513-1365(4) by either:

(i) The first regularly scheduled eligibility review; or

(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1350, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1350, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.575 and Section 1924 (42 USC 1396r-5). 98-11-033, § 388-513-1350, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

WAC 388-513-1360 Determining excluded resources for long-term care (LTC) services. This section describes resources the department excludes when determining a client's eligibility for LTC services.

(1) Effective July 1, 1996, if an aged, blind, or disabled client purchases a long-term care insurance policy approved by the Washington insurance commissioner under the Washington long-term care partnership program, the department reduces the client's available resources by the amount paid by the policy for LTC services. The amount the department excludes in this process is not subject to the rules described in WAC 388-513-1365 and 388-513-1366 for a transfer of assets.

(2) The amount of resources described in subsection (1) remains subject to estate recovery rules, if the client retained ownership of them.

(3) If a client has a community spouse, the value of one automobile is excluded regardless of its use or value. This is in addition to the vehicle described in WAC 388-470-0040(7), if the client's current period of institutional status began on or after October 1, 1989.

(4) For SSI-related clients, the department excludes resources described in WAC 388-470-0020 and 388-470-0040.

(5) For clients who are not SSI-related, the department excludes resources according to the rules of the program used to relate them to medical eligibility.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1360, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1360, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and 48.85.020. 96-12-002 (Order 3982), § 388-513-1360, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1360, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-380.]

WAC 388-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1366 for rules used to evaluate the transfer of an asset made before March 1, 1997.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC 388-513-1360 with the exception of the client's home, unless the transfer meets the conditions described in subsection (1)(d);

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4), and the asset is transferred:

(i) To the client's spouse or to another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To the client's child who meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-fours years old or younger and meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) is less than the value of the transferred asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (1)(f) as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC 388-505-0595.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in subsection (6)(a)(ii).

(7) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1360 does not affect the client's eligibility;

(b) That remains after an acquisition described in subsection (7)(a) becomes an available resource as of the first day of the following month.

(8) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(9) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in (9)(a) is divided by the statewide average monthly private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole months found by following subsections (9)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-513-1365, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1365, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1365, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.585 and § 17 of the Social Security Act. 97-05-040, § 388-513-1365, filed 2/14/97, effective 3/17/97. Statutory Authority: RCW 74.08.090. 95-02-027 (Order 3818), § 388-513-1365, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-513-1365, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-395.]

WAC 388-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made before March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1365 for rules used to evaluate the transfer of an asset on or after March 1, 1997.

(1) When evaluating the transfer of an asset made before March 1, 1997, the department must apply rules described in WAC 388-513-1365 (1) through (4) and (7) through (11) in addition to the rules described in this section.

(2) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received before October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty months, if the asset was transferred before August 11, 1993; or

(b) Thirty-six months, if the asset was transferred on or after August 11, 1993.

(3) If a client or the client's spouse transferred an asset without receiving adequate compensation before August 11, 1993, the department must establish a penalty period that:

(a) Runs concurrently for transfers made in more than one month in the look-back period; and

(b) Begins on the first day of the month in which the asset is transferred and ends on the last day of the month which is the lesser of:

(i) Thirty months after the month of transfer; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(4) If a client or the client's spouse transferred an asset without receiving adequate compensation on or after August 11, 1993 and before March 1, 1997, the department must establish a penalty period as follows:

(a) If the transfer is made during the look-back period, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

(b) If the transfer is made while the client is receiving LTC services or during a period of ineligibility, then the penalty period:

(i) Begins on the latter of the first day of the month:

(A) In which the transfer is made; or

(B) After a previous penalty period has ended; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1366, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1380 Determining a client's participation in the cost of care for long-term care (LTC) services. This section describes how the department allocates income and excess resources when determining participation in the cost of care (in the post-eligibility process). The department applies rules described in WAC 388-513-1315 to define what income and resources must be used in this process.

(1) For a client receiving institutional or hospice services in a medical facility, the department applies all subsections of this rule.

(2) For a client receiving waivered services at home or in an alternate living facility, the department applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a client receiving hospice services at home, the department applies rules used for the community options program entry system (COPES).

(4) The department allocates excess resources in an amount equal to incurred medical expenses that are not subject to third-party payment and for which the client is liable, including:

(a) Health insurance and Medicare premiums, deductions, and co-insurance charges; and

(b) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan.

(5) The amount of excess resources described in subsection (4) is limited to the following amounts:

(a) For LTC services provided under the categorically needy (CN) program, the amount described in WAC 388-513-1315(3); or

(b) For LTC services provided under the medically needy (MN) program, the amount described in WAC 388-513-1395 (2)(a) or (b).

(6) The department allocates nonexcluded income up to a total of the medically needy income level (MNIL) in the following order:

(a) A personal needs allowance (PNA) of:

(i) One hundred sixty dollars for a client living in a state veterans' home;

(ii) Ninety dollars for a veteran or a veteran's surviving spouse, who receives an improved pension and does not live in a state veterans' home; or

(iii) Forty-one dollars and sixty-two cents for all other clients in a medical facility.

(b) Federal, state, or local income taxes:

(i) Mandatorily withheld from earned or unearned income for income tax purposes before receipt by the client; or

(ii) Not covered by withholding, but are owed, become an obligation, or have been paid by the client during the time period covered by the PNA.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program as described in WAC 388-503-0510 (1); 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 employment expenses are not deducted.

(d) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(7) The department allocates nonexcluded income after deducting amounts described in subsection (6) in the following order:

(a) Income garnisheed for child support:

(i) For the time period covered by the PNA; and

(ii) Not deducted under another provision in the post-eligibility process.

(b) A monthly needs allowance for the community spouse not to exceed, effective January 1, 2000, two thousand one hundred three dollars, unless a greater amount is allocated as described in subsection (9) of this section. The monthly needs allowance:

(i) Consists of a combined total of both:

(A) An amount added to the community spouse's gross income to provide a total of one thousand four hundred seven dollars; and

(B) Excess shelter expenses as specified under subsection (8) of this section; and

(ii) Is allowed only to the extent the client's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community or institutionalized spouse who:

(i) Resides with the community spouse, equal to one-third of the amount that one thousand four hundred seven dollars exceeds the dependent family member's income.

(ii) Does not reside with the community spouse, equal to the MNIL for the number of dependent family members in the home less the income of the dependent family members. Child support received from an absent parent is the child's income.

(d) Incurred medical expenses described in subsections (4)(a) and (b) not used to reduce excess resources.

(e) Maintenance of the home of a single client or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the 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 client's circumstances after ninety days.

(8) For the purposes of this section, "excess shelter expenses" equal the actual expenses under subsection (8)(b) less the standard shelter allocation under subsection (8)(a). For the purposes of this rule:

(a) The standard shelter allocation is four hundred twenty-two dollars, effective April 1, 2000; and

(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard utility allowance, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(9) The amount allocated to the community spouse may be greater than the amount in subsection (7)(b) only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(10) A client who continues to receive SSI in a medical facility does not participate the SSI income in the cost of care for medical services.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924(g) of the Social Security Act. 00-17-058, § 388-513-1380, filed 8/9/00, effective 9/9/00. Statutory Authority: RCW 72.36.160, 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924(g) of the Social Security Act, Section 4715 of the BBA of 1997 (Public Law 105-33, HR 2015). 99-11-017, § 388-513-1380, filed 5/10/99, effective 6/10/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 43.20B.460, 11.92.180, and Section 1924 (42 USC 396r-5). 98-08-077, § 388-513-1380, filed 3/31/98, effective 4/1/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(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.]

WAC 388-513-1395 Determining eligibility for institutional or hospice services and for facility care only under the medically needy (MN) program. This section describes how the department determines a client's eligibility for institutional or hospice services and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance under the MN program.

(1) To be eligible for institutional or hospice services under the MN program, a client must meet the financial requirements described in subsection (5)(a). In addition, a cli-

ent must meet program requirements described in WAC 388-513-1315; and

(a) Be an SSI-related client with nonexcluded income as described in subsection (4)(a) that is more than the special income level (SIL); or

(b) Be a child not described in subsection (1)(a) with nonexcluded income as described in subsection (4)(b) that exceeds the categorically needy (CN) standard for the children's medical program.

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total is less than the:

(a) Private facility rate plus the amount of recurring medical expenses, for institutional services; or

(b) Private hospice rate plus the amount of recurring medical expenses, for hospice services received at home.

(3) The department determines a client's nonexcluded resources for institutional and hospice services under the MN program in the following way:

(a) For an SSI-related client, the department reduces available resources described in WAC 388-513-1350 by excluding resources described in WAC 388-513-1360;

(b) For a child not described in subsection (3)(a), no determination of resource eligibility is required.

(4) The department determines a client's nonexcluded income for institutional and hospice services under the MN program in the following way:

(a) For an SSI-related client, the department reduces available income as described in WAC 388-513-1325 and 388-513-1330 by:

(i) Excluding income described in WAC 388-513-1340;

(ii) Disregarding income described in WAC 388-513-1345; and

(iii) Subtracting previously incurred medical expenses that:

(A) Are not subject to third-party payment;

(B) Have not been used to satisfy a previous spenddown liability; and

(C) Are amounts for which the client remains liable.

(b) For a child not described in subsection (4)(a), the department:

(i) Follows the income rules described in WAC 388-505-0210 for the children's medical program; and

(ii) Subtracts the medical expenses described in subsection (4)(a)(iii).

(5) If the combined total of a client's nonexcluded income, which when added to nonexcluded resources in excess of the standard described in WAC 388-513-1350(1), is:

(a) Less than the department-contracted rate plus the amount of recurring medical expenses, the client:

(i) Is eligible for institutional and hospice services and noninstitutional medical assistance;

(ii) Is approved for a choice of three or six months as described in chapter 388-416 WAC; and

(iii) Participates in the cost of care as described in WAC 388-513-1380;

(b) Less than the private facility rate plus the amount of recurring medical expenses, but more than the department-contracted rate, the client:

(i) Is eligible for facility care only that is approved for a choice of three or six months as described in chapter 388-416 WAC;

(ii) Participates in the cost of care as described in WAC 388-513-1380; and

(iii) Is approved for noninstitutional medical assistance for a choice of three or six months as described in chapters 388-416 and 388-519 WAC, if income and resources remaining after allocations described in WAC 388-513-1380 are used to satisfy any spenddown liability.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1395, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1395, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-513-1395, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-513-1395, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1395, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-400.]

WAC 388-513-1396 Clients living in a fraternal, religious, or benevolent nursing facility. This section describes how the department determines eligibility for institutional services and noninstitutional medical assistance for a client living in a fraternal, religious, or benevolent nursing facility.

(1) For a client living in a licensed nursing facility operated by a fraternal, religious, or benevolent organization who meets all other eligibility requirements, the department approves institutional services and noninstitutional medical assistance, if:

(a) Any contract between the client and the facility excludes such benefits on a free or prepaid basis for life; or

(b) The facility is unable to fulfill the terms of the contract and has:

(i) Voided the contract; and

(ii) Refunded any of the client's existing assets to the client.

(2) For a client described in subsection (1), the department denies institutional services and noninstitutional medical assistance, if the client:

(a) Signs a contract with the organization that includes such benefits on a free or prepaid basis for life; and

(b) Surrenders income and/or resources to the organization in exchange for such benefits.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1396, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1396, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-310.]

Chapter 388-515 WAC
ALTERNATE LIVING—INSTITUTIONAL MEDICAL

WAC

WAC 388-515-1505 Community options program entry system (COPES). This section describes the financial eligibility requirements for waivered services under the COPES program and the rules used to determine a client's participation in the cost of care.

(1) The department establishes eligibility for COPES for a client who:

(a) Is eighteen years of age or older;

(b) Meets the disability criteria of the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1);

(c) Requires the level of care provided in a nursing facility;

(d) Is in a medical facility, or will likely be placed in one within the next thirty days in the absence of waivered services described in WAC 388-71-0410 and 388-71-0415;

(e) Has attained institutional status as described in WAC 388-513-1320;

(f) Has been determined to be in need of waivered services and is approved for a plan of care as described in WAC 388-71-0435;

(g) Is able to live at home with community support services and chooses to do so, or in a department-contracted:

(i) Adult residential care (ARC) facility;

(ii) Enhanced adult residential care (EARC) facility;

(iii) Licensed adult family home (AFH); or

(iv) Assisted living (AL) facility.

(h) Is not subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1365 and 388-513-1366; and

(i) Meets the income and resource requirements described in subsection (2).

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

(a) Nonexcluded income must be at or below the SIL; and

(b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(3) A client who is eligible for SSI does not participate SSI income in the cost of care. Such a client who is:

(a) Living at home, retains a maintenance needs amount as described in subsection (5); or

(b) Living in an ARC, EARC, AFH, or AL:

(i) Retains a personal needs allowance (PNA) of fifty-eight dollars and eighty-four cents; and

(ii) Pays remaining SSI income to the facility for the cost of board and room.

(4) A client who is eligible for the general assistance expedited Medicaid disability (GAX) program does not participate in the cost of care. Such a client who is:

(a) Living at home, retains a maintenance needs amount as described in subsection (5); or

(b) Living in an ARC, EARC, AFH, or AL:

(i) Retains a PNA of thirty-eight dollars and eighty-four cents; and

(ii) Pays remaining income and GAX grant to the facility for the cost of board and room.

(5) An SSI-related client living at home retains a maintenance needs amount equal to the following:

(a) Up to one hundred percent of the one-person Federal Poverty Level (FPL), if the client is:

(i) Single; or

(ii) Married, and is:

(A) Not living with the community spouse; or

(B) Whose spouse is receiving long-term care (LTC) services outside of the home.

(b) Up to one hundred percent of the one-person FPL for each client, if both are receiving COPES services;

(c) Up to the one-person medically needy income level (MNIL) for a married client who is living with a community spouse who is not receiving COPES.

(6) An SSI-related client living in an ARC, EARC, AFH, or AL receives a maintenance needs amount equal to the one-person MNIL and:

(a) Retains a PNA taken from the MNIL of fifty-eight dollars and eighty-four cents; and

(b) Pays the remainder of the MNIL to the facility for the cost of board and room.

(7) The client's income that remains:

(a) After allocations described in subsection (5) or (6) is allocated as described in WAC 388-513-1380 (7)(a) through (d), (8) and (9); and

(b) After allocations described in subsection (7)(a) is the client's participation in the cost of care.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1505, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-515-1505, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-14-058 (Order 100346), § 388-515-1505, filed 6/27/96, effective 7/28/96; 95-20-030 (Order 3899), § 388-515-1505, filed 9/27/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-515-1505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-200.]

WAC 388-515-1510 Community alternatives program (CAP) and outward bound residential alternatives (OBRA). This section describes the eligibility requirements for waivered services under the CAP and OBRA programs and the rules used to determine a client's participation in the cost of care.

(1) The department establishes eligibility for CAP and OBRA services for a client who:

(a) Is both Medicaid eligible under the categorically needy (CN) program and meets the requirements for services

provided by the division of developmental disabilities (DDD);

(b) Has attained institutional status as described in WAC 388-513-1320;

(c) Has been assessed as requiring the level of care provided in an intermediate care facility for the mentally retarded (IMR);

(d) Has a department-approved plan of care that includes support services to be provided in the community;

(e) Is able to reside in the community according to the plan of care and chooses to do so;

(f) Meets the income and resource requirements described in subsection (2); and

(g) For the OBRA program only, the client must be a medical facility resident at the time of application.

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

(a) Nonexcluded income must be at or below the SIL; and

(b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(3) A client who is eligible for supplemental security income (SSI) does not participate in the cost of care for CAP or OBRA services.

(4) An SSI-related client retains a maintenance needs amount of up to the SIL, who is:

(a) Living at home; or

(b) Living in an alternate living facility described in WAC 388-513-1305(1).

(5) A client described in subsection (4)(b) retains the greater of:

(a) The SSI grant standard; or

(b) An amount equal to a total of the following:

(i) A personal needs allowance (PNA) of thirty-eight dollars and eighty-four cents; plus

(ii) The facility's monthly rate for board and room, which the client pays to the facility; plus

(iii) The first twenty dollars of monthly earned or unearned income; and

(iv) The first sixty-five dollars plus one-half of the remaining earned income not previously excluded.

(6) If a client has a spouse in the home who is not receiving CAP or OBRA services, the department allocates the client's income in excess of the amounts described in subsections (4) and (5) as an additional maintenance needs amount in the following order:

(a) One for the spouse, as described in WAC 388-513-1380 (7)(b); and

(b) One for any other dependent family member in the home, as described in WAC 388-513-1380 (7)(c).

(7) A client's participation in the cost of care for CAP or OBRA services is the client's income:

(a) That exceeds the amounts described in subsections (4), (5), and (6); and

(b) Remains after deductions for medical expenses not subject to third-party payment for which the client remains liable, included in the following:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical care recognized under state law but not covered by Medicaid.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1510, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-515-1510, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1510, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-515-1510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-210.]

WAC 388-515-1530 Coordinated community AIDS services alternatives (CASA) program. This section describes the eligibility requirements for waivered services under the CASA program and the rules used to determine a client's participation in the cost of care.

(1) The department establishes eligibility for CASA services for a client who:

(a) Meets the disability criteria of the supplemental security income (SSI) program as described in WAC 388-503-0510(1);

(b) Has attained institutional status as described in WAC 388-513-1320;

(c) Has been diagnosed with:

(i) Acquired Immune Deficiency Syndrome (AIDS) or disabling Class IV human immunodeficiency virus disease; or

(ii) P2 HIV/AIDS, if fourteen years old or younger;

(d) Has been certified by the client's physician or nurse practitioner to be in the terminal state of life;

(e) Has been assessed as being medically at risk for needing inpatient care;

(f) Has a plan of care approved by the department and the department of health (DOH);

(g) Does not have private insurance, including a COBRA extension, that covers inpatient hospital care;

(h) Is able to live at home or in an alternate living facility (ALF) described in WAC 388-513-1305(1) and chooses to do so; and

(i) Meets the income and resource requirements described in subsection (2).

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or an eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

(a) Nonexcluded income must be at or below the SIL; and

(b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(3) A client who is eligible for SSI does not participate in the cost of care for CASA services.

(4) An SSI-related client retains a maintenance needs amount, if:

(a) Living at home, of up to the SIL; or

(b) Living in an ALF described in WAC 388-513-1305(1), of thirty-eight dollars and eighty-four cents.

(5) The income of a client described in subsections (4)(a) or (b) that exceeds the maintenance needs amount is allocated as described in WAC 388-513-1380 (7)(a) through (d), (8) and (9).

(6) The income of a client described in subsection (4)(b) that exceeds the maintenance needs amount and the amount described in subsection (5) is paid to the facility for the cost of board and room up to an amount that is equal to the difference between the:

(a) Amount of the SIL; and

(b) The combined total of amounts described in subsections (4)(b) and (5).

(7) A client's participation in the cost of care for CASA services is the amount of income that remains after allocations described in subsections (4), (5), and (6).

(8) The client must meet any participation obligation, in order to remain eligible.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1530, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-515-1530, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1530, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 95-18-001 (Order 3882), § 388-515-1530, filed 8/23/95, effective 9/23/95; 94-10-065 (Order 3732), § 388-515-1530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-220.]

Chapter 388-517 WAC
MEDICARE-RELATED MEDICAL ELIGIBILITY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-517-1710 Medicare cost-sharing programs. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1710, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1710, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-060.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300.

388-517-1715 Qualified Medicare beneficiary (QMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1715, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1715, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1715, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(1) and 388-517-0500(6).

388-517-1720 Qualified Medicare beneficiaries—Income and resources. [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).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1730 Special low-income Medicare beneficiaries (SLMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1730, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1730, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1730, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(2) and 388-517-0300(4).

388-517-1740 Special low-income Medicare beneficiaries (SLMB)—Income and resources. [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).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1750 Qualified disabled working individuals (QDWI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1750, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1750, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1750, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(6) and 388-478-0085.

388-517-1760 Qualified disabled working individuals (QDWI) income and resources. [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).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1770 Qualified individuals (QI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1770, filed 5/19/98, effective 6/19/98.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050,

74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(7) and 388-478-0085(5).

WAC 388-517-0300 Medicare cost-sharing programs. (1) Clients eligible for the following programs receive benefits which help pay their Medicare coverage out-of-pocket costs:

(a) The qualified medicare beneficiary (QMB); and

(b) The special low-income medicare beneficiary (SLMB) and the expanded special low income Medicare beneficiary (ESLMB); and

(c) The Medicare buy-in program; and

(d) The qualified disabled working individual (QDWI); and

(e) The qualified individual (QI).

(2) To be eligible for any of these programs, clients must not have countable resources which exceed the resource standard in WAC 388-478-0085(6).

(3) Clients eligible for or receiving Medicare Part A and meeting the department's income standards have their Medicare Part A and Part B premiums, coinsurance, and deductibles paid for them under the QMB program. A person is income-eligible for QMB:

(a) When their countable income does not exceed the standard in WAC 388-478-0085(1); or

(b) When they meet the requirements of subsection (a) if their annual Social Security cost-of-living increase is not counted as income until April 1 of each year.

(4) Clients eligible for or receiving Medicare Part A benefits and meeting the department's income standards have their Part B Medicare premium paid for them under the SLMB or ESLMB program. In determining eligibility for SLMB or ESLMB, the annual Social Security cost-of-living increase is not counted as income until April 1 of each year. A person is income-eligible:

(a) For SLMB when their countable income is within the range specified in 388-478-0085(2);

(b) For ESLMB when:

(i) Their countable income is within the range specified in WAC 388-478-0085(3); and

(ii) They are not otherwise eligible for categorically needy (CN) or medically needy (MN) coverage; and

(iii) Until December 31st of each year or until the date that the annual allotment of federal funds is exhausted.

(5) Clients who are eligible for categorically needy (CN) or medically needy (MN) medical coverage, but not eligible for QMB or SLMB programs may be eligible for a third Medicare cost-sharing program. If they are eligible for or receiving Medicare Part A coverage, they receive the state-funded buy-in program. Under the buy-in program the department pays the following:

(a) Their Medicare Part A premiums, if any; and

(b) Their Medicare Part B premiums; and

(c) Their Medicare Part B coinsurance, and deductibles.

(6) Clients who are not eligible for QMB, SLMB or buy-in may be eligible for assistance with their Medicare out-of pocket costs. Clients who meet the following conditions have their Medicare Part A premium(s) paid for them under the QDWI program. A person is income-eligible for QDWI when:

(a) They are not otherwise eligible for CN or MN medical coverage; and

(b) They are eligible for Medicare Part A; and

(c) Their countable income does not exceed the standard in WAC 388-478-0085(4).

(7) Persons not eligible for any other Medicare cost-sharing program discussed in this section may receive compensation of one dollar and seven cents per month under the QI program. Total reimbursement is limited to the amount of money made available for this program from the federal government. The benefit is payable annually as partial reimbursement of their Medicare Part B premiums. A person is income-eligible for QI when:

(a) They are not otherwise eligible for CN or MN medical coverage; and

(b) Their countable income does not exceed the standard in WAC 388-478-0085(5).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-517-0300, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1710, 388-517-1730, 388-517-1750 and 388-517-1770.]

Chapter 388-519 WAC
SPENDDOWN

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-519-1905 Base period. [Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-519-1905, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-519-1905, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-519-1905, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-416-0025 and 388-519-0120.

388-519-1910 Allowable income deductions and exemptions. [Statutory Authority: RCW 74.08.090. 96-14-057 (Order 3986), § 388-519-1910, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1910, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-020 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020, 388-450-0110, 388-450-0150, 388-450-0210 and 388-519-0110.

388-519-1930 Computing spenddown; allowable spenddown expenses. [Statutory Authority: RCW 74.08.090. 96-14-057 (Order 3986), § 388-519-1930, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1930, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-020 and 388-99-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-519-0100 and 388-476-0070.

388-519-1950 Institutional spenddown. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-519-1950, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-519-0100 Eligibility for the medically needy program. (1) A person who meets the following con-

ditions is considered for medically needy (MN) coverage under the special rules in chapter 388-513 WAC.

(a) A person who meets the institutional status requirements of WAC 388-513-1320; or

(b) A person who receives waiver services under chapter 388-515 WAC.

(2) MN coverage is considered under this chapter when a person:

(a) Is not excluded under subsection (1) of this section; and

(b) Is not eligible for categorically needy (CN) medical coverage because they have CN countable income which is above the CN income standard.

(3) MN coverage is available for children, for persons who are pregnant or for persons who are SSI-related. MN coverage is available to an aged, blind, or disabled ineligible spouse of an SSI recipient even though that spouse's countable income is below the CN income standard. Adults with no children must be SSI related in order to be qualified for MN coverage.

(4) A person not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to those used to arrive at CN countable income. The following deductions are used to calculate their countable income for MN. Those deductions to income are applied to each month of the base period and determine MN countable income:

(a) All health insurance premiums expected to be paid by the client during the base period are deducted from their income; and

(b) For persons who are SSI-related and who are married, see the income provisions for the nonapplying spouse in WAC 388-450-0210; and

(c) For persons who are not SSI-related and who are married, an income deduction is allowed for a nonapplying spouse:

(i) If the nonapplying spouse is living in the same home as the applying person; and

(ii) The nonapplying spouse is receiving community and home based services under chapter 388-515 WAC; then

(iii) The income deduction is equal to the one person MNIL less the nonapplying spouse's actual income.

(5) A person who meets the above conditions is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070. They are certified as eligible for up to twelve months of MN medical coverage. Certain SSI or SSI-related clients have a special MNIL. That MNIL exception is described in WAC 388-513-1305.

(6) A person whose MN countable income exceeds the MNIL may become eligible for MN medical coverage when they have or expect to have medical expenses. Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.

(7) That portion of a person's MN countable income which is over the department's MNIL standard is called "excess income."

(8) When a person has or will have "excess income" they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown."

(9) A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter a person is ineligible for MN coverage if their resources exceed the program standard in WAC 388-478-0070. A person who is considered for MN coverage under chapter 388-513 WAC is allowed to spenddown excess resources.

(10) No extensions of coverage or automatic redetermination process applies to MN coverage. A client must submit an application for each eligibility period under the MN program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0320, 388-518-1840, 388-519-1930 and 388-522-2230.]

WAC 388-519-0110 Spenddown of excess income for the medically needy program. (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.

(2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.

(3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) A client is not or will not be resource eligible for the required base period; or

(c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.

(6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).

(7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:

(a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;

(b) Second, medical expenses which would not be covered by the MN program;

(c) Third, hospital expenses paid by the person during the base period;

(d) Fourth, hospital expenses, regardless of age, owed by the applying person;

(e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and

(f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.

(8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

(9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.

(10) To be counted toward spenddown, medical expenses must:

(a) Not have been used to meet a previous spenddown; and

(b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:

(i) Forty-five days of the date of the service; or

(ii) Thirty days after the base period ends; and

(c) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period and be for services for:

(A) The applying person; or

(B) A family member legally or blood-related and living in the same household as the applying person.

(ii) Be for services received and paid for during the base period; or

(iii) Be for services received and paid for during a previous base period if that client payment was made necessary due to delays in the certification for that base period.

(11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do not qualify if they were paid by the program before the first day of the base period.

(12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:

(a) Charges for services which would have been covered by the department's medical programs as described in chapter 388-529 WAC, less any confirmed third party payments which apply to the charges; and

(b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable items or services must have been provided or prescribed by a licensed health care provider; and

(c) Medical insurance and Medicare copayments or coinsurance (premiums are income deductions under WAC 388-519-0100(4)); and

(d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days.

(13) Medical expenses may be used more than once if:

(a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and

(b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.

(14) To be considered toward spenddown, written proof of medical expenses must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.

(15) Once a person meets their spenddown and they are issued a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a clients failure to identify or list medical expenses.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1830, 388-518-1840, 388-519-1905, 388-519-1910, 388-519-1930 and 388-522-2230.]

WAC 388-519-0120 Spenddown—Medically indigent program. (1) Persons ineligible for CN or MN coverage are considered for the medically indigent (MI) program under chapter 388-438 WAC. Medically indigent spenddown differs from medically needy spenddown in the following ways:

(a) In addition to spending down income in excess of the MNIL, the amount of countable resources which is in excess of the standard in WAC 388-478-0070 is spent down.

(b) The base period for MI begins on the first day of the month in which the following occurred:

(i) Emergency ambulance transportation; or

(ii) Hospital emergency room services were received; or

(iii) The person was hospitalized for the emergency condition.

(c) The base period for MI is three months and it can join retroactive and prospective months into the same base period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0120, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1905.]

Chapter 388-523 WAC
MEDICAL EXTENSIONS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-523-2305 Medical extensions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210,

[74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-523-2305, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-523-2305, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-029.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

388-523-2320 Medicaid quarterly reporting. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-523-2320, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

WAC 388-523-0100 Medical extensions. (1) A family who received temporary assistance for needy families (TANF) or state family assistance (SFA) cash or related medical assistance in any three of the last six months is eligible for extended medical benefits when they are ineligible for TANF/SFA-related medical because:

(a) They receive child or spousal support, which exceeds the payment standard described in WAC 388-478-0020, and they are not eligible for any other categorically needy (CN) medical program; or

(b) Their earnings increased resulting in income exceeding the TANF/SFA payment standard described in subsection (1)(a).

(2) A family described in subsection (1)(a) is eligible to receive four months of extended medical benefits beginning the month after termination from cash or TANF/SFA-related medical assistance, provided the family includes a child as defined in WAC 388-404-0005.

(3) A family described in subsection (1)(b) is eligible to receive six months of extended medical benefits when:

(a) They continue to meet the eligibility requirements of a TANF/SFA-related medical program, other than income; and

(b) The family includes a child.

(4) A family described in subsection (3) will not receive extended medical benefits for any family member who has been found ineligible for cash assistance because of fraud in any of the six months prior to the extended medical period.

(5) A family receiving extended medical benefits described in subsection (4) of this section is eligible for up to an additional six calendar months of extended medical benefits as long as:

(a) The family continues to include a child; and

(b) The family's gross earned income, after child care deductions in the preceding three months averages less than, one hundred eighty-five percent of the Federal Poverty Level (FPL), as described in WAC 388-478-0075; and

(c) A caretaker relative has had earnings in each of the three previous months, prior to the month of request for the second six month extension; and

(d) The family reports to the department family earnings and child care costs relating to employment by the twenty-first day of the:

(i) Fourth month of the initial six month extension period; and

(ii) First month of the second six month extension; and

(iii) Fourth month of the second six month extension.

(6) Certain circumstances may prevent a family from meeting the requirements in subsection (5)(b), (c) and (d) of this section. If that occurs, good cause may exist and the family remains eligible for the additional six month medical extension. Reasons for good cause include, but are not limited to:

(a) Illness, mental impairment, injury, trauma, or stress; or

(b) Lack of understanding the reporting requirement due to a language barrier; or

(c) Transportation problems; or

(d) Payment for work in each month of the reporting period was paid in a different month than it was earned; or

(e) The client expected to be able to meet the family medical needs, but could not; or

(f) The client was given incorrect information about the reporting requirements.

(7) Postpartum and family planning extensions are described in WAC 388-462-0015.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-523-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2210, 388-523-2305 and 388-523-2320.]

Chapter 388-526 WAC
MEDICAL FAIR HEARINGS

WAC

WAC 388-526-2610 Prehearing reviews for clients who request a fair hearing. (1) A client who does not agree with a department decision regarding medical or dental services has a right to a fair hearing under chapter 388-02 WAC.

(a) See chapter 388-538 WAC for hearing requests regarding managed care plans;

(b) See chapter 388-542 WAC for hearing requests regarding the children's health insurance program (CHIP);

(c) See WAC 388-502-0165 for requests for noncovered services.

(2) When a fair hearing is requested, either the client or MAA has the right to request and the client receive a medical assessment appropriate to the nature of the decision from one or more professionally qualified persons who are not a party to the action being appealed. WAC 388-538-120 applies to clients who are managed care enrollees.

(3) After receiving a request for a fair hearing, MAA may request additional information from the client, the provider, or the department. After MAA reviews the available information, the result may be:

(a) A reversal of the initial department decision;

(b) Resolution of the client's issue(s); or

(c) A fair hearing conducted per chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 34.05.060. 00-21-062, § 388-526-2610, filed 10/16/00, effective 11/16/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-526-2610, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-040.]

Chapter 388-527 WAC
ESTATE RECOVERY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-527-2710 Recovery from estates. [Statutory Authority: RCW 74.08.090 and OBRA 1993, HB 2492. 94-17-035 (Order 3768), § 388-527-2710, filed 8/10/94, effective 9/10/94. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-527-2710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-047.] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.

388-527-2720 Restitution. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-527-2720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-050] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.

388-527-2735 Liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2735, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.

388-527-2752 Deferring recovery. [Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2752, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.

388-527-2753 No liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2753, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.

WAC 388-527-2700 Purpose. The department will recover from the estate of a deceased client, the cost of medical care correctly paid on the client's behalf by the department as described by this chapter.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2700, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2730 Estate recovery definitions. For estate recovery purposes:

"Estate" means all real and personal property and any other assets that pass upon the client's death under the client's will or by intestate succession pursuant to chapter 11.04 RCW or under chapter 11.62 RCW. An estate also includes:

(1) For a client who died after June 30, 1995 and before July 27, 1997, nonprobate assets as defined by RCW 11.02.005, except property passing through a community property agreement; or

(2) For a client who died after July 26, 1997, nonprobate assets as defined by RCW 11.02.005.

The value of the estate shall be reduced by any valid liability against the deceased client's property at the time of death.

"Long-term care services" means the services administered directly or through contract by the aging and adult services administration of the department, including but not limited to nursing facility care and home and community services.

"State-funded long-term care" means the long-term care services that are paid only with state funds.

"Medical assistance" means the federal aid medical care program provided under Title XIX of the Federal Social Security Act.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2730, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2730, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2733 No liability for medical care. (1) The client's estate is not liable for services provided before July 26, 1987.

(2) The client's estate is not liable when the client died before July 1, 1994 and on the date of death there was:

(a) A surviving spouse; or

(b) A surviving child who was either:

(i) Under twenty-one years of age; or

(ii) Blind or disabled as defined under chapter 388-511 WAC.

(3) The estate of a frail elder or vulnerable adult under RCW 74.34.010 is not liable for the cost of adult protective services (APS) paid for only by state funds.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2733, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2737 Deferring recovery. When a client died after June 30, 1994 and received services after June 30, 1994, recovery from the estate is deferred until:

(1) The death of the surviving spouse, if any; and

(2) There is no surviving child who is:

(a) Under twenty-one years of age, or

(b) Blind or disabled as defined under chapter 388-511 WAC.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2737, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2740 Age when recovery applies. The client's age and the date when services were received determines whether the client's estate is liable for the cost of medical care provided. Subsection (1) of this section covers liability for medical assistance and subsection (2) covers liability for state-funded long-term care services. An estate may be liable under both subsections.

(1) For a client who on July 1, 1994 was:

(a) Age sixty-five or older, the client's estate is liable for medical assistance that was subject to recovery and which was provided on and after the date the client became age sixty-five or after July 26, 1987, whichever is later;

(b) Age fifty-five through sixty-four years of age, the client's estate is liable for medical assistance that was subject to

recovery and which was provided on and after July 1, 1994; or

(c) Under age fifty-five, the client's estate is liable for medical assistance subject to recovery provided on and after the date the client became age fifty-five.

(2) The client's estate is liable for state-funded long-term care services provided on and after July 1, 1995 regardless of the client's age when the services were provided.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2740, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2740, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2742 Services subject to recovery. The medical services the client received and the dates when services were provided determines whether the client's estate is liable for the medical care provided. Subsection (1) of this section covers liability for medical assistance and subsection (2) covers liability for state-funded long-term care services. An estate can be liable under both subsections.

(1) The client's estate is liable for:

(a) All medical assistance services provided from July 26, 1987 through June 30, 1994;

(b) The following medical assistance services provided after June 30, 1994 and before July 1, 1995:

(i) Nursing facility services;

(ii) Home and community-based services; and

(iii) Hospital and prescription drug services provided to a client while receiving nursing facility services or home and community-based services.

(c) The following medical assistance services provided after June 30, 1995:

(i) Nursing facility services;

(ii) Home and community-based services;

(iii) Adult day health;

(iv) Medicaid personal care;

(v) Private duty nursing administered by the aging and adult services administration of the department; and

(vi) Hospital and prescription drug services provided to a client while receiving services described under (c)(i), (ii), (iii), (iv), or (v) of this subsection.

(2) The client's estate is liable for all state-funded long-term care services and related hospital and prescription drug services provided after June 30, 1995.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2742, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2742, filed 9/6/95, effective 10/7/95.]

WAC 388-527-2750 Waiver of recovery if undue hardship. Recovery is waived under this section when recovery would cause an undue hardship, except as provided in subsection (3) of this section. This waiver is limited to the period during which undue hardship exists.

(1) Undue hardship exists when:

(a) The estate subject to adjustment or recovery is the sole income-producing asset of one or more of the heirs and income is limited; or

(b) Recovery would result in the impoverishment of one or more of the heirs; or

(c) Recovery would deprive an heir of shelter and the heir lacks the financial means to obtain and maintain alternative shelter.

(2) Undue hardship does not exist when:

(a) The adjustment or recovery of the client's cost of assistance would merely cause the client's family members inconvenience or restrict the family's lifestyle.

(b) The heir divests assets to qualify under the undue hardship provision.

(3) When a deceased client's assets were disregarded in connection with a long-term care insurance policy or contract under chapter 48.85 RCW, recovery is not waived.

(4) When a waiver is not granted, the department will provide notice to the person who requested the waiver. The denial of a waiver must state:

(a) The requirements of an application for an adjudicative proceeding to contest the department's decision to deny the waiver; and

(b) Where assistance may be obtained to make such application.

(5) A person may contest the department's decision in an adjudicative proceeding when that person requested the department waive recovery, and suffered a loss because that request was not granted.

(6) An application for an adjudicative proceeding under this section must:

(a) Be in writing;

(b) State the basis for contesting the department's denial of the request to waive recovery;

(c) Include a copy of the department's denial of the request to waive recovery;

(d) Be signed by the applicant and include the applicant's address and telephone number;

(e) Be served within twenty-eight days of the date the applicant received the department's decision denying the request for a waiver. If the applicant shows good cause, the application may be filed up to thirty days late; and

(f) Be served on the office of financial recovery (OFR) as described in WAC 388-527-2795.

(7) An adjudicative proceeding held under this section shall be governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-527-2750, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2750, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2750, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2754 Assets not subject to recovery and other limits on recovery. (1) Recovery does not apply to the first fifty thousand dollars of the estate value at the time of death and is limited to thirty-five percent of the remaining value of the estate for services the client:

(a) Received before July 25, 1993; and

(b) When the client died with:

(i) No surviving spouse;

(ii) No surviving child who is:

(A) Under twenty-one years of age;

(B) Blind; or

(C) Disabled.

(iii) A surviving child who is twenty-one years of age or older.

(2) For services received after July 24, 1993, all services recoverable under WAC 388-527-2742 will be recovered, even from the first fifty thousand dollars of estate value that is exempt above, except as set forth in subsection (3) of this section.

(3) For a client who received services after July 24, 1993 and before July 1, 1994, the following property, up to a fair market value of two thousand dollars, is not recovered from the estate of the client:

(a) Family heirlooms,

(b) Collectibles,

(c) Antiques,

(d) Papers,

(e) Jewelry,

(f) Photos, and

(g) Other personal effects of the deceased client and to which a surviving child is entitled.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2754, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2754, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2790 Filing a lien against real property. (1) Liens are filed, adjustment sought, and other recoveries effected by the department for medical assistance or state-funded long-term care, or both, correctly paid on behalf of a client consistent with 42 U.S.C. 1396p and chapters 43.20B RCW and 388-527 WAC.

(2) When the department seeks to recover from a client's estate the cost of medical assistance or state-funded long-term care, or both, provided to the client, prior to filing a lien against the deceased client's real property, notice shall be given to:

(a) The probate estate's personal representative, if any; or

(b) Any other person known to have title to the affected property.

(3) Prior to filing a lien against any of the deceased client's real property, a person known to have title to the property shall be notified and have an opportunity for an adjudicative proceeding as follows:

(a) Any person known to have title to the property shall be served with a notice of intent to file lien, which shall state:

(i) The deceased client's name, social security number, if known, date of birth, and date of death;

(ii) The amount of medical assistance, or state-funded long-term care, or both, correctly paid on behalf of the deceased client the department seeks to recover;

(iii) The department's intent to file a lien against the deceased client's real property to recover the medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client;

(iv) The county in which the real property is located; and

(v) The right of the person known to have title to the property to contest the department's decision to file a lien by applying for an adjudicative proceeding with the office of financial recovery (OFR).

(b) An adjudicative proceeding can determine whether:

(i) The amount of medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client alleged by the department's notice of intent to file a lien is correct; and

(ii) The deceased client had legal title to the real property at the time of the client's death.

(4) An application for an adjudicative proceeding must:

(a) Be in writing;

(b) State the basis for contesting the department's notice of intent to file the lien;

(c) Be signed by the applicant and state the applicant's address and telephone number;

(d) Be served on (OFR) within twenty-eight days of the date the applicant received the department's notice of intent to file the lien. An application filed up to thirty days late may be treated as timely filed if the applicant shows good cause for filing late; and

(e) Be served on OFR as described in WAC 388-527-2795.

(5) Persons known to have title to the property shall be notified of the time and place of the adjudicative proceeding by the department when it receives an application for the same.

(6) An adjudicative proceeding under this section shall be governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

(7) If no known title holder requests an adjudicative proceeding, a lien shall be filed by the department twenty-eight days after the date that the notice of intent to file the lien letter was mailed. The lien will be filed against the deceased client's real property in the amount of the correctly paid medical assistance or state-funded long-term care, or both.

(8) If an adjudicative proceeding is conducted in accordance with this regulation, when the final agency decision is issued, the department will file a lien against the deceased client's real property for the amount of the correctly paid medical assistance or state-funded long-term care, or both, as established by that final agency decision.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-527-2790, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2790, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2790, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2795 Serving notices on office of financial recovery (OFR). (1) Legal service must be by personal service or certified mail, return receipt requested, to OFR at the address described in this section.

(2) The mailing address of the office of financial recovery is:

Office of Financial Recovery
P.O. Box 9501
Olympia, WA 98507-9501.

(3) The physical location of the office of financial recovery is:

Blake Office Park
4450 10th Avenue Southeast
Lacey, Washington.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2795, filed 5/18/99, effective 6/18/99.]

Chapter 388-529 WAC
SCOPE OF MEDICAL SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-529-2910 Scope of care—Categorically needy. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2910, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.

388-529-2920 Scope of care—Medically needy. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2920, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-060.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.

388-529-2930 Scope of care—GAU/ADATSA—Medical care services. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2930, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.

388-529-2940 Scope of care—Children's health. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2940, filed 5/3/94, effective 6/3/94.] Repealed by 00-05-039, filed 2/10/00, effective 3/12/00. Statutory Authority: RCW 74.08.090, 74.09.520.

388-529-2950 Scope of care—Medically indigent. [Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-529-2950, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-529-2950, filed 5/3/94, effective 6/3/94. Formerly WAC 388-100-035.] Repealed by 00-05-039, filed 2/10/00, effective 3/12/00. Statutory Authority: RCW 74.08.090, 74.09.520.

388-529-2960 Scope of care—Qualified Medicare beneficiary (QMB), special low-income Medicare beneficiary and qualified disabled working individual (QDWI). [Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510. 98-04-004, § 388-529-2960, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2960, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0100.

WAC 388-529-0100 Scope of covered medical services by program. (1) The scope of medical care which clients can receive is based on the medical program for which they are eligible. Clients eligible for the following medical programs have coverage for the medically necessary services indicated in the specific columns in the chart provided in WAC 388-529-0200:

(a) Categorically needy (CN) medical coverage is provided as described in the "CN" column. Coverage is modified by the provisions in this section and those found in other medical-assistance-related WAC;

(b) Medically needy (MN) medical coverage is provided as described in the "MN" column and as modified in this section and in other medical-assistance-related WAC;

(c) General assistance - unemployable (GAU) or alcohol and drug abuse treatment and support act (ADATSA) medical coverage is provided as described in the "MCS" column. Coverage is modified by the provisions in WAC 388-556-0500;

(d) The state-funded children's health program has medical coverage as described in the "CN" column and in subsection (1)(a) of this section;

(e) State-funded medically indigent (MI) program has medical coverage as described in the "MI" column to the extent that services are related to the qualifying emergency condition. Coverage begins after the client has met the annual emergency medical expense requirement (EMER) as described in WAC 388-438-0100.

(f) Pregnant undocumented aliens have medical coverage as described in the "CN" column and in subsection (1)(a) of this section.

(2) "Medically necessary" is a standard for coverage of services under the CN and MN programs. The term is defined in WAC 388-500-0005.

(3) Entries in WAC 388-529-0200 have the following meanings and conditions:

(a) "Yes":

(i) The service must be medically necessary as defined by the program; and

(ii) The service may have conditions placed on coverage in order to ensure that medical necessity exists. Examples are:

(A) The prior authorization requirement,

(B) The primary care provider referral requirement,

(C) The limit on eyeglasses to be covered for adults only once in a twenty-four-month period without documentation of special circumstances, etc.

(b) "HK" - the services are provided to children under the healthy kids program as described in WAC 388-534-0100. This is consistent with the broader scope of coverage under the healthy kids program.

(c) "No" - This entry is used to describe coverage limitations of state-funded programs and indicates that the services are not covered. However, medically necessary services may be available under an "exception to rule" as described in chapter 388-440 WAC.

(d) "L" - the services are provided under limited circumstances described further under WAC 388-529-0200.

(e) "R" - the services are provided only as they are directly connected to emergency medical conditions. These program restrictions are described in WAC 388-438-0100.

(4) Coverage described in this chapter may be further limited by the notations defined in WAC 388-529-0200 and other medical-assistance-related WAC. Services may require prior authorization to ensure that medical necessity exists.

(5) Medical service categories not listed in WAC 388-529-0200 may not be covered under typical circumstances. Seeking specific coverage decisions in advance of service delivery is advised. Medical service providers may request authorization for any service which they see as medically necessary under WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-529-0100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-529-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0350, 388-529-2910, 388-529-2920 and 388-529-2930.]

WAC 388-529-0200 Medical services available to eligible clients. The following chart lists the medically necessary services available to clients eligible for a variety of assistance programs. Eligibility groups for CN, MCS, MN, and MI coverage are described in WAC 388-529-0100.

MEDICAL SERVICES	CN1/	MCS	MN	MI
Adult day health	Yes	Yes	Yes	No
Advanced RN practitioner services	Yes	Yes	Yes	No
Ambulance/ground and air	Yes	Yes	Yes	R2/
Anesthesia services	Yes	Yes	Yes	R2/
Audiology (hearing exams)	Yes	Yes	HK only	No
Blood/blood derivatives/ Blood administration	Yes3/	Yes3/	Yes3/	R2/-3/
Case management - maternity	L4/	No	L4/	No
Chiropractic care	HK only	No	HK only	No
Clinic services	Yes	Yes	Yes	No
Community mental health centers	Yes	L5/	Yes	No
Dental services	Yes	No	Yes	No
Dentures only	Yes	Yes	Yes	No
Detoxification	Yes	Yes	Yes	Yes2/
Drugs and pharmaceutical supplies	Yes	Yes	Yes	No
Elective surgery	Yes	Yes	Yes	No
Emergency room services	Yes	Yes	Yes	R2/
Emergency surgery	Yes	Yes	Yes	R2/
Eyeglasses and exams	Yes6/	Yes6/	Yes6/	No
Family planning services7/	Yes	Yes	Yes	No
Healthy kids (HK) (EPSDT)	Yes	No	Yes	No
Hearing aids	Yes	Yes	HK only	No
Home health services	Yes	Yes	Yes	No
Hospice	Yes	No	Yes	No
Indian health clinics	Yes	No	Yes	No
Inpatient hospital care	Yes	Yes	Yes	R2/
Intermediate care facility/services for mentally retarded	Yes	Yes	Yes	N/A
Involuntary commitment	Yes	Yes	Yes	Yes2/
Maternity support services	Yes	No	Yes	No
Medical equipment, durable (DME)	Yes	Yes	Yes	No
Midwife services	Yes	Yes	Yes	R2/
Neuromuscular centers	Yes	No	Yes	No
Nursing facility services	Yes	Yes	Yes	Yes2/
Nutrition therapy	HK only	No	HK only	No
Optometry	Yes	Yes	Yes	No
Organ transplants	Yes	Yes	Yes	R2/
Out-of-state care	Yes	No	Yes	No
Outpatient hospital care	Yes	Yes	Yes	R2/
Oxygen/respiratory therapy	Yes	Yes	Yes	R2/
Pain management (chronic)	Yes	Yes	Yes	No
Personal care services	Yes8/	No	HK only8/	No
Physical/speech/occupational therapy	Yes	Yes	HK and L9/	No
Physical medicine and rehabilitation	Yes	Yes	Yes	R2/
Physician	Yes	Yes	Yes	R2/
Podiatry	Yes	Yes	Yes	No
Private duty nursing	L10/	L10/	L10/	No
Prosthetic devices/mobility aids	Yes	Yes	Yes	R2/
Psychiatric services	Yes	No	Yes	No
Psychological evaluation	L11/	L11/	L11/	No
Rural health services and Federally qualified health Centers (FQHC)	Yes	Yes	Yes	No
	Yes	No	Yes	No
School medical services 12/	Yes	No	Yes	No

Substance abuse/outpatient	Yes	No	Yes	No
Surgical appliances	Yes	Yes	Yes	R2/
Total enteral/parenteral nutrition	Yes	Yes	Yes	No
Transportation other than ambulance	Yes	Yes	Yes	No
X-ray and lab services	Yes	Yes	Yes	R2/

(1) Notation 1/ indicates that the CN column applies to all categorically needy (CN) programs, the state-funded children's health program. It also describes the services available to pregnant women who are undocumented aliens.

(2) Notation 2/ restricts the coverage to those services directly connected to an emergency medical condition which requires hospital services. Emergency requirements are described in WAC 388-438-0100.

(3) Notation 3/ indicates that services are limited as described in WAC 388-87-045.

(4) Notation 4/ indicates that the services are limited to pregnant women who have been identified as being in a "high-risk" circumstance under WAC 388-86-017.

(5) Notation 5/ indicates that clients must meet the program definitions and program priorities of the community mental health act. Limited grants are available to counties for the funding of these services.

(6) Notation 6/ indicates that eyeglasses are limited under WAC 388-86-030. Special circumstances and specific approval apply to more frequent services than those specified in WAC 388-86-030.

(7) Notation 7/ indicates that family planning services are available to all clients of the medical programs except for the medically indigent program. Some clients are eligible only for family planning services which is noted on the medical identification card. These services are described in WAC 388-462-0015.

(8) Notation 8/ indicates that services which are not medical services may be covered under certain qualifying conditions. These benefits are covered under the direction of the aging and adult services administration for CN eligible adults under home and community based programs; the division of developmental disabilities; or the children's services administration under WAC 388-86-087.

(9) Notation 9/ indicates that the services are not normally provided to clients, however, they are covered when the client is receiving department approved home health care services as described in WAC 388-86-045.

(10) Notation 10/ indicates that services are authorized according to the conditions listed in WAC 388-86-071.

(11) Notation 11/ indicates that the department limits services as described in WAC 388-86-067 and 388-86-095.

(12) Notation 12/ indicates a special medical program for children who are Medicaid eligible under an individualized education plan under the special education program of a school. This medical program is described further in WAC 388-86-022.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-529-0200, filed 7/31/98, effective 9/1/98. Formerly WAC 388-086-0015 and 388-086-0080.]

Chapter 388-530 WAC
PHARMACY SERVICES

WAC

WAC 388-530-1000 The medical assistance administration (MAA) drug program. (1) The medical assistance administration (MAA) reimburses providers for prescription drugs and pharmaceutical supplies according to department rules and subject to the exceptions and restrictions listed in this chapter.

(2) MAA reimburses only pharmacies that are MAA-enrolled providers and meet the general requirements for providers described under WAC 388-502-0020.

(3) Prescription drugs must be:

(a) Medically necessary as defined in WAC 388-500-0005;

(b) Billed according to the conditions under WAC 388-502-0150 and 388-502-0160; and

(c) Within the scope of an eligible client's medical care program. Refer to chapter 388-529 WAC.

(4) Acceptance and filling of a prescription for a client eligible for a medical care program constitutes acceptance of MAA's rules and fees. See WAC 388-502-0100 for general conditions of payment.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1000, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1000, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1050 Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this chapter.

"Actual acquisition cost (AAC)" means the actual price a provider paid for a drug marketed in the package size of drug purchased, or sold by a particular manufacturer or labeler. Actual acquisition cost is calculated based on factors including, but not limited to:

(1) Invoice price, including other invoice-based considerations;

(2) Order quantity and periodic purchase volume discount policies of suppliers (wholesalers and/or manufacturers);

(3) Membership/participation in purchasing cooperatives;

(4) Advertising and other promotion/display allowances, free merchandise deals; and

(5) Transportation or freight allowances.

"Administer" means the direct application of a prescription drug by injection, inhalation, ingestion, or any other means, to the body of a patient by a practitioner, or at the direction of the practitioner.

"Automated maximum allowable cost (AMAC)" means the rate established for all multiple-source drugs designated by three or more products at least one of which must be under a federal drug rebate contract and which are not on the maximum allowable cost (MAC) list.

"Average wholesale price (AWP)" means the average price of a drug product from wholesalers nationwide at a point in time.

"Compendia of drug information" includes the following:

(1) The American Hospital Formulary Service Drug Information;

(2) The United States Pharmacopeia Drug Information; and

(3) DRUGDEX Information System.

"Compounding" means the act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription.

"Contract drugs" means drugs manufactured or distributed by manufacturers/labelers who signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

"Deliver or delivery" means the transfer of a drug or device from one person to another.

"Department" means the department of social and health services (DSHS).

"Dispense as written (DAW)" means an instruction to the pharmacist forbidding substitution of a generic drug or a therapeutically equivalent product for the specific drug product prescribed.

"Dispensing fee" means the fee MAA sets to reimburse pharmacy providers in addition to ingredient costs, for expenses that include but are not limited to, information provided to the client as required by state laws and federal regulations, compounding time, and overhead expenses incurred in filling medical assistance prescriptions.

"Drug file" means a list of drugs provided to the medical assistance administration's (MAA's) drug data base and maintained by a drug file contractor.

"Drug file contractor" also referred to as **"drug pricing file contractor,"** means the entity which has contracted to provide MAA, at specified intervals, the latest information and/or data base on drugs and related supplies produced, prepared, processed, packaged, labeled, distributed, marketed, or sold in the marketplace. Contractor-provided information includes, but is not limited to, identifying characteristics of the drug (national drug code, drug name, manufacturer/labeler, dosage form, and strength) for the purpose of identifying and facilitating payment for drugs billed to MAA.

"Drug rebates" means payments provided by pharmaceutical manufacturers to state Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services.

"Drug-related supplies" means nonpharmaceutical items necessary for administration or delivery of a drug.

"Drug utilization review (DUR)" means a quality review for covered outpatient drugs that assures prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

"Emergency kit" means a set of limited pharmaceuticals furnished to a nursing facility by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the emergency needs of an individual nursing facility.

"Estimated acquisition cost (EAC)" means MAA's estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler.

"Expedited prior authorization" means the process for authorizing selected drugs in which providers use a set of numeric codes to indicate to MAA the acceptable indications/conditions/diagnoses/criteria that are applicable to a particular request for drug authorization.

"Experimental drugs" means drugs the FDA has not approved, or approved drugs when used for medical indications other than those listed by the FDA.

"Federal upper limit (FUL)" means the maximum allowable payment set by the Health Care Financing Administration (HCFA) for a multiple source drug.

"Ingredient cost" means the portion of a prescription's cost attributable to the drug ingredients, chemical components, and/or substances.

"Less than effective drug" or **"DESI"** means a drug for which:

(1) Effective approval of the drug application has been withdrawn by the Food and Drug Administration (FDA) for safety or efficacy reasons as a result of the drug efficacy study implementation (DESI) review; or

(2) The secretary of the department of health and human services (DHHS) has issued a notice of an opportunity for a hearing under section 505(e) of the federal Food, Drug, and Cosmetic Act on a proposed order of the secretary to withdraw approval of an application for such drug under such section because the secretary has determined the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling.

"Long-term therapy" means treatment a client receives or will receive continuously through and beyond ninety days.

"Maximum allowable cost (MAC)" means the maximum amount that MAA will pay for a specific dosage form and strength of a multiple source drug product.

"Medically accepted indication" means any indicated use for a covered outpatient drug:

(1) Approved under the federal Food, Drug, and Cosmetic Act;

(2) Which appears in peer-reviewed medical literature; or

(3) Which is accepted by one or more of the references listed in the compendia of drug information.

"Modified unit dose delivery system" (also known as blister packs or "bingo/punch cards") means a method in which each patient's medication is delivered to a nursing facility:

(1) In individually sealed, single dose packages or "blisters"; and

(2) In quantities for one month's supply, unless the prescriber specifies short-term therapy.

"Multiple-source drug" means a drug marketed or sold by:

(1) Two or more manufacturers or labelers; or

(2) The same manufacturer or labeler:

(a) Under two or more different proprietary names; or

(b) Under a proprietary name and a generic name.

"National drug code (NDC)" means the eleven-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

"Noncontract drugs" are drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services.

"Nonprescription drugs" means drugs that may be lawfully sold without a prescription.

"Obsolete NDC" means a national drug code replaced or discontinued by the manufacturer or labeler.

"Over-the-counter (OTC) drugs" means drugs that do not require a prescription before they can be dispensed.

"Pharmacist" means a person licensed in the practice of pharmacy by the state in which the prescription is filled.

"Pharmacy research specialist" means a licensed pharmacist employed by MAA.

"Pharmacy" means every location licensed by the State Board of Pharmacy in the state where the practice of pharmacy is conducted.

"Point-of-sale (POS)" means a pharmacy claims processing system capable of receiving and adjudicating claims on-line.

"Practice of pharmacy" means the practice of and responsibility for:

(1) Accurately interpreting prescription orders;

(2) Compounding, dispensing, labeling, administering, and distributing of drugs and devices;

(3) Providing drug information to the client that includes, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices;

(4) Monitoring of drug therapy and use;

(5) Proper and safe storage of drugs and devices;

(6) Documenting and maintaining records;

(7) Initiating or modifying drug therapy in accordance with written guidelines or protocols previously established and approved for a pharmacist's practice by a practitioner authorized to prescribe drugs; and

(8) Participating in drug utilization reviews.

"Practitioner" means an individual who has met the professional and legal requirements necessary to provide a health care service, such as a physician, nurse, dentist, physical therapist, pharmacist or other person authorized by state law as a practitioner.

"Prescriber" means a physician, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person authorized by law or rule to prescribe drugs. See WAC 246-863-100 for pharmacists' prescriptive authority.

"Prescription" means an order for drugs or devices issued by a practitioner authorized by state law or rule to prescribe drugs or devices in the course of the practitioner's professional practice for a legitimate medical purpose.

"Prescription drugs" means drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or that are restricted to use by practitioners only.

"Prior authorization program" means a medical assistance administration (MAA) program, subject to the requirements of 42 U.S.C. 1396r-8 (d)(5), that may require, as condition of payment, that a drug on MAA's drug file be prior authorized. See WAC 388-530-1200.

"Prospective drug utilization review (Pro-DUR)" means a process in which a request for a drug product for a particular patient is screened, before the product is dispensed, for potential drug therapy problems.

"Reconstitution" means the process of returning a single active ingredient, previously altered for preservation and storage, to its approximate original state.

"Retrospective drug utilization review (Retro-DUR)" means the process in which patient drug utilization is reviewed on a periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

"Risk/benefit ratio" means the result of assessing the side effects compared to the positive therapeutic outcome of therapy.

"Single source drug" means a drug produced or distributed under an original new drug application approved by the FDA.

"Substitute" means to replace, with the prescriber's authorization:

(1) An equivalent generic drug product of the identical base or salt as the specific drug product prescribed; or

(2) A therapeutically equivalent drug other than the identical base or salt.

"Terminated drug product" means a product for which the shelf life expiration date has been met, per manufacturer notification.

"Therapeutic alternative" means a drug product that contains a different therapeutic agent than the drug in question, but is the same pharmacological or therapeutic class and

can be expected to have a similar therapeutic effect when administered to patients in a therapeutically equivalent dosage.

"Therapeutically equivalent" means chemically dissimilar prescription drugs with the same efficacy and safety when administered to an individual, as determined by:

(1) Information from the FDA;

(2) Published and peer-reviewed scientific data;

(3) Randomized controlled clinical trials; and

(4) Other scientific evidence.

"Tiered dispensing fee system" means a system of paying pharmacies different dispensing fee rates, based on the individual pharmacy's total annual prescription volume and/or drug delivery system used.

"True unit dose delivery" means a method in which each patient's medication is delivered to the nursing facility in quantities sufficient only for the day's required dosage.

"Unit dose drug delivery" means true unit dose or modified unit dose delivery systems.

"Usual and customary charge" means the fee that the provider typically charges the general public for the product or service.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1050, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1050, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1100 Covered drugs and pharmaceutical supplies. (1) The medical assistance administration (MAA) covers medically necessary prescribed drugs and pharmaceutical supplies, subject to the restrictions described in this section and other published WAC, except for those excluded under WAC 388-530-1150. MAA reimburses a provider for drugs listed in subsection (1)(a) through (e) of this section only when the manufacturer has a signed rebate agreement with the federal Department of Health and Human Services. Refer to WAC 388-530-1125 for information on the drug rebate program. Covered drugs and supplies include:

(a) Outpatient drugs, generic or brand name.

(b) Over-the-counter (OTC) drugs when the drug:

(i) Is a less costly therapeutic alternative; and

(ii) Does not require prior authorization.

(c) Drugs requiring prior authorization when:

(i) Prior authorized by MAA; or

(ii) They meet MAA's published expedited prior authorization criteria and follow the process defined in WAC 388-530-1050.

(d) Oral, topical and/or injectable drugs, vaccines for immunizations, and biologicals, prepared or packaged for individual use.

(e) Drugs with obsolete national drug codes (NDCs) for up to two years from the date the NDC is designated obsolete, if the drug is not a terminated drug product as defined in WAC 388-530-1050.

(f) Drug-related supplies as determined in consultation with federal guidelines.

(g) Family planning supplies used in conjunction with family planning under chapter 388-532 WAC, including nonprescribed OTC supplies.

(h) Drugs and supplies provided under unusual and extenuating circumstances to clients by providers who request and receive MAA approval.

(2) MAA determines if certain drugs are medically necessary and covered with or without restrictions based on evidence contained in compendia of drug information and/or peer-reviewed medical literature.

(a) Decisions regarding restrictions are based on, but are not limited to:

(i) Client safety;

(ii) FDA-approved indications;

(iii) Quantity;

(iv) Client age and/or gender; and

(v) Cost.

(b) Restrictions apply to, but are not limited to:

(i) Drugs covered in the nursing facility per diem rate;

(ii) Number of refills within a calendar month; and

(iii) Refills requested before seventy-five percent of the therapy days' supply has elapsed.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1100, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1100, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1125 Drug rebate program. MAA covers only those outpatient prescription drugs supplied by manufacturers who have a drug rebate contract with the Health Care Financing Administration (HCFA). MAA may make exceptions based on medical necessity and on a case-by-case basis. Exceptions require prior authorization - refer to WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1125, filed 12/7/00, effective 1/7/01.]

WAC 388-530-1150 Noncovered drugs and pharmaceutical supplies and reimbursement limitations.

(1) The medical assistance administration (MAA) does not cover:

(a) Noncontract drugs, brand or generic, when the manufacturer has not signed a rebate agreement with the federal Department of Health and Human Services. Refer to WAC 388-530-1125 for information on the drug rebate program.

(b) A drug prescribed:

(i) For weight loss or gain;

(ii) For infertility, frigidity, impotency, or sexual dysfunction;

(iii) For cosmetic purposes or hair growth; or

(iv) To promote smoking cessation.

(c) OTC drugs/supplies, unless described under WAC 388-530-1100 (1)(b), or for family planning as described under chapter 388-532 WAC.

(d) Prescription vitamins and mineral products, except:

(i) When prescribed for clinically documented deficiencies;

(ii) Prenatal vitamins only when prescribed and dispensed to pregnant women; or

(iii) Fluoride preparations for children under the early and periodic screening, diagnosis, and treatment (EPSDT or "healthy kids") services.

(e) A drug prescribed for an indication that is not evidence based as determined by:

(i) MAA in consultation with federal guidelines; or

(ii) The Drug Utilization and Education (DUE) Council; and

(iii) MAA medical consultants and pharmacy research specialist.

(f) Drugs listed in the federal register as "less-than-effective" ("DESI" drugs) or which are identical, similar, or related to such drugs.

(g) Outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee.

(h) Drugs that are:

(i) Not approved by the FDA; or

(ii) Prescribed for non-FDA approved indications or dosing unless prior authorized; or

(iii) Unproven for efficacy or safety.

(i) Drugs requiring prior authorization for which MAA authorization has been denied.

(j) Preservatives, flavoring and/or coloring agents.

(k) Less than a one-month supply of drugs for long-term therapy.

(l) A drug with an obsolete NDC more than two years from the date the NDC is designated obsolete.

(m) Products or items that do not have an eleven-digit NDC.

(2) MAA does not reimburse enrolled providers for:

(a) Outpatient drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:

(i) Diagnosis-related group (DRG);

(ii) Ratio of costs-to-charges (RCC);

(iii) Nursing facility per diem;

(iv) Managed care capitation rates;

(v) Block grants; or

(vi) Drugs prescribed for clients who are on the MAA hospice program when the drugs are related to the terminal condition.

(b) Any drug regularly supplied as an integral part of program activity by other public agencies.

(c) Prescriptions written on pre-signed prescription blanks filled out by nursing facility operators or pharmacists. MAA may terminate the core provider agreement of pharmacies involved in this practice.

(d) Drugs used to replace those taken from nursing facility emergency kits.

(e) Drugs used to replace a physician's stock supply.

(f) Free pharmaceutical samples.

(g) Terminated drug products.

(3) MAA evaluates a request for a drug that is listed as noncovered in this section under the provisions of WAC 388-501-0160 which relates to noncovered services. The request for a noncovered drug is called exception to rule. See WAC 388-501-0160 for information about exception to rule.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1150, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1150, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1200 Prior authorization program. (1) The medical assistance administration (MAA) pharmacy research specialist, medical consultants, and drug utilization review team evaluate drugs to determine prior authorization status on the drug file, and may consult with the Drug Utilization and Education (DUE) Council, and participating MAA providers.

(2) To facilitate the evaluation process for a drug product, a drug manufacturer may send the pharmacy research specialist a written request and the following supporting documentation:

(a) Background data about the drug;

(b) Product package information;

(c) Any pertinent clinical studies; and

(d) Any additional information the manufacturer considers appropriate.

(3) Evaluation of a drug includes, but is not limited to, the following criteria:

(a) There is a federal drug rebate contract agreement signed by the manufacturer;

(b) The drug is a less-than-effective drug;

(c) The drug has a favorable risk/benefit ratio;

(d) The drug file status of:

(i) Like drugs; and

(ii) Less costly therapeutic alternative drugs;

(e) The drug falls into one of the categories authorized by federal law to be excluded from coverage; and

(f) The drug has a potential for abuse.

(4) MAA updates and reviews the drug file list as necessary and periodically publishes a list of drugs not requiring prior authorization.

(5) Manufacturers may seek review of formulary decisions by writing to the MAA medical director.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1200, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1200, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1250 Prior authorization process. (1) MAA requires pharmacies to obtain prior authorization for:

(a) Drugs with a prior authorization indicator on the drug file;

(b) Drugs that have specific per-month dose or unit limits as indicated by the FDA; and

(c) Additional fills in a calendar month for drugs dispensed for a less than thirty-four day supply when:

(i) Two fills for the same prescription have been dispensed, except for:

(A) Compounded prescriptions;

(B) OTC contraceptives; or

(C) Drugs prescribed to a suicidal patient or a patient at risk for potential drug abuse; or

(ii) Four fills in the same calendar month for the same prescription have been dispensed for any of the following:

(A) Antibiotics;

(B) Anti-asthmatics;

(C) Schedule II and III drugs;

(D) Antineoplastic agents;

(E) Topical preparations; or

(F) Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations.

(2) The pharmacy provider must make a request to MAA for a drug requiring prior authorization before dispensing the drug. The pharmacy provider must:

(a) Ensure the request states the medical diagnosis and includes medical justification for the drug; and

(b) Keep on file the medical justification communicated to the pharmacy by the prescriber.

(3) MAA evaluates a request for prior authorization based on, but not limited to:

(a) Requirements in this section;

(b) Requirements under WAC 388-530-1000, 388-530-1150, and 388-501-0165; and

(c) The least costly alternative between two or more preparations of equal effectiveness.

(4) MAA authorizes certain prescribed drugs through a process called "expedited prior authorization." MAA determines which drugs can be authorized through the expedited prior authorization process by establishing specific utilization criteria which include, but are not limited to:

(a) High cost;

(b) Potential for clinical misuse;

(c) Narrow therapeutic indication; and

(d) Safety.

(5) MAA may authorize reimbursement at the brand name estimated acquisition cost (EAC) for a brand name multiple-source drug that would have been reimbursed at the maximum allowable cost (MAC) for that multiple-source drug, if:

(a) The pharmacist calls for prior authorization; and

(b) The prescriber indicates:

(i) "Dispense as written" for the prescription; and

(ii) That a specific brand is "medically necessary" for a particular client; or

(c) The availability of generics in the marketplace is severely curtailed and the price disparity between the brand name EAC and the generic MAC is such that clients would be denied the medication.

(6) MAA provides a response to a request for drugs requiring prior authorization by telephone or other telecommunication device within twenty-four hours if the request is received during normal state business hours. If a provider needs prior authorization to dispense a drug during a weekend or Washington state holiday, the provider may dispense the drug without prior authorization only when:

(a) Given in an emergency;

(b) MAA receives justification within seventy-two hours of the fill date, excluding weekends and Washington state holidays; and

(c) MAA agrees with the justification and approves the request.

(7) MAA's prior authorization:

(a) Is limited to a decision of medical appropriateness for a drug; and

(b) Does not guarantee payment.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1250, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1250, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1300 General reimbursement methodology. (1) MAA's total reimbursement for a prescription drug must not exceed the lowest of:

(a) Estimated acquisition cost (EAC) plus a dispensing fee;

(b) Maximum allowable cost (MAC) plus a dispensing fee;

(c) Federal Upper Limit (FUL) plus a dispensing fee;

(d) Actual acquisition cost (AAC) plus a dispensing fee for drugs purchased under section 340 B of the Public Health Service (PHS) Act and dispensed to medical assistance clients; or

(e) The provider's usual and customary charge to the non-Medicaid population.

(2) MAA selects the in-state pharmaceutical wholesalers used to set EAC and MAC.

(3) MAA may solicit assistance from representative pharmacy providers, through their state associations, when establishing EAC and/or MAC.

(4) If the pharmacy provider offers a discount, rebate, promotion or other incentive which directly relates to the reduction of the price of a prescription to the individual non-Medicaid customer, the provider must similarly reduce its charge to MAA for the prescription.

(5) If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAA when giving the free product to a medical assistance client.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1300, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1300, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1350 Estimated acquisition cost methodology. MAA determines EAC as follows:

(1) No more than once every three years and no less than once every ten years, MAA:

(a) Takes a minimum sample of two hundred fifty of the top national drug codes (NDCs) paid by MAA, excluding drugs under the MAC program; and

(b) Determines pharmacies' average acquisition costs for these products.

(2) The pharmacies' average acquisition cost for the products in the NDC sample is based on in-state wholesalers' charges to pharmacy subscribers.

(3) MAA represents the average acquisition cost for each product on the sample list as a percentage of the average published wholesale price (AWP), determined for that product by MAA's drug pricing file contractor.

(4) MAA averages the percentages obtained from the sample, and that average represents the EAC.

(5) MAA may set EAC for specified drugs or drug categories at a percentage of AWP other than that determined in subsection (4) of this section when MAA considers it necessary. MAA ends the exemption when it considers the necessity no longer exists.

(6) MAA pays EAC for a drug with an established MAC when the EAC for the particular drug is lower than the MAC price.

(7) MAA bases EAC drug reimbursement on the actual package size dispensed.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1350, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1350, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1400 Maximum allowable cost methodology. (1) MAA establishes a maximum allowable cost (MAC) for a multiple-source drug which is available from at least three manufacturers/labelers.

(2) MAA may exclude from MAC selected multiple-source drugs when clinical response significantly differs between brand and generic equivalents.

(3) MAA determines the MAC for a multiple-source drug by:

(a) Obtaining copies of in-state wholesalers' product catalogs;

(b) Identifying what products are available from each in-state wholesaler for each MAC drug;

(c) Determining the average pharmacy subscriber's acquisition costs for these products;

(d) Ranking the products in descending order by acquisition cost; and

(e) Establishing the MAC at a level which gives most pharmacists access to two products.

(4) MAA may establish a MAC for a drug using the maximum allowable cost set by another third party for that drug.

(5) The MAC established for a multiple-source drug does not apply if the written prescription identifies that a specific brand is medically necessary for a particular client. In such cases EAC for the particular brand applies, provided prior authorization is obtained from MAA as specified under WAC 388-530-1250(5), Prior authorization.

(6) The MAC established for a multiple-source drug applies to all package sizes of that drug, except those identified as unit dose NDCs by the manufacturer(s) of the drug.

(7) MAA pays the EAC for a multiple-source product if the EAC for that product is less than the MAC established for the drug.

(8) The automated maximum allowable cost (AMAC) pricing applies to multiple-source drugs:

(a) Produced by three or more manufacturers/labelers at least one of which must have a federal drug rebate agreement; and

(b) Which are not on the MAC list.

(9) AMAC reimbursement for all products within a generic code number (GCN) sequence is at the EAC of the third lowest priced product in that sequence, or the EAC of the lowest priced drug under a federal rebate agreement in that sequence, whichever is higher.

(10) For a multiple-source product under AMAC, MAA pays the EAC if the EAC for the multiple-source product is less than the AMAC established for that product.

(11) MAA recalculates AMAC each time there is a pricing update provided by the drug file contractor to any product in GCN sequences.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1400, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1400, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1410 Federal upper limit (FUL) methodology. (1) MAA adopts the federal upper limit (FUL) set by the Health Care Financing Administration (HCFA) unless a lower MAC is already in place for the multiple source drug.

(2) MAA pays the EAC for a multiple source product if the EAC for that product is less than the FUL established for that drug.

(3) MAA's maximum payment for multiple source drugs for which HCFA has set a FUL will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAA.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1410, filed 12/7/00, effective 1/7/01.]

WAC 388-530-1425 Payment methodology for drugs purchased under the Public Health Service (PHS) Act. (1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed only by PHS-qualified health facilities to medical assistance clients. These medications must be billed using the actual acquisition cost (AAC) of the drug plus the appropriate dispensing fee.

(2) Drugs provided or dispensed by other specified providers must be billed using AAC. See WAC 388-530-1700.

(3) AAC includes allowances or discounts for volume purchases, purchasing cooperatives, and advertising or other promotional allowances.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1425, filed 12/7/00, effective 1/7/01.]

WAC 388-530-1450 Dispensing fee determination. Subject to the provisions of WAC 388-530-1300, MAA pays a dispensing fee for each covered prescription.

(1) MAA adjusts the dispensing fee by considering factors including, but not limited to:

(a) Legislative appropriations for vendor rates;

(b) Input from provider and/or advocacy groups;

(c) Input from state-employed or contracted actuaries; and

(d) Dispensing fees paid by other third-party payers, including, but not limited to, health care plans and other states' Medicaid agencies.

(2) MAA uses a tiered dispensing fee system which reimburses higher volume pharmacies at a lower fee and small volume pharmacies at a higher fee.

(3) MAA uses total annual prescription volume (both Medicaid and non-Medicaid) reported to MAA to determine each pharmacy's dispensing fee tier.

(a) A pharmacy which fills more than thirty-five thousand prescriptions annually is a high-volume pharmacy.

(b) A pharmacy which fills between fifteen thousand one and thirty-five thousand prescriptions annually is a mid-volume pharmacy.

(c) A pharmacy which fills fifteen thousand or fewer prescriptions annually is a low-volume pharmacy.

(4) MAA determines a pharmacy's annual total prescription volume as follows:

(a) MAA sends out a prescription volume survey form to pharmacy providers during the first quarter of the calendar year;

(b) Pharmacies return completed prescription volume surveys to MAA by the date specified. Pharmacy providers

not responding to the survey by the specified date are assigned to the high volume category;

(c) Pharmacies must include all prescriptions dispensed from the same physical location in the pharmacy's total prescription count;

(d) Hospital based pharmacies which serve both inpatient and outpatient clients are not required to include hospital inpatient doses/prescriptions in the total volume reported to MAA;

(e) MAA considers prescriptions dispensed to nursing facility clients as outpatient prescriptions;

(f) Assignment to a new dispensing fee tier is effective on the first of the month following the date specified by MAA.

(5) A pharmacy may request a change in dispensing fee tier during the interval between the annual prescription volume surveys. The pharmacy must substantiate such a request with documentation showing that the pharmacy's most recent six-month dispensing data, annualized, would qualify the pharmacy for the new tier. If MAA receives the documentation by the twentieth of the month, assignment to a new dispensing fee tier is effective on the first of the following month.

(6) MAA grants general dispensing fee rate increases only when authorized by the legislature. Amounts authorized for dispensing fee increases may be distributed nonuniformly (e.g., tiered dispensing fee based upon volume).

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1450, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1450, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1500 Reimbursement for compounded prescriptions. (1) MAA does not consider reconstitution to be compounding.

(a) MAA may consider the act of combining two or more active ingredients or the adjustment of therapeutic strengths and/or forms by a pharmacist in the preparation of a prescription to be compounding if the client's drug therapy needs are unable to be met by commercially available dosage strengths and/or forms of the medically necessary drug.

(b) The pharmacist must ensure the need for the adjustment of the drug's therapeutic strength and/or form is well documented in the client's file.

(2) Compounded prescriptions are reimbursed as follows:

(a) MAA allows only the lowest cost for each covered ingredient whether EAC, MAC, or amount billed.

(b) MAA applies current prior authorization requirements to drugs used as ingredients in compounded prescriptions, except as provided under subsection (2)(c) of this section. MAA denies payment for a drug requiring prior authorization used as an ingredient in a compounded prescription when prior authorization was not obtained.

(c) MAA may designate selected drugs as not requiring prior authorization when used for compounded prescriptions, but requiring prior authorization for other uses Refer to the pharmacy billing instructions.

(d) MAA reimburses a dispensing fee as described under WAC 388-530-1450 for:

(i) Each covered or prior authorized drug ingredient billed separately; and

(ii) Drugs used in compounding under subsection (2)(c) of this section.

(e) MAA does not pay a separate fee for compounding time.

(3) In addition to reimbursement for ingredient and dispensing fees, MAA may set maximum allowable fees, called compounded prescription preparation fees, for special procedures, equipment, or supplies used in compounding prescriptions.

(a) The pharmacy must note in its records any necessary special procedures, equipment, supplies, or containers used in preparing the compounded prescription.

(b) MAA adjusts compounded prescription preparation fees by considering factors including, but not limited to:

(i) Legislative appropriations for vendor rates;

(ii) Input from provider and/or advocacy groups;

(iii) Audit findings regarding costs of compounding equipment and supplies, as specified in subsection (4) of this section; and

(iv) Compounded prescription preparation fees paid by other third-party payers, including but not limited to health care plans and other states' Medicaid agencies.

(c) MAA does not reimburse compounded prescription preparation fees for infusion products; MAA reimbursement for home infusion and other intravenous admixtures is limited to ingredient costs and dispensing fees only.

(d) MAA reimburses pharmacies for only one preparation fee for each compounded prescription.

(e) Pharmacies bill MAA for compounded prescription preparation fees using state-assigned drug codes, which MAA publishes periodically in the pharmacy billing instructions.

(f) A separate dispensing fee does not apply to the state assigned drug preparation fee codes.

(4) MAA may audit selected pharmacies dispensing compounded prescriptions, to determine acquisition or estimated costs of equipment and/or supplies used in compounding.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1500, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1500, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1550 Unit dose drug delivery systems. (1) MAA pays for unit dose drug delivery systems only for clients residing in nursing facilities, except as provided in subsections (6) and (7) of this section.

(2) Unit dose delivery systems may be true or modified.

(3) MAA pays pharmacies that provide unit dose delivery service MAA's highest allowable dispensing fee for each prescription dispensed to clients in nursing facilities. MAA reimburses ingredient costs for drugs under unit dose systems at the appropriate MAC, FUL, AAC, EAC, or billed charge, whichever is lowest. MAA reimburses unit dose providers for drugs dispensed in manufacturers' unit dose packaging at the EAC for the specific unit dose NDCs.

(4) MAA pays a pharmacy that dispenses drugs in bulk containers or multi-dose form to clients in nursing facilities the regular dispensing fee applicable to the pharmacy's total

annual prescription volume tier. Drugs MAA considers not deliverable in unit dose form include, but are not limited to, liquids, creams, ointments, ophthalmic and otic solutions. MAA reimburses ingredient costs for such drugs at the lowest of MAC, FUL, AAC, EAC, or billed charge.

(5) MAA pays a pharmacy that dispenses drugs prepackaged by the manufacturer in unit dose form to clients in nursing facilities the regular dispensing fee applicable to that pharmacy's total annual prescription volume tier. MAA reimburses ingredient costs at the EAC applicable to the unit dose NDC.

(6) MAA reimburses for manufacturer-designated unit dose drugs dispensed to clients not residing in nursing facilities only when such drugs:

(a) Are available in the marketplace only in manufacturer-designated unit dose packaging; and

(b) Would otherwise have been covered outpatient drugs. The unit dose dispensing fee does not apply in such cases. MAA pays the pharmacy the dispensing fee applicable to the pharmacy's total annual prescription volume tier.

(7) MAA may pay for unit dose delivery systems for developmentally disabled (DD) clients residing in approved community living arrangements.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1550, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1550, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1600 Unit dose pharmacy billing requirements. (1) To be eligible for a unit dose dispensing fee, a pharmacy must:

(a) Notify MAA in writing of its intent to provide unit dose service;

(b) Identify the nursing facility(ies) to be served;

(c) Indicate the approximate date unit dose service to the facility(ies) will commence; and

(d) Sign an agreement to follow department requirements for unit dose reimbursement.

(2) Under a unit dose delivery system, a pharmacy must bill only for the number of drug units actually used by the medical assistance client in the nursing facility, except as provided in subsections (3) and (4) of this section.

(3) The pharmacy must submit an adjustment form or claims reversal of the charge to MAA for the cost of all unused drugs returned to the pharmacy from the nursing facility on or before the sixtieth day following the date the drug was dispensed, except as provided in subsection (4) of this section. Such adjustment must conform to the nursing facility's monthly log as described in subsection (6).

(4) Unit dose providers do not have to credit MAA for federally designated schedule two drugs which are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

(5) Pharmacies must not charge clients or MAA a fee for repackaging a client's bulk medications in unit dose form. The costs of repackaging are the responsibility of the nursing facility when the repackaging is done:

(a) To conform with a nursing facility's drug delivery system; or

(b) For the nursing facility's convenience.

(6) The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each nursing facility served, including but not limited to the following information:

(a) Facility name and address;

(b) Client's name and patient identification code (PIC);

(c) Drug name/strength;

(d) NDC;

(e) Quantity and date dispensed;

(f) Quantity and date returned;

(g) Value of returned drugs or amount credited;

(h) Explanation for no credit given or nonreusable returns; and

(i) Prescription number.

(7) Upon MAA's request, the pharmacy must submit copies of the logs referred to in subsection (6).

(8) When the pharmacy submits the completed annual prescription volume survey to MAA, it must include an updated list of nursing facilities served under unit dose systems.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1600, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.04.050, 74.08.090, 42 CFR 447.333 and Attachment 4.19-B, Page 2-b of the State Plan under Title XIX of the Social Security Act. 98-14-005, § 388-530-1600, filed 6/18/98, effective 7/19/98. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1600, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1625 Compliance packaging services. (1) MAA reimburses pharmacies for compliance packaging services provided to clients considered at risk for adverse drug therapy outcomes. Clients who are eligible for compliance packaging services must not reside in a nursing home or other inpatient facility, and must meet (a) and either (b) or (c) of this subsection.

(a) Have one or more of the following representative disease conditions:

(i) Alzheimer's disease;

(ii) Blood clotting disorders;

(iii) Cardiac arrhythmia;

(iv) Congestive heart failure;

(v) Depression;

(vi) Diabetes;

(vii) Epilepsy;

(viii) HIV/AIDS;

(ix) Hypertension;

(x) Schizophrenia; or

(xi) Tuberculosis.

(b) Concurrently consume two or more prescribed medications for chronic medical conditions, that are dosed at three or more intervals per day; or

(c) Have demonstrated a pattern of noncompliance that is potentially harmful to their health.

(2) Compliance packaging services include:

(a) Reusable hard plastic containers of any type (e.g., medisets); and

(b) Nonreusable compliance packaging devices (e.g., blister packs).

(3) MAA pays a filling fee and reimburses pharmacies for the compliance packaging device or container. The frequency of fills and number of payable compliance packaging

devices per client is subject to limits specified by MAA. MAA does not pay filling or preparation fees for blister packs.

(4) Pharmacies must use the HCFA-1500 claim form to bill MAA for compliance packaging services.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1625, filed 12/7/00, effective 1/7/01.]

WAC 388-530-1650 Reimbursement for pharmaceutical supplies. (1) The medical assistance administration (MAA) reimburses for covered pharmaceutical supplies not already included in other payment systems.

(2) MAA bases reimbursement of pharmaceutical supplies on MAA-published fee schedules.

(3) MAA uses any or all of the following methodologies to set the maximum allowable for a pharmaceutical device/supply:

(a) Pharmacy provider's acquisition cost. Upon review of the claim, MAA may require an invoice which must show the name of the drug, the manufacturer, drug strength, and cost;

(b) Medicare's reimbursement for the item; or

(c) A specified discount off the item's list price or manufacturer's suggested retail price (MSRP).

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1650, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1650, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1700 Drugs and pharmaceutical supplies from nonpharmacy providers. The medical assistance administration (MAA) reimburses for covered drugs, supplies, and devices provided or administered by nonpharmacy providers under specified conditions.

(1) MAA reimburses actual acquisition cost (AAC) to a physician or ARNP for a covered drug (oral, topical or injectable) prepared or packaged for individual use and provided or administered to a client during an office visit. When the cost of the drug provided or administered to the client exceeds the established fee, the physician or ARNP may submit to MAA a photocopy of the invoice for the actual drug cost. The invoice must show the name of the drug, the manufacturer, drug strength, quantity, and cost.

(2) MAA reimburses drugs and supplies provided to clients by local health departments according to its established fee schedules.

(3) MAA does not reimburse providers for the cost of vaccines obtained through the state department of health (DOH); MAA does pay a fee for administering the vaccine.

(4) MAA reimburses family planning clinics:

(a) For oral contraceptives, the lesser of the family planning clinic's certified full fee or MAA's maximum allowable fee per cycle of birth control pills. The certified full fee is the clinic's acquisition cost for each cycle of birth control pills, as reported annually by the clinic to DOH;

(b) For contraceptive supplies and devices, the clinic's actual acquisition cost or MAA's maximum allowable fee, whichever is specified by MAA; and

(c) For other drugs, supplies, and devices, according to MAA's established fee schedules.

(5) MAA may request family planning clinics and other nonpharmacy providers to submit an invoice for the actual cost of the drug, supply, or device billed. If an invoice is requested, the invoice must show the name of the drug, supply, or device, the drug or product manufacturer, drug strength, and quantity or product description and quantity, and cost.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1700, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1700, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1750 Drugs and pharmaceutical supplies for clients with any third-party coverage. (1) Except as specified under contract, the medical assistance administration (MAA) does not reimburse providers for any drugs or pharmaceutical supplies provided to clients who have pharmacy benefits under MAA-contracted managed care plans. The managed care plan is responsible for payment.

(2) The following definitions apply to this section:

(a) "Closed pharmacy network" means an arrangement made by an insurer which restricts prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy that is not included on the exclusive list.

(b) "Private point-of-sale (POS) authorization system" means an insurer's system, other than the MAA POS system, which requires that coverage be verified by or submitted to the insurer's agent for authorization at the time of service and at the time the prescription is filled.

(3) This subsection applies to MAA clients who have a third-party resource that is a managed care entity other than an MAA-contracted plan, or have other insurance that requires the use of "closed pharmacy networks" or "private point-of-sale authorization." MAA will not pay pharmacies for prescription drug claims until the pharmacy provider submits an explanation of benefits from the private insurance that demonstrates that the pharmacy provider has complied with the terms of coverage.

(a) If the private insurer pays a fee based on the incident of care, the pharmacy provider must file a claim with MAA consistent with MAA's billing requirements.

(b) If the private insurer pays the pharmacy provider a monthly capitation fee for all prescription costs related to the client, the pharmacy provider must submit a claim to MAA for the amount of the client copayment, coinsurance, and/or deductible. MAA pays the provider the lesser of:

(i) The billed amount; or

(ii) MAA's maximum allowable fee for the prescription.

(4) For clients eligible for both Medicare and medical assistance, MAA reimburses providers for:

(a) An amount up to MAA's maximum allowable fee for drugs Medicare does not cover, but MAA does cover; or

(b) Deductible and/or coinsurance amounts up to Medicare's or MAA's maximum allowable fee, whichever is less, for drugs Medicare and MAA cover; or

(c) Deductible and/or coinsurance amounts for clients under the qualified Medicare beneficiary (QMB) program for drugs Medicare does cover but MAA does not cover.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-14-071, § 388-530-1750, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1750, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1800 Requirements for pharmacy claim payment. (1) When billing for pharmacy services, providers must:

(a) Use the appropriate department claim form or electronic billing specifications; and

(b) Include the actual eleven-digit NDC number of the product dispensed.

(2) When billing drugs requiring authorization, providers must insert the authorization number in the appropriate data field on the drug claim.

(3) When billing drugs under the expedited authorization process, providers must insert the authorization number which includes the corresponding criteria code in the appropriate data field on the drug claim.

(4) Pharmacy services for clients on restriction under WAC 388-501-0135 must be prescribed by the client's primary care provider and are paid only to the client's primary pharmacy, except in cases of:

(a) Emergency;

(b) Family planning services; or

(c) Services properly referred from the client's assigned pharmacy or physician/ARNP.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-530-1800, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1800, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1850 Drug utilization and education (DUE) council. MAA establishes a drug utilization and education (DUE) council and determines membership rotation.

(1) The DUE council must:

(a) Have a minimum of eight and a maximum of ten members, representing actively practicing health care professionals who have recognized knowledge and expertise in one or more of the following:

(i) The clinically appropriate prescribing of covered outpatient drugs;

(ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs;

(iii) Drug use review, evaluation, and intervention;

(iv) Medical quality assurance; and

(v) Disease state management.

(b) Be made up of at least one-third but not more than fifty-one percent physicians, and at least one-third but not more than fifty-one percent pharmacists; and

(c) Include an advanced registered nurse practitioner and a physicians assistant.

(2) The DUE council meets periodically to:

(a) Advise MAA on drug utilization review activities;

(b) Review provider and patient profiles;

(c) Recommend adoption of standards and treatment guidelines for drug therapy;

(d) Provide interventions targeted toward therapy problems; and

(e) Produce an annual report.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1850, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1850, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1900 Drug utilization and claims review. (1) Drug utilization review (DUR) consists of:

(a) A prospective drug utilization review (Pro-DUR) that requires all pharmacy providers to:

(i) Obtain patient allergies, idiosyncracies, or chronic condition which may relate to drug utilization. See WAC 246-875-020 (1)(h)(i);

(ii) Screen for potential drug therapy problems; and

(iii) Counsel the patient in accordance with existing state pharmacy laws and federal regulations; and

(b) A retrospective drug utilization review (Retro-DUR), in which MAA provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.

(2) MAA performs a periodic sampling of claims to determine if drugs are appropriately dispensed and billed. If a review of the sample finds that a provider is inappropriately dispensing or billing for drugs, MAA may implement corrective action that includes, but is not limited to:

(a) Educating the provider regarding the problem practice(s);

(b) Recouping the payment for the drug; and/or

(c) Terminating the provider's core provider agreement.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1900, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1900, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1950 Point-of-sale (POS) system/prospective drug utilization review (Pro-DUR). (1) All pharmacy drug claims received by MAA for payment are adjudicated by the MAA point-of-sale (POS) system.

(2) All pharmacy drug claims processed through the POS system undergo a system-facilitated prospective drug utilization review (Pro-DUR) screening as a complement to the Pro-DUR screening required of pharmacists.

(3) MAA selects national council for prescription data processing (NCPDP) codes for pharmacy provider use in overriding MAA POS system alert messages.

(4) If the MAA POS system identifies a potential drug therapy problem during Pro-DUR screening, a message will alert the pharmacy provider indicating the type of potential problem.

(a) Alerts to possible drug therapy problems include, but are not limited to:

(i) Therapeutic duplication;

(ii) Duration of therapy exceeds maximum;

(iii) Drug-to-drug interaction;

(iv) Drug disease precaution;

(v) High dose;

(vi) Ingredient duplication;

(vii) Drug-to-client age conflict;

(viii) Drug-to-client gender conflict; or

(ix) Refill too soon.

(b) The dispensing pharmacist evaluates the potential drug therapy conflict.

(i) If the conflict is resolved, the pharmacy may process the claim using the applicable NCPDP code.

(ii) If the conflict is not resolved, MAA requires prior authorization for claims when an alert message is triggered in the POS system and NCPDP code is not appropriate.

(5) POS/Pro-DUR screening is not applicable to pharmacy claims included in the managed care capitated rate.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1950, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-08-018 (Order 3960), § 388-530-1950, filed 3/26/96, effective 4/26/96.]

WAC 388-530-2050 Reimbursement of out-of-state prescriptions. (1) MAA reimburses out-of-state pharmacies for prescription drugs provided to an eligible client within the scope of the client's medical care program if the pharmacy:

(a) Contracts with MAA to be an enrolled provider; and

(b) Meets the same criteria MAA requires for in-state pharmacy providers.

(2) MAA considers pharmacies located in bordering areas listed in WAC 388-501-075 the same as in-state pharmacies.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-2050, filed 12/7/00, effective 1/7/01; 00-01-088, § 388-530-2050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-2050, filed 10/9/96, effective 11/9/96.]

Chapter 388-531 WAC
PHYSICIAN-RELATED SERVICES

WAC

WAC 388-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, apply to this chapter. Defined words and phrases are bolded the first time they are used in the text.

"Acquisition cost" means the cost of an item excluding shipping, handling, and any applicable taxes.

"Acute care" means care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015).

"Acute physical medicine and rehabilitation (PM&R)" means a comprehensive inpatient and 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 specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 388-550-2501).

"Add-on procedure(s)" means secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" means the medical condition responsible for a hospital admission, as defined by ICD-9-M diagnostic code.

"Advanced registered nurse practitioner (ARNP)" means a registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Aging and adult services administration (AASA)" means the administration that administers directly or contracts for long-term care services, including but not limited to nursing facility care and home and community services. See WAC 388-15-202.

"Allowed charges" means the maximum amount reimbursed for any procedure that is allowed by MAA.

"Anesthesia technical advisory group (ATAG)" means an advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Base anesthesia units (BAU)" means a number of anesthesia units assigned to a surgical procedure that includes the usual pre-operative, intra-operative, and post-operative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" means services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" means supplies which are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

"By report (BR)" 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. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

"Call" means a face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" means a reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Certified registered nurse anesthetist (CRNA)" means an advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the National Certification and scope of practice.

"Children's health insurance plan (CHIP)," see chapter 388-542 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" means regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" means dollar amounts MAA uses to calculate the maximum allowable fee for physician-related services.

"Covered service" means a service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT," see "current procedural terminology."

"Critical care services" means physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Diagnosis code" means a set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

"Emergency medical condition(s)" means a medical condition(s) that manifests itself by acute symptoms of sufficient severity so 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.

"Emergency services" means medical services required by and provided to a patient experiencing an emergency medical condition.

"Estimated acquisition cost (EAC)" means the department's best estimate of the price providers generally and currently pay for drugs and supplies.

"Evaluation and management (E&M) codes" means procedure codes which categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" means the process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of safety and effectiveness. See WAC 388-531-0500. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the FDA or other requisite government body, if such approval is required.

"Fee-for-service" means the general payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MAA's healthy options program or children's health insurance program (CHIP) programs.

"Flat fee" means the maximum allowable fee established by MAA for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" as defined by Medicare, means a Medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement," see WAC 388-531-1700.

"HCPCS Level II" means a coding system established by the HCFA to define services and procedures not included in CPT.

"Health Care Financing Administration (HCFA)" means the agency within the federal Department of Health and Human Services (DHHS) with oversight responsibility for the Medicare and Medicaid programs.

"Health Care Financing Administration Common Procedure Coding System (HCPCS)" means the name used for the Health Care Financing Administration codes made up of CPT and HCPCS level II codes.

"Health care team" means a group of health care providers involved in the care of a client.

"Hospice" means a medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"ICD-9-CM," see "International Classification of Diseases, 9th Revision, Clinical Modification."

"Informed consent" means that an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and

(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and

(3) Given the client a copy of the consent form; and

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

(5) Given the client oral information about all of the following:

(a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" means an acute hospital stay for longer then twenty-four hours when the medical care record shows the need for inpatient care beyond twenty-four hours. All admissions are considered inpatient hospital admissions, and are paid as such, regardless of the length of stay, in the following circumstances:

(1) The death of a client;

(2) Obstetrical delivery;

(3) Initial care of a newborn; or

(4) Transfer to another acute care facility.

"International Classification of diseases, 9th Revision, Clinical Modification (ICD-9-CM)" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alphanumerical designations (coding).

"Investigational" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of benefit for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, in which the potential risks and potential benefits are examined, demonstrating the proposed service to be of greater overall benefit to the client in the particular circumstance than another, generally available service.

"Life support" means mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension" means a process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization.

"Maximum allowable fee" means the maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary," see WAC 388-500-0005.

"Medicare Physician Fee Schedule Data Base (MPFSDB)" means the official HCFA publication of the Medicare policies and RVUs for the RBRVS reimbursement program.

"Medicare Program Fee Schedule for Physician Services (MPFSPS)" means the official HCFA publication of the Medicare fees for physician services.

"Medicare Clinical Diagnostic Laboratory Fee Schedule" means the fee schedule used by Medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

"Mentally incompetent" means a client who has been declared mentally incompetent by a federal, state, or local court.

"Modifier" means a two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Outpatient" means a client who is receiving medical services in other than an inpatient hospital setting.

"Peer-reviewed medical literature" means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

"Physician care plan" means a written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" means physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology," see "CPT, current procedural terminology."

"PM&R," see acute physical medicine and rehabilitation.

"Podiatric service" means the diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Pound indicator (#)" means a symbol (#) indicating a CPT procedure code listed in MAA fee schedules that is not routinely covered.

"Preventive" means medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization" means a process by which clients or providers must request and receive MAA approval for certain medical services, equipment, or supplies, based on medical necessity, before the services are provided to clients,

as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

"Professional component" means the part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" means the probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" means face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider," see WAC 388-500-0005.

"Radioallergosorbent test" or **"RAST"** means a blood test for specific allergies.

"RBRVS," see resource based relative value scale.

"RVU," see relative value unit.

"Reimbursement" means payment to a provider or other MAA-approved entity who bills according to the provisions in WAC 388-502-0100.

"Reimbursement steering committee (RSC)" means an interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, MAA, and department of labor and industries.

"Relative value guide (RVG)" means a system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" means a unit which is based on the resources required to perform an individual service or intervention.

"Resource based relative value scale (RBRVS)" means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"RBRVS RVU" means a measure of the resources required to perform an individual service or intervention. It is set by Medicare based on three components - physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"RSC RVU" means a unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"Stat laboratory charges" means charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"State unique procedure codes" means procedure codes established by the RSC to define services or procedures not contained in CPT or HCPCS level II.

"Sterile tray" means a tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by HCFA to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" means an advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, MAA, and department of labor and industries.

"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 the procedure and service reimbursement that recognizes the equipment cost and technician time.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0050, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0100 Scope of coverage for physician-related services—General and administrative. (1) **The medical assistance administration (MAA)** covers medical services, equipment, and supplies when they are both:

(a) Within the scope of an eligible client's medical care program. Refer to chapter 388-529 WAC; and

(b) **Medically necessary** as defined in 388-500-0005.

(2) MAA evaluates a request for any service that is listed as noncovered in WAC 388-531-0150 under the provisions of WAC 388-501-0165.

(3) MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165 which related to medical necessity.

(4) MAA evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165.

(5) MAA covers the following physician-related services, subject to the conditions in subsection (1), (3), and (4) of this section:

(a) Allergen immunotherapy services;

(b) Anesthesia services;

(c) Dialysis and end stage renal disease services (refer to chapter 388-540 WAC);

(d) Emergency physician services;

(e) ENT (ear, nose, and throat) related services;

(f) Early and periodic screening, diagnosis, and treatment (**EPSDT**) services (refer to WAC 388-534-0100);

(g) Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when recommended after a multidisciplinary evaluation including at least urology, endocrinology, and psychiatry;

(h) Family planning services (refer to chapter 388-532 WAC);

(i) **Hospital** inpatient services (refer to chapter 388-550 WAC);

(j) Maternity care, delivery, and newborn care services (refer to chapter 388-533 WAC);

(k) Office visits;

(l) Vision-related services, per chapter 388-544 WAC;

(m) Osteopathic treatment services;

(n) Pathology and laboratory services;

(o) Physiatry and other rehabilitation services (refer to chapter 388-550 WAC);

(p) Podiatry services;

(q) Primary care services;

(r) Psychiatric services, provided by a psychiatrist;

(s) Pulmonary and respiratory services;

(t) Radiology services;

(u) Surgical services;

(v) Surgery to correct defects from birth, illness, or trauma, or for mastectomy reconstruction; and

(w) Other **outpatient** physician services.

(6) MAA covers physical examinations for MAA clients only when the physical examination is one or more of the following:

(a) A screening exam covered by the EPSDT program (see WAC 388-534-0100);

(b) An annual exam for clients of the division of developmental disabilities; or

(c) A screening pap smear, mammogram, or prostate exam.

(7) By providing covered services to a client eligible for a medical care program, a provider who has signed an agreement with MAA accepts MAA's rules and fees as outlined in the agreement, which includes federal and state law and regulations, billing instructions, and MAA issuances.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0100, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0150 Noncovered physician-related services—General and administrative. (1) Except as provided in WAC 388-531-0100 and subsection (2) of this section, MAA does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(e) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 388-501-0165;

(f) Hair transplantation;

(g) Marital counseling or sex therapy;

(h) More costly services when MAA determines that less costly, equally effective services are available;

(i) Vision-related services listed as noncovered in chapter 388-544 WAC;

(j) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 388-531-1750;

(k) Physician-supplied medication, except those drugs administered by the physician in the physician's office;

(l) Physical examinations or routine checkups, except as provided in WAC 388-531-0100;

(m) Routine foot care. This does not include clients who have a medical condition that affects the feet, such as diabetes or arteriosclerosis obliterans. Routine foot care includes, but is not limited to:

(i) Treatment of mycotic disease;

(ii) Removal of warts, corns, or calluses;

(iii) Trimming of nails and other hygiene care; or

(iv) Treatment of flat feet;

(n) Except as provided in WAC 388-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, or the application of associated services.

(o) Nonmedical equipment; and

(p) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas.

(2) MAA covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A Medicaid program for qualified **Medicare** beneficiaries (QMBs); or

(c) A waiver program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0150, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0200 Physician-related services requiring prior authorization. (1) MAA requires **prior authorization** for certain services. Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE)**. See WAC 388-501-0165.

(2) The EPA process is designed to eliminate the need for telephone prior authorization for selected admissions and procedures.

(a) The provider must create an authorization number using the process explained in MAA's physician-related billing instructions.

(b) Upon request, the provider must provide supporting clinical documentation to MAA showing how the authorization number was created.

(c) Selected nonemergent admissions to contract hospitals require EPA. These are identified in MAA billing instructions.

(d) Procedures requiring expedited prior authorization include, but are not limited to, the following:

(i) Bladder repair;

(ii) Hysterectomy for clients age forty-five and younger, except with a diagnosis of cancer(s) of the female reproductive system;

(iii) Outpatient magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA);

(iv) Reduction mammoplasties/mastectomy for geynecomastia; and

(v) Strabismus surgery for clients eighteen years of age and older.

(3) MAA evaluates new technologies under the procedures in WAC 388-531-0550. These require prior authorization.

(4) Prior authorization is required for the following:

(a) Abdominoplasty;

(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R)**;

(c) Cochlear implants, which also:

(i) For coverage, must be performed in an ambulatory surgery center (ASC) or an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim;

(d) Diagnosis and treatment of eating disorders for clients twenty-one years of age and older;

(e) Osteopathic manipulative therapy in excess of MAA's published limits;

(f) Panniculectomy;

(g) Surgical procedures related to weight loss or reduction; and

(h) Vagus nerve stimulator insertion, which also:

(i) For coverage, must be performed in an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim.

(5) MAA may require a second opinion and/or consultation before authorizing any elective surgical procedure.

(6) Children six year of age and younger do not require authorization for hospitalization.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0200, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0250 Who can provide and bill for physician-related services. (1) The following enrolled providers are eligible to provide and bill for physician-related medical services which they provide to eligible clients:

(a) Advanced registered nurse practitioners (ARNP);

(b) Federally qualified health centers (FQHCs);

(c) Health departments;

(d) Hospitals currently licensed by the department of health;

(e) Independent (outside) laboratories **CLIA** certified to perform tests. See WAC 388-531-0800;

(f) Licensed radiology facilities;

(g) Medicare-certified ambulatory surgery centers;

(h) Medicare-certified rural health clinics;

(i) Providers who have a signed agreement with MAA to provide screening services to eligible persons in the EPSDT program;

(j) Registered nurse first assistants (RNFA); and

(k) Persons currently licensed by the state of Washington department of health to practice any of the following:

(i) Dentistry (refer to chapter 388-535 WAC);

(ii) Medicine and osteopathy;

(iii) Nursing;

(iv) Optometry; or

(v) Podiatry.

(2) MAA does not reimburse for services performed by any of the following practitioners:

(a) Acupuncturists;

(b) Christian Science practitioners or theological healers;

(c) Counselors;

(d) Herbalists;

(e) Homeopaths;

(f) Massage therapists as licensed by the Washington state department of health;

(g) Naturopaths;

(h) Sanipractors;

(i) Those who have a master's degree in social work (MSW), except those employed by an FQHC;

(j) Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010; or

(k) Any other licensed practitioners providing services which the practitioner is not:

(i) Licensed to provide; and

(ii) Trained to provide.

(3) MAA reimburses practitioners listed in subsection (2) of this section for physician-related services if those services are mandated by, and provided to, clients who are eligible for one of the following:

(a) The EPSDT program;

(b) A Medicaid program for qualified Medicare beneficiaries (QMB); or

(c) A waiver program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0250, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0300 Anesthesia providers and covered physician-related services. MAA bases coverage of anesthesia services on Medicare policies and the following rules:

(1) MAA reimburses providers for covered anesthesia services performed by:

(a) Anesthesiologists;

(b) **Certified registered nurse anesthetists (CRNAs)**;

(c) Oral surgeons with a special agreement with MAA to provide anesthesia services; and

(d) Other providers who have a special agreement with MAA to provide anesthesia services.

(2) MAA covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) MAA covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions:

(b) Maternity per subsection (9) of this section. See WAC 388-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC 388-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

(a) Perform a pre-anesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) MAA does not allow the anaesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by Medicare instructions.

(6) MAA requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, MAA reimburses the base anesthesia units (BAU) for the major procedure only.

(b) MAA does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, MAA reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive fifty percent of the allowed amount.

(ii) For anesthesia provided by a team, MAA limits reimbursement to one hundred percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) MAA pays CRNAs or anesthesiologists for pain management services.

(b) MAA allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) MAA does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC 388-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter 388-533 WAC for more information about maternity-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0300, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0350 Anesthesia services—Reimbursement for physician-related services. (1) MAA reimburses anesthesia services on the basis of base anesthesia units (BAU) plus time.

(2) MAA calculates payment for anesthesia by adding the BAU to the time units and multiplying that sum by the conversion factor. The formula used in the calculation is: (BAU x fifteen)+ time) x (conversion factor divided by fifteen)=reimbursement.

(3) MAA obtains BAU values from the relative value guide (**RVG**), and updates them annually. MAA and/or the anesthesia technical advisory group (**ATAG**) members establish the base units for procedures for which anesthesia is appropriate but do not have BAUs established by RVSP and are not defined as add-on.

(4) MAA determines a budget neutral anesthesia conversion factor by:

(a) Determining the BAUs, time units, and expenditures for a **base period** for the provided procedure. Then,

(b) Adding the latest BAU RVSP to the time units for the base period to obtain an estimate of the new time unit for the procedure. Then,

(c) Multiplying the time units obtained in (b) of this subsection for the new period by a conversion factor to obtain estimated expenditures. Then,

(d) Comparing the expenditures obtained in (c) of this subsection with base period expenditure levels obtained in (a) of this subsection. Then,

(e) Adjusting the dollar amount for the anesthesia conversion factor and the projected time units at the new BAUs equals the allocated amount determined in (a) of this subsection.

(5) MAA calculates anesthesia time units as follows:

(a) One minute equals one unit.

(b) The total time is calculated to the next whole minute.

(c) Anesthesia time begins when the anesthesiologist, surgeon, or CRNA begins physically preparing the client for the induction of anesthesia; this must take place in the operating room or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be added together as long as there is continuous monitoring. Examples of this include, but are not limited to, the following:

(i) The time a client spends in an anesthesia induction room; or

(ii) The time a client spends under the care of an operating room nurse during a surgical procedure.

(d) Anesthesia time ends when the anesthesiologist, surgeon, or CRNA is no longer in constant attendance (i.e., when the client can be safely placed under post-operative supervision).

(6) MAA changes anesthesia **conversion factors** if the legislature grants a vendor rate increase, or other increase, and if the effective date of that increase is not the same as MAA's annual update.

(7) If the legislatively authorized vendor rate increase or other increase becomes effective at the same time as MAA's annual update, MAA applies the increase after calculating the budget-neutral conversion factor.

(8) When more than one surgical procedure is performed at the same operative session, MAA uses the BAU of the major procedure to determine anesthesia **allowed charges**. MAA reimburses add-on procedures as defined by CPT only for the time spent on the add-on procedure that is in addition to the time spent on the major procedure.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0350, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0400 Client responsibility for reimbursement for physician-related services. Clients may be responsible to reimburse the provider, as described under WAC 388-501-0100, for services that are not covered under the client's medical care program. Clients whose care is provided under CHIP may be responsible for copayments as outlined in chapter 388-542 WAC. Also, see WAC 388-502-0160, Billing the client.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0400, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0450 Critical care—Physician-related services. (1) MAA reimburses the following physicians for critical care services:

(a) The attending physician who assumes responsibility for the care of a client during a life-threatening episode;

(b) More than one physician if the services provided involve multiple organ systems; or

(c) Only one physician for services provided in the emergency room.

(2) MAA reimburses preoperative and postoperative critical care in addition to a **global surgical package** when all the following apply:

(a) The client is critically ill and the physician is engaged in work directly related to the individual client's care, whether that time is spent at the immediate bedside or elsewhere on the floor;

(b) The critical injury or illness acutely impairs one or more vital organ systems such that the client's survival is jeopardized;

(c) The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and

(d) The provider uses any necessary, appropriate modifier when billing MAA.

(3) MAA limits payment for critical care services to a maximum of three hours per day, per client.

(4) MAA does not pay separately for certain services performed during a critical care period when the services are provided on a per hour basis. These services include, but are not limited to, the following:

(a) Analysis of information data stored in computers (e.g., ECG, blood pressure, hematologic data);

(b) Blood draw for a specimen;

(c) Blood gases;

(d) Cardiac output measurement;

(e) Chest X-rays;

(f) Gastric intubation;

(g) Pulse oximetry;

(h) Temporary transcutaneous pacing;

(i) Vascular access procedures; and

(j) Ventilator management.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0450, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0500 Emergency physician-related services. (1) MAA reimburses for E&M services provided in the hospital emergency department to clients who arrive for immediate medical attention.

(2) MAA reimburses emergency physician services only when provided by physicians assigned to the hospital emergency department or the physicians on **call** to cover the hospital emergency department.

(3) MAA pays a provider who is called back to the emergency room at a different time on the same day to attend a return visit the same client. When this results in multiple claims on the same day, the time of each encounter must be clearly indicated on the claim.

(4) MAA does not pay emergency room physicians for **hospital admission** charges or additional service charges.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0550 Experimental and investigational services. (1) When MAA makes a determination as to whether a proposed service is experimental or investigational, MAA follows the procedures in this section. The policies and procedures and any criteria for making decisions are available upon request.

(2) The determination of whether a service is experimental and/or investigational is subject to a case-by-case review under the provisions of WAC 388-501-0165 which relate to medical necessity. MAA also considers the following:

(a) Evidence in **peer-reviewed medical literature**, as defined in WAC 388-531-0050, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications;

(b) Whether evidence indicates the service or treatment is more likely than not to be as beneficial as existing conventional treatment alternatives for the treatment of the condition in question;

(c) Whether the service or treatment is generally used or generally accepted for treatment of the condition in the United States;

(d) Whether the service or treatment is under continuing scientific testing and research;

(e) Whether the service or treatment shows a demonstrable benefit for the condition;

(f) Whether the service or treatment is safe and efficacious;

(g) Whether the service or treatment will result in greater benefits for the condition than another generally available service; and

(h) If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

(3) MAA applies consistently across clients with the same medical condition and health status, the criteria to determine whether a service is experimental. A service or treatment that is not experimental for one client with a particular medical condition is not determined to be experimental for another enrollee with the same medical condition and health status. A service that is experimental for one client with a particular medical condition is not necessarily experimental for another, and subsequent individual determinations must consider any new or additional evidence not considered in prior determinations.

(4) MAA does not determine a service or treatment to be experimental or investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of greater overall benefit to the client in question than another generally available service.

(5) All determinations that a proposed service or treatment is "experimental" or "investigation" are subject to the review and approval of a physician who is:

(a) Licensed under chapter 18.57 RCW or an osteopath licensed under chapter 18.71 RCW;

(b) Designated by MAA's medical director to issue such approvals; and

(c) Available to consult with the client's treating physici8an by telephone.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0550, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0600 HIV/AIDS Counseling and testing as physician-related services. MAA covers one pre- and one post-HIV/AIDS counseling/testing session per client each time the client is tested for HIV/AIDS.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0600, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0650 Hospital physician-related services not requiring authorization when provided in MAA-approved centers of excellence or hospitals authorized to provide the specific services. MAA covers the following services without prior authorization when provided in MAA-approved centers of excellence. MAA issues periodic publications listing centers of excellence. These services include the following:

(1) All transplant procedures specified in WAC 388-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400. See also WAC 388-531-0700;

(3) Sleep studies including but not limited to polysomnograms for clients one year of age and older. MAA allows sleep studies only in outpatient hospital settings as described under WAC 388-550-6350. See also WAC 388-531-1500;

(4) Diabetes education, in a DOH-approved facility, per WAC 388-550-6300; and

(5) MAA-approved structured weight loss programs. See also WAC 388-531-1600.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0650, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0700 Inpatient chronic pain management physician-related services. (1) MAA covers inpatient chronic pain management services only when the services are obtained through an MAA-approved chronic pain facility.

(2) A client qualifies for inpatient chronic pain management services when all of the following apply:

(a) The client has had chronic pain for at least three months, that has not improved with conservative treatment, including tests and therapies;

(b) At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and

(c) Clients with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs or alcohol for six months.

(3) For chronic pain management, MAA limits coverage to only one inpatient hospital stay per client's lifetime, up to a maximum of twenty-one days.

(4) MAA reimburses for only the chronic pain management services and procedures that are listed in the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0700, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0750 Inpatient hospital physician-related services. (1) MAA separately reimburses the attending provider for inpatient hospital professional services rendered by the attending provider during the surgical follow-up period only if the services are performed for an emergency condition or a diagnosis that is unrelated to the inpatient stay.

(2) MAA reimburses for only one inpatient hospital call per client, per day for the same or related diagnoses. If a call is included in the **global surgery reimbursement**, MAA does not reimburse separately.

(3) MAA reimburses a hospital admission related to a planned surgery through the global fee for surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0750, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0800 Laboratory and pathology physician-related services. (1) MAA reimburses providers for laboratory services only when:

(a) The provider is certified according to Title XVII of the Social Security Act (Medicare), if required; and

(b) The provider has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) MAA includes a handling, packaging, and mailing fee in the reimbursement for lab tests and does not reimburse these separately.

(3) MAA reimburses only one blood drawing fee per client, per day. MAA allows additional reimbursement for an

independent laboratory when it goes to a nursing facility or a private home to obtain a specimen.

(4) MAA reimburses only one catheterization for collection of a urine specimen per client, per day.

(5) MAA reimburses automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not all tests are performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, MAA reimburses the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

(i) A clinic;

(ii) A hospital laboratory;

(iii) An independent laboratory; or

(iv) A physician's office.

(6) MAA allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) MAA reimburses STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order, the physician must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) MAA reimburses for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) MAA does not reimburse for drug screens for clients in the division of alcohol and substance abuse (DASA)-contracted methadone treatment programs. These are reimbursed through a contract issued by DASA.

(9) MAA does not cover for drug screens to monitor any of the following:

(a) Program compliance in either a residential or outpatient drug or alcohol treatment program;

(b) Drug or alcohol abuse by a client when the screen is performed by a provider in private practice setting; or

(c) Suspected drug use by clients in a residential setting, such as a group home.

(10) MAA may require a drug or alcohol screen in order to determine a client's suitability for a specific test.

(11) An independent laboratory must bill MAA directly. MAA does not reimburse a medical practitioner for services referred to or performed by an independent laboratory.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0800, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0850 Laboratory and pathology physician-related services reimbursement. (1) MAA pays for clinical diagnostic laboratory procedures based on the **Medicare clinical diagnostic laboratory fee schedule (MCDLF)** for the state of Washington. MAA obtains information used to update fee schedule regulations from Program Memorandum and Regional Medicare Letters as published by HCFA.

(2) MAA updates budget-neutral fees each July by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Determining in total the ratio of current MAA fees to existing Medicare fees. Then,

(c) Determining new MAA fees by adjusting the new Medicare fee by the ratio. Then,

(d) Multiplying the units of service by the new MAA fee to obtain total estimated expenditures. Then,

(e) Comparing the expenditures in subsection (14)(d) of this section to the base period expenditures. Then,

(f) Adjusting the new ratio until estimated expenditures equals the base period amount.

(3) MAA calculates maximum allowable fees (MAF) by:

(a) Calculating fees using methodology described in subsection (2) of this section for procedure codes that have an applicable Medicare clinical diagnostic laboratory fee (MCDLF).

(b) Establishing **RSC** fees for procedure codes that have no applicable MCDLF.

(c) Establishing maximum allowable fees, or **"flat fees"** for procedure codes that have no applicable MCDLF or RSC fees. MAA updates flat fee reimbursement only when authorized by the legislature.

(d) MAA reimbursement for clinical laboratory diagnostic procedures does not exceed the regional MCDLF schedule.

(4) MAA increases fees if the legislature grants a vendor rate increase or other increase. If the legislatively authorized increase becomes effective at the same time as MAA's annual update, MAA applies the increase after calculating budget-neutral fees.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0850, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0900 Neonatal intensive care unit (NICU) physician-related services. (1) MAA pays the physician directing the care of a neonate or infant in an NICU, for NICU services.

(2) NICU services include, but are not limited to, any of the following:

(a) Patient management;

(b) Monitoring and treatment of the neonate, including nutritional, metabolic and hematologic maintenance;

(c) Parent counseling; and

(d) Personal direct supervision by the **health care team** of activities required for diagnosis, treatment, and supportive care of the patient.

(3) Payment for NICU care begins with the date of admission to the NICU.

(4) MAA reimburses a provider for only one NICU service per client, per day.

(5) A provider may bill for NICU services in addition to**prolonged services** and newborn resuscitation when the provider is present at the delivery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0900, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0950 Office and other outpatient physician-related services. (1) MAA reimburses for the following:

(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and.

(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 388-531-0500.

(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (1) of this section.

(3) See physician billing instructions for procedures that are included in the office call and cannot be billed separately.

(4) Using selected diagnosis codes, MAA reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.

(5) MAA may reimburse providers for injection procedures and/or injectable drug products only when:

(a) The injectable drug is administered during an office visit; and

(b) The injectable drug used is from office stock and purchased by the provider from a pharmacist or drug manufacturer as described in WAC 388-530-1200.

(6) MAA does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) MAA does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; MAA does reimburse an administrative fee. If the immunization is given in a health department and is the only service provided, MAA reimburses a minimum E&M service.

(8) MAA reimburses immunizations at **estimated acquisition costs (EAC)** when the immunizations are not part of the vaccine for children program. MAA reimburses a separate administration fee for these immunizations. Covered immunizations are listed in the fee schedule.

(9) MAA reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) MAA does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. MAA does pay separately for the administration of these injections when they are provided on the same day as an E&M service. MAA does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. MAA reimburses separately for the drug(s).

(b) MAA does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same day as an E&M service. If the injection is the only service provided, MAA pays an administrative fee. MAA reimburses separately for the drug.

(c) MAA reimburses injectable drugs at **acquisition cost**. The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by MAA. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing MAA for the following drugs:

(i) Classified drugs where the billed charge to MAA is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to MAA is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) MAA reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent times, MAA reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) MAA covers the antigen, the antigen preparation, and an administration fee.

(e) MAA reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) MAA reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) MAA reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on the Medicare pricing method for calculating the estimated acquisition cost (EAC), or maximum allowable cost (MAC) when generics are available;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

(ii) The dosage and strength used; and

(iii) The national drug code (NCD).

(12) Notwithstanding the provisions of this section, MAA reserves the option of determining drug pricing for any particular drug based on the best evidence available to MAA, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) MAA may request an invoice as necessary.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0950, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1000 Ophthalmic physician-related services. Refer to chapter 388-544 WAC for ophthalmic and vision-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1000, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1050 Osteopathic manipulative treatment. (1) MAA reimburses osteopathic manipulative therapy (OMT) only when OMT is provided by an osteopathic physician licensed under chapter 18.71 RCW.

(2) MAA reimburses OMT only when the provider bills using the appropriate CPT codes that involve the number of body regions involved.

(3) MAA allows an osteopathic physician to bill MAA for an E&M service in addition to the OMT when one of the following apply:

(a) The physician diagnoses the condition requiring manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require manipulative therapy.

(4) MAA limits reimbursement for manipulations to ten per client, per calendar year. Reimbursement for each manipulation includes a brief evaluation as well as the manipulation.

(5) MAA does not reimburse for physical therapy services performed by osteopathic physicians.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1050, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1100 Out-of-state physician services. (1) MAA covers medical services provided to eligible clients who are temporarily located outside the state, subject to the provisions of this chapter and WAC 388-501-0180.

(2) Out-of-state border areas as described under WAC 388-501-0175 are not subject to out-of-state limitations. MAA considers physicians in border areas as providers in the state of Washington.

(3) In order to be eligible for reimbursement, out-of-state physicians must meet all criteria for, and must comply with all procedures required of in-state physicians, in addition to other requirements of this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1100, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1150 Physician care plan oversight services. (1) MAA covers **physician care plan** oversight services only when:

(a) A physician provides the service; and

(b) The client is served by a home health agency, a nursing facility, or a **hospice**.

(2) MAA reimburses for physician care plan oversight services when both of the following apply:

(a) The facility/agency has established a plan of care; and

(b) The physician spends thirty or more minutes per calendar month providing oversight for the client's care.

(3) MAA reimburses only one physician per client, per month, for physician care plan oversight services.

(4) MAA reimburses for physician care plan oversight services during the global surgical reimbursement period only when the care plan oversight is unrelated to the surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1150, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1200 Physician office medical supplies. (1) Refer to RBRVS billing instructions for a list of:

(a) Supplies that are a routine part of office or other outpatient procedures and that cannot be billed separately; and

(b) Supplies that can be billed separately and that MAA considers nonroutine to office or outpatient procedures.

(2) MAA reimburses at acquisition cost certain supplies under fifty dollars that do not have a maximum allowable fee listed in the fee schedule. The provider must retain invoices for these items and make them available to MAA upon request.

(3) Providers must submit invoices for items costing fifty dollars or more.

(4) MAA reimburses for **sterile tray** for certain surgical services only. Refer to the fee schedule for a list of covered items.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1200, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1250 Physician standby services. (1) MAA reimburses **physician standby** services only when the standby physician does not provide care or service to other clients during this period, and either:

(a) The services are provided in conjunction with newborn care history and examination, or result in an admission to a neonatal intensive care unit on the same day; or

(b) A physician requests another physician to stand by, resulting in the prolonged attendance by the second physician without face-to-face client contact.

(2) MAA does not reimburse physician standby services when any of the following occur:

(a) The standby ends in a surgery or procedure included in a global surgical reimbursement;

(b) The standby period is less than thirty minutes; or

(c) Time is spent proctoring another physician.

(3) One unit of physician standby service equals thirty minutes. MAA reimburses subsequent periods of physician standby service only when full thirty minutes of standby is provided for each unit billed. MAA rounds down fractions of a thirty-minute time unit.

(4) The provider must clearly document the need for physician standby services in the client's medical record.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1250, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1300 Podiatric physician-related services. (1) MAA covers podiatric services as listed in this section when provided by any of the following:

(a) A medical doctor;

(b) A doctor of osteopathy; or

(c) A podiatric physician.

(2) MAA reimburses for the following:

(a) Nonroutine foot care when a medical condition that affects the feet (such as diabetes or arteriosclerosis obliterans) requires that any of the providers in subsection (1) of this section perform such care;

(b) One treatment in a sixty-day period for debridement of nails. MAA covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) Impression casting. MAA includes ninety-day follow-up care in the reimbursement;

(d) A surgical procedure performed on the ankle or foot, requiring a local nerve block, and performed by a qualified provider. MAA does not reimburse separately for the anesthesia, but includes it in the reimbursement for the procedure; and

(e) Custom fitted and/or custom molded orthotic devices:

(i) MAA's fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) MAA includes an E&M fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical record.

(3) MAA does not reimburse podiatrists for any of the following radiology services:

(a) X-rays for soft tissue diagnosis;

(b) Bilateral x-rays for a unilateral condition;

(c) X-rays in excess of two views;

(d) X-rays that are ordered before the client is examined; or

(e) X-rays for any part of the body other than the foot or ankle.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1300, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1350 Prolonged physician-related service. (1) MAA reimburses prolonged services based on established Medicare guidelines. The services provided may or may not be continuous. The services provided must meet both of the following:

(a) Consist of face-to-face contact between the physician and the client; and

(b) Be provided with other services.

(2) MAA allows reimbursement for a prolonged service procedure in addition to an E&M procedure or consultation, up to three hours per client, per diagnosis, per day, subject to other limitations in the CPT codes that may be used. The applicable CPT codes are indicated in the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1350, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1400 Psychiatric physician-related services. (1) MAA limits psychotherapy to one hour per day, per client, up to a total of twelve hours per calendar year. This includes family or group psychotherapy. Psychotherapy must be provided by a psychiatrist in the office, in the client's home, or in a nursing facility.

(2) MAA reimburses only one hospital call for direct psychiatric client care, per client, per day. Psychiatrists must bill the total time spent on direct psychiatric client care during each visit. Making rounds is considered direct client care and includes any one of the following:

(a) Brief (up to one hour), individual psychotherapy;

(b) Family/group therapy;

(c) Electroconvulsive therapy; or

(d) Pharmacologic management.

(3) MAA reimburses psychiatrists for either hospital care or psychotherapy, but not for both on the same day.

(4) MAA reimburses psychiatrists for a medical physical examination in the hospital in addition to a psychiatric diagnostic or evaluation interview examination.

(5) MAA reimburses only one psychiatric diagnostic interview examination in a calendar year unless a significant change in the client's circumstances renders an additional evaluation medically necessary.

(6) MAA requires psychiatrists to use hospital E&M codes when billing for daily rounds.

(7) MAA does not cover for psychiatric sleep therapy.

(8) Medication adjustment is the only psychiatric service for which MAA reimburses psychiatric ARNPs.

(9) MAA reimburses for one interactive or insight oriented call per client, per day, in an office or outpatient setting. Individual psychotherapy, interactive services may be billed only for clients age twenty and younger.

(10) DSHS providers must comply with chapters 275-55 and 275-57 WAC for hospital inpatient psychiatric admissions, and must follow rules adopted by the division of mental health or the appropriate regional support network (RSN). MAA does not reimburse for those psychiatric services that are eligible for reimbursement under those agencies.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1400, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1450 Radiology physician-related services. (1) MAA reimburses radiology services subject to the limitations in this section and under WAC 388-531-0300.

(2) MAA does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Pre-existing renal insufficiency; and/or

(g) Other clinical situations where use of any media except LOCM would constitute a danger to the health of the client.

(3) MAA reimburse separately for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures. Providers must submit invoices for these procedures when requested by MAA, and reimbursement is at acquisition cost.

(4) MAA reimburses general anesthesia for radiology procedures. See WAC 388-531-0300.

(5) MAA reimburses radiology procedures in combination with other procedures according to the rules for multiple

surgeries. See WAC 388-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) MAA reimburses consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate **professional component** modifier.

(7) MAA reimburses for portable x-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of contract media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column or skull.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1450, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1500 Sleep studies. (1) MAA covers sleep studies only when all of the following apply:

(a) The study is done to establish a diagnosis of narcolepsy or of sleep apnea;

(b) The study is done only at an MAA-approved sleep study center that meets the standards and conditions in subsections (2), (3), and (4) of this section; and

(c) An ENT consultation has been done for a client under ten years of age.

(2) In order to become an MAA-approved sleep study center, a sleep lab must send MAA verification of both of the following:

(a) Sleep lab accreditation by the American Academy of Sleep Medicine; and

(b) Physician's Board Certification by the American Board of Sleep Medicine.

(3) Registered polysomnograph technicians (PSGT) must meet the accreditation standards of the American Academy of Sleep Medicine.

(4) When a sleep lab changes directors, MAA requires the provider to submit accreditation for the new director. If an accredited director moves to a facility that MAA has not approved, the provider must submit certification for the facility.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1500, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1550 Sterilization physician-related services. (1) For purposes of this section, sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. A hysterectomy is a surgical procedure or operation for the purpose of removing the uterus. Hysterectomy results in sterilization, but MAA does not cover hysterectomy performed solely for that purpose. Both hysterectomy and sterilization procedures require the use of specific consent forms.

STERILIZATION

(2) MAA covers sterilization when all of the following apply:

(a) The client is at least eighteen years of age at the time consent is signed;

(b) The client is a mentally competent individual;

(c) The client has voluntarily given **informed consent** in accordance with all the requirements defined in this subsection; and

(d) At least thirty days, but not more than one hundred eighty days, have passed between the date the client gave informed consent and the date of the sterilization.

(3) MAA does not require the thirty-day waiting period, but does require at least a seventy-two hour waiting period, for sterilization in the following circumstances:

(a) At the time of premature delivery, the client gave consent at least thirty days before the expected date of delivery. The expected date of delivery must be documented on the consent form;

(b) For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

(4) MAA waives the thirty-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, and completes a sterilization consent form. One of the following circumstances must apply:

(a) The client became eligible for **medical assistance** during the last month of pregnancy;

(b) The client did not obtain medical care until the last month of pregnancy; or

(c) The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery.

(5) MAA does not accept informed consent obtained when the client is in any of the following conditions:

(a) In labor or childbirth;

(b) Seeking to obtain or obtaining an abortion; or

(c) Under the influence of alcohol or other substances that affect the client's state of awareness.

(6) MAA has certain consent requirements that the provider must meet before MAA reimburses sterilization of a **mentally incompetent** or institutionalized client. MAA requires both of the following:

(a) A court order; and

(b) A sterilization consent form signed by the legal guardian, sent to MAA at least thirty days prior to the procedure.

(7) MAA reimburses epidural anesthesia in excess of the six-hour limit for sterilization procedures that are performed in conjunction with or immediately following a delivery. MAA determines total billable units by:

(a) Adding the time for the sterilization procedure to the time for the delivery; and

(b) Determining the total billable units by adding together the delivery BAUs, the delivery time, and the sterilization time.

(c) The provider cannot bill separately for the BAUs for the sterilization procedure.

(8) The physician identified in the "consent to sterilization" section of the DSHS-approved sterilization consent form must be the same physician who completes the "physi-

cian's statement" section and performs the sterilization procedure. If a different physician performs the sterilization procedure, the client must sign and date a new consent form at the time of the procedure that indicates the name of the physician performing the operation under the "consent for sterilization" section. This modified consent must be attached to the original consent form when the provider bills MAA.

(9) MAA reimburses all attending providers for the sterilization procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. MAA reimburses after the procedure is completed.

HYSTERECTOMY

(10) Hysterectomies performed for medical reasons may require expedited prior authorization as explained in WAC 388-531-0200(2).

(11) MAA reimburses hysterectomy without prior authorization in either of the following circumstances:

(a) The client has been diagnosed with cancer(s) of the female reproductive organs; and/or

(b) The client is forty-six years of age or older.

(12) MAA reimburses all attending providers for the hysterectomy procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. If a prior authorization number is necessary for the procedure, it must be on the claim. MAA reimburses after the procedure is completed.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1550, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1600 Structured weight loss physician-related services. MAA covers structured outpatient weight loss only through an MAA-approved program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1600, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1650 Substance abuse detoxification physician-related services. (1) MAA reimburses substance abuse detoxification services under state-unique codes.

(2) MAA covers physician services for three-day alcohol detoxification or five-day drug detoxification services for a client eligible for medical care program services in an MAA-enrolled hospital-based detoxification center.

(3) MAA covers treatment in programs qualified under chapter 275-25 WAC and certified under chapter 275-19 WAC or its successor.

(4) MAA covers detoxification and medical stabilization services to chemically using pregnant (CUP) women for up to twenty-seven days in an inpatient hospital setting.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1650, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1700 Surgical physician-related services. (1) MAA's global surgical reimbursement for all covered surgeries includes all of the following:

(a) The operation itself;

(b) Postoperative dressing changes, including:

(i) Local incision care and removal of operative packs;

(ii) Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints;

(iii) Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; or

(iv) Change and removal of tracheostomy tubes.

(c) All additional medical or surgical services required because of complications that do not require additional operating room procedures.

(2) MAA's global surgical reimbursement for major surgeries, includes all of the following:

(a) Preoperative visits, in or out of the hospital, beginning on the day before surgery; and

(b) Services by the primary surgeon, in or out of the hospital, during a standard ninety-day postoperative period.

(3) MAA's global surgical reimbursement for minor surgeries includes all of the following:

(a) Preoperative visits beginning on the day of surgery; and

(b) Follow-up care for zero or ten days, depending on the procedure.

(4) When a second physician provides follow-up services for minor procedures performed in hospital emergency departments, MAA does not include these services in the global surgical reimbursement. The physician may bill these services separately.

(5) MAA's global surgical reimbursement for multiple surgical procedures is as follows:

(a) Payment for multiple surgeries performed on the same client on the same day equals one hundred percent of MAA's allowed fee for the highest value procedure. Then,

(b) For additional surgical procedures, payment equals fifty percent of MAA's allowed fee for each procedure.

(6) MAA allows separate reimbursement for any of the following:

(a) The initial evaluation or consultation;

(b) Preoperative visits more than one day before the surgery;

(c) Postoperative visits for problems unrelated to the surgery; and

(d) Postoperative visits for services that are not included in the normal course of treatment for the surgery.

(7) MAA's reimbursement for endoscopy is as follows:

(a) The global surgical reimbursement fee includes follow-up care for zero or ten days, depending on the procedure.

(b) Multiple surgery rules apply when a provider bills multiple endoscopies from different endoscopy groups. See subsection (4) of this section.

(c) When a physician performs more than one endoscopy procedure from the same group on the same day, MAA pays the full amount of the procedure with the highest maximum allowable fee.

(d) MAA pays the procedure with the second highest maximum allowable fee at the maximum allowable fee minus the base diagnostic endoscopy procedure's maximum allowed amount.

(e) MAA does not pay when payment for other codes within an endoscopy group is less than the base code

(8) MAA restricts reimbursement for surgery assists to selected procedures as follows:

(a) MAA applies multiple surgery reimbursement rules for surgery assists apply. See subsection (4) of this section.

(b) Surgery assists are reimbursed at twenty percent of the maximum allowable fee for the surgical procedure.

(c) A surgical assist fee for a registered nurse first assistant (RNFA) is reimbursed if the nurse has been assigned a provider number.

(d) A provider must use a modifier on the claim with the procedure code to identify surgery assist.

(9) MAA bases payment splits between preoperative, intraoperative, and postoperative services on Medicare determinations for given surgical procedures or range of procedures. MAA pays any procedure that does not have an established Medicare payment split according to a split of ten percent - eighty percent - ten percent respectively.

(10) For preoperative and postoperative critical care services provided during a global period refer to WAC 388-531-0450.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1700, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1750 Transplant coverage for physician-related services. MAA covers transplants when performed in an MAA-approved center of excellence. See WAC 388-550-1900 for information regarding transplant coverage.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1750, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1800 Transplant coverage—Medical criteria to receive transplants. See WAC 388-550-2000 for information about medical criteria to receive transplants.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1800, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(l) MAA bases the payment methodology for most physician-related services on Medicare's RBRVS. MAA obtains information used to update MAA's RBRVS from the **MPFSPS**.

(2) MAA updates and revises the following RBRVS areas each January prior to MAA's annual update.

(3) MAA determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a**base period**. Then,

(b) Applying the latest Medicare RVU obtained from the MPFSDB, as published in the MPFSPS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels.

(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) MAA calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable Medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GPCI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable Medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GPCI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, MAA establishes maximum allowable fees, also known as "flat" fees.

(i) MAA does not use the conversion factor for these codes.

(ii) MAA updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at EAC. (See WAC 388-530-1050 for explanation of EAC.) When the provider receives immunization materials from the department of health, MAA pays the provider a flat fee only for administering the immunization.

(B) A **cast material maximum allowable fee** is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, MAA reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) MAA reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The **technical advisory group** reviews RBRVS changes.

(6) MAA also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as MAA's annual update.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, MAA applies the increase after calculating budget-neutral fees. MAA pays providers a higher reim-

bursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) MAA does not allow separate reimbursement for bundled services. However, MAA allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

CPT/HCFA MODIFIERS

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for MAA to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1850, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1900 Reimbursement—General requirements for physician-related services. (1) MAA reimburses physicians and related providers for covered services provided to eligible clients on a fee-for-service basis, subject to the exceptions, restrictions, and other limitations listed in this chapter and other published issuances.

(2) In order to be reimbursed, physicians must bill MAA according to the conditions of payment under WAC 388-501-0150 and other issuances.

(3) MAA does not separately reimburse certain administrative costs or services. MAA considers these costs to be included in the reimbursement. These costs and services include the following:

(a) Delinquent payment fees;

(b) Educational supplies;

(c) Mileage;

(d) Missed or canceled appointments;

(e) Reports, client charts, insurance forms, copying expenses;

(f) Service charges;

(g) Take home drugs; and

(h) Telephoning (e.g., for prescription refills).

(4) MAA does not routinely pay for procedure codes which have a "#" indicator in the fee schedule. MAA reviews these codes for conformance to Medicaid program policy only as an exception to policy or as a limitation extension. See WAC 388-501-0160 and 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1900, filed 12/6/00, effective 1/6/01.]

Chapter 388-532 WAC
FAMILY PLANNING SERVICES

WAC

WAC 388-532-050 Family planning definitions. **"Family planning services"** means services, including the use of contraceptive techniques, that a client uses to plan the number and spacing of the client's children.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800. 00-14-066, § 388-532-050, filed 7/5/00, effective 8/5/00.]

WAC 388-532-100 Family planning services. (1) The department informs eligible clients about available family planning services. This service includes, but is not limited to, information about the synthetic progestin capsule implant form of contraception.

(2) For eligible clients, the department provides the following services when needed in conjunction with family planning:

(a) Physicians' services;

(b) Advanced registered nurse practitioners' (ARNP) services;

(c) Clinic or hospital services;

(d) Laboratory services; and

(e) Contraceptive supplies and/or prescription drugs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800. 00-14-066, § 388-532-100, filed 7/5/00, effective 8/5/00.]

Chapter 388-533 WAC
MATERNITY-RELATED SERVICES

WAC

WAC 388-533-0300 Enhanced benefits for pregnant women. The medical assistance administration (MAA) provides enhanced services to eligible women during and after their pregnancy.

(1) Refer to WAC 388-462-0015 for client eligibility requirements.

(2) MAA requires **providers** to have specific MAA approval prior to becoming an approved maternity support services (MSS) provider. MSS services must be provided by professionals from all of the following fields:

(a) Community health nursing;

(b) Nutrition; and

(c) Social work.

(3) MAA allows paraprofessional community health workers to provide MSS services to eligible clients when both of the following are met:

(a) The services are provided under the supervision of one of the qualified professionals described in subsection (2) of this section; and

(b) The services provided are limited to basic health education.

(4) A client may choose to receive MSS services from any MAA-approved MSS provider.

(5) In addition to the client's standard scope of care, MAA covers the following enhanced benefits (MSS) for eligible women during and after their pregnancy:

(a) One childbirth education course per pregnancy (see subsection (9) in this section);

(b) Assessment, counseling, education, and interventions by those qualified professionals described in subsections (2) and (3) of this section; and

(c) Child care for the client's children (see subsection (7) of this section).

(6) MSS providers refer a client who may need chemical dependency assessment to a provider who is contracted with the division of alcohol and substance abuse (DASA)(see chapter 440-22 WAC). Enhanced benefits for eligible pregnant women through DASA include:

(a) Assessment for alcohol/drug use;

(b) Parenting education; and

(c) Treatment for alcohol/drug use.

(7) MAA requires the MSS provider to do the following for child care under this section:

(a) Screen for the eligible woman's need for child care;

(b) Discuss and encourage a safe and healthy child care plan; and

(c) Authorize the child care. The MSS provider may authorize child care for any of the following reasons:

(i) Health care appointments for the client;

(ii) The maternity services medical provider ordered bed rest for the client; or

(iii) Other circumstances that the MSS provider considers necessary and are specifically approved by MAA.

(8) MAA covers up to ten MSS visits. If it is determined that a client is at high-risk for a poor birth outcome (see the maternity case management program), MAA may cover up to twenty visits. The MSS provider must maintain documentation of the high-risk circumstances in the client's file.

(9) MAA allows a provider to bill only once per client per pregnancy for childbirth education. The provider must document that the client attended at least one childbirth education session in order for MAA to reimburse for the service.

(10) MAA publishes MSS program billing instructions that contain specific process requirements for the MSS program.

[Statutory Authority: RCW 74.08.090, 74.09.770, and 74.09.800. 00-14-068, § 388-533-0300, filed 7/5/00, effective 8/5/00.]

WAC 388-533-0350 Maternity case management. (1) The medical assistance administration's (MAA) maternity case management (MCM) services are designed to assist pregnant or parenting client(s) obtain needed medical, social, educational, and other services.

(2) To receive MCM services the client must be eligible for MAA's pregnancy and birth coverage under WAC 388-462-015. In addition, the client must:

(a) Be pregnant and at high risk for a poor birth outcome as documented by a completed MCM intake (see MAA's MCM billing instructions); or

(b) Have experienced a poor birth outcome and have the MCM intake completed as described in subsection (3)(b) or (c) of this section.

(3) The MCM intake that initiates MCM services must be completed:

(a) During the eligible client's pregnancy;

(b) By the day of discharge from the hospital of the eligible birth mother; or

(c) By the day of discharge from the hospital of the eligible newborn child.

(4) MAA considers a client to be at high risk for a poor birth outcome if the client meets any of the following conditions. The client:

(a) Is age seventeen years or younger;

(b) Uses alcohol or other drug(s);

(c) Is in an environment where alcohol or drugs pose a risk; or

(d) Demonstrates an inability to obtain needed resources or services and is experiencing any three of the following:

(i) Has an inadequate physical or emotional support system or has an uninvolved domestic partner;

(ii) Has two or more children at home, ages four and/or younger;

(iii) Has an eighth grade or less education;

(iv) Has a physical disability;

(v) Has medical factors that MAA recognizes as related to poor pregnancy or birth outcomes (e.g., diabetes; see MAA's specific program billing instructions);

(vi) Has refugee status;

(vii) Is mentally impaired (e.g., mental depression is interfering with daily functioning);

(viii) Is homeless;

(ix) Is in a household that has current or recent incidents of violence (i.e., physical or sexual abuse);

(x) Is limited English proficient;

(xi) Is eighteen or nineteen years of age; or

(xii) Entered into prenatal care after twenty-eight weeks gestation.

(5) MAA covers MCM services provided to the eligible woman for up to sixty days postpartum, and provided to the eligible infant until age one.

(6) MAA covers MCM services provided to high-risk clients in addition to the services described in WAC 388-533-0300, Enhanced benefits for pregnant women. A client may receive services under WAC 388-533-0300 and services under this section at the same time or at different times.

(7) MAA reimburses only those providers who have been specifically approved by and contracted with MAA to furnish MCM services. For approval, providers must contact:

The Medical Assistance Administration
Division of Program Support, Family Services Section
POB 45530, Olympia, Washington 98504-5530.

(8) MCM providers must document the qualifying high-risk factors in the client's MCM case file. There must be an active MCM service plan demonstrating client need for MCM services, and the provider must periodically review and update the plan. MCM providers must not bill MAA for MCM services once the client is able to obtain needed services or systems without MCM assistance.

(9) MAA's reimbursement for MCM services may vary, depending on the client's specific risk factors and need(s).

(10) MAA publishes MCM program billing instructions that contain specific process requirements for the MCM program.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-533-0350, filed 11/16/00, effective 12/17/00.]

WAC 388-533-0400 Maternity care and newborn delivery. (1) The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter. Defined words and phrases are bolded the first time they are used in the text.

(a) **"Birthing center"** means a specialized facility licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC.

(b) **"Bundled services"** means those services that are integral to a major procedure that may be bundled with the major procedure for the purposes of reimbursement. Under this chapter, certain bundled services must be billed separately (unbundled) when the services are provided by different providers.

(c) **"Facility fee"** means that portion of MAA's reimbursement that covers the hospital or birthing center charges. This does not include MAA's reimbursement for the professional fee defined below.

(d) **"Global fee"** means the fee MAA pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services and postpartum care.

(e) **"High-risk"** pregnancy means any pregnancy that poses a significant risk of a poor birth outcome.

(f) **"Professional fee"** means that portion of MAA's reimbursement that covers the services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. (See WAC 388-531-1850 for reimbursement methodology).

(2) MAA covers full scope maternity care and newborn delivery services to its clients who qualify for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-462-0015 for client eligibility).

(3) MAA does not provide full scope maternity care and delivery services to its clients who qualify for medically indigent (MI) scope of care (see WAC 388-462-0015 for client eligibility). Clients who qualify for MI scope of care have hospital delivery coverage only.

(4) MAA does not provide maternity care and delivery services to its clients who are eligible for:

(a) Family planning only (a pregnant client under this program should be referred to the local office for eligibility review); or

(b) Any other program not listed.

(5) MAA requires providers of maternity care and newborn delivery services to meet all of the following. Providers must:

(a) Be currently licensed by the state of Washington's department of health (DOH) and/or department of licensing;

(b) Have signed core provider agreements with MAA;

(c) Be practicing within the scope of their licensure; and

(d) Have valid certifications from the appropriate federal or state agency, if such is required to provide these services (e.g., federally qualified health centers (FQHCs), laboratories certified through the Clinical Laboratory Improvement Amendment (CLIA), etc.).

(6) MAA covers total obstetrical care services (reimbursed under a **global fee**). Total obstetrical care includes all of the following:

(a) Routine antepartum care that begins in any trimester of a pregnancy;

(b) Delivery (intrapartum care/birth) services; and

(c) Postpartum care. This includes family planning counseling.

(7) When an eligible client receives all the services listed in subsection (6) of this section from one provider, MAA reimburses that provider in one of the following ways:

(a) Through a global obstetrical fee; or

(b) Through separate fees in any combination:

(i) First trimester antepartum care;

(ii) Second trimester antepartum care;

(iii) Third trimester antepartum care;

(iv) Delivery services (intrapartum care); and

(v) Postpartum care.

(8) When an eligible client receives services from more than one provider, MAA reimburses each provider for the services furnished. The separate services that MAA reimburses appear in subsection (7)(b) of this section.

(9) MAA reimburses for antepartum care services in one of the following two ways:

(a) Under a global fee (for total obstetrical care); or

(b) Under separate trimester care fees.

(10) MAA's fees for antepartum care include all of the following:

(a) An initial and any subsequent patient history;

(b) All physical examinations;

(c) Recording and tracking the client's weight and blood pressure;

(d) Recording fetal heart tones;

(e) Routine chemical urinalysis (including all urine dipstick tests); and

(f) Maternity counseling.

(11) MAA covers certain antepartum services in addition to the **bundled services** listed in subsection (10) of this section. MAA reimburses separately for any the following:

(a) A prenatal assessment fee for a pregnant client (limited to one prenatal assessment fee per pregnancy per provider);

(b) An enhanced prenatal management fee (a monthly fee for medically necessary increased prenatal monitoring). MAA provides a list of diagnoses and/or conditions that MAA identifies as justifying more frequent monitoring visits. MAA reimburses for either (b) or (c) of this subsection, but not both;

(c) A prenatal management fee for **"high-risk"** maternity clients. This monthly fee is payable to either a physician or a certified nurse midwife. MAA reimburses for either (b) or (c) of this subsection, but not both;

(d) Necessary prenatal laboratory tests except routine chemical urinalysis, including all urine dipstick tests, as described in subsection (10)(e) of this section; and/or

(e) Treatment of medical problems that are not related to the pregnancy. MAA pays these fees to physicians or advanced registered nurse practitioners.

(12) MAA covers high-risk pregnancies. MAA considers a pregnant client to have a high-risk pregnancy when the client:

(a) Has any high-risk medical condition (whether or not it is related to the pregnancy); or

(b) Has a diagnosis of multiple births.

(13) MAA covers delivery services for clients with high-risk pregnancies, described in subsection (12) of this section, when the delivery services are provided in a hospital.

(14) MAA covers the **facility fee** for delivery services in the following settings:

(a) Inpatient hospital; or

(b) Birthing centers.

(15) MAA covers the **professional fee** for delivery services in the following settings:

(a) Hospitals, to a provider who meets the criteria in subsection (5) of this section and who has privileges in the hospital;

(b) Planned home birth settings for providers who are participating in MAA's home birth pilot project; or

(c) **Birthing centers**, as described in WAC 388-533-0600.

(16) MAA covers hospital delivery services for an eligible client as defined in subsections (2), (3), and (4)(b) of this section. MAA's bundled reimbursement for the professional fee for hospital delivery services include:

(a) The admissions history and physical examination;

(b) The management of uncomplicated labor (intrapartum care);

(c) The vaginal delivery of the newborn (with or without episiotomy or forceps); and

(d) Cesarean delivery of the newborn.

(17) MAA pays only a labor management fee to a provider who begins intrapartum care and unanticipated medical complications prevent that provider from following through with the birthing services.

(18) In addition to the MAA reimbursement for professional services in subsection (16) of this section, MAA may reimburse separately for services provided by any of the following professional staff:

(a) A stand-by physician in cases of high risk delivery and/or newborn resuscitation;

(b) A physician assistant when delivery is by cesarean section;

(c) A registered nurse - "first assist" when delivery is by cesarean section;

(d) A physician, advanced registered nurse practitioner, or licensed midwife for newborn examination as the delivery setting allows; and/or

(e) An obstetrician/gynecologist specialist for external cephalic version and consultation.

(19) In addition to the professional delivery services fee in subsection (16) or the global/total fees (i.e., those that include the hospital delivery services) in subsections (6) and (7) of this section, MAA allows additional fees for any of the following:

(a) High-risk vaginal delivery;

(b) Multiple vaginal births. MAA's typical reimbursement covers delivery of the first child. For each subsequent child, MAA reimburses at fifty percent of the provider's usual and customary charge, up to MAA's maximum allowable fee; or

(c) High-risk cesarean section delivery.

(20) MAA does not reimburse separately for any of the following:

(a) More than one child delivered by cesarean section during a surgery. MAA's cesarean section surgery fee covers one or multiple surgical births;

(b) Post-operative care for cesarean section births. This is included in the surgical fee. Post-operative care is not the same as or part of postpartum care.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, § 388-533-0400, filed 11/13/00, effective 12/14/00.]

WAC 388-533-0500 Planned home births—Pilot project. (1) MAA covers planned home births only as part of a pilot project.

(2) Prior to participating in the planned home birth pilot project providers must be approved by MAA.

(3) To meet minimum requirements for participation, a provider must have all of the following:

(a) A core provider agreement with MAA;

(b) A current license, in good standing, as a:

(i) Physician under chapter 18.57 or 18.71 RCW;

(ii) Nurse midwife under chapter 18.79 RCW; or

(iii) Midwife under chapter 18.50 RCW.

(c) A diploma of graduation from an accredited midwifery, nurse midwifery or medical school, or copy of current national certified professional midwife (CPM) certification, and additional documentation, if necessary, to show a minimum attendance of:

(i) Five births in a home setting as an observer; and

(ii) Ten births in a home setting as the primary attendant or primary under the supervision of a practitioner who meets or exceeds the requirements in this subsection. Three or more of these births must have been with a client for whom the applicant provided care during at least four prenatal visits, attended all stages (one-four) of labor and birth, performed a newborn exam, and conducted one postpartum home visit within seventy-two hours after birth.

(d) Current CPR certification for:

(i) Adult CPR; and

(ii) Neonatal resuscitation, including the use of positive pressure ventilation and chest compressions.

(e) Liability insurance coverage and documentation of liability insurance claims history;

(f) A written plan for consultation, emergency transfer, and transport of both the mother and newborn. The plan must:

(i) For the mother, specify a physician(s) who has complete obstetrical privileges, including cesarean sections, and who has admitting privileges to the closest appropriate hospital;

(ii) For the newborn, specify a physician(s) who has an active pediatric practice and admitting privileges to the closest appropriate hospital;

(iii) Identify the hospital(s) to which the mother and newborn will be transferred in the event of a maternal/neonatal emergency; and

(iv) Identify emergency transport providers that will be used to transport the mother and/or newborn to the hospital, including private ambulance, municipal aid car, and helicopter service.

(g) Arrangements for twenty-four hour per day coverage by an MAA-approved home birth provider;

(h) Documentation of contact with local area emergency medical services to determine the level of response capability in the area, and to facilitate communication; and

(i) An informed consent form to be signed by each client to indicate agreement to participate in a planned home birth.

(4) A provider may apply to participate in the project by submitting to MAA:

(a) A letter of interest;

(b) Verification of meeting the minimum requirements in subsection (3); and

(c) A signed statement of intent to comply with project requirements.

(5) The participating provider must do all of the following:

(a) Verify each client is eligible for the categorically needy program or medically needy program scope of care;

(b) Assure each client passes the risk screening criteria published in MAA's planned home birth pilot project billing instructions, and follow indications for consultation and referral;

(c) Plan for a home birth only if the client is expected to deliver vaginally and without complication;

(d) Prior to planning a home birth, obtain a signed consent form from the client agreeing to participate in a planned home birth, and keep the signed form in the client's file;

(e) Provide medically necessary equipment, supplies, and medications for each client;

(f) Make appropriate referral of the newborn for screening and medically necessary follow-up care;

(g) Inform parents of the benefits of a newborn blood screening test, and offer to send the newborn's blood sample to the department of health for testing;

(h) Refer the client or newborn to a physician or hospital when medically appropriate;

(i) Submit to the MAA-designated quality assurance/quality improvement (QA/QI) organization a completed planned home birth outcome report (on an MAA approved form) for each client for program evaluation. MAA requires the completed report before payment is made, even if the client is transferred to another provider or delivery setting and the provider is billing for only a portion of the maternity care.

(j) Notify MAA immediately of changes in licensure and/or provider status;

(k) Renew participation status every two years by submitting documentation to verify continued compliance with the minimum requirements in subsection (3); and

(l) Comply with the requirements in this chapter.

(6) MAA does not cover planned home births for women identified with any of the following conditions:

(a) Previous cesarean section;

(b) Current alcohol and/or drug addiction or abuse;

(c) Significant hematological disorders/coagulopathies;

(d) History of deep venous thromboses or pulmonary embolism;

(e) Cardiovascular disease causing functional impairment;

(f) Chronic hypertension;

(g) Significant endocrine disorders including pre-existing diabetes (type I or type II);

(h) Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests;

(i) Isoimmunization, including evidence of Rh sensitization/platelet sensitization;

(j) Neurologic disorders or active seizure disorders;

(k) Pulmonary disease or active tuberculosis or severe asthma uncontrolled by medication;

(l) Renal disease;

(m) Collagen-vascular diseases;

(n) Current severe psychiatric illness;

(o) Cancer affecting site of delivery;

(p) Known multiple gestation;

(q) Known breech presentation in labor with delivery not imminent; or

(r) Other significant deviations from normal as assessed by the home birth provider.

(7) The planned home birth pilot project will run for five years from the effective date of this rule, however:

(a) MAA may terminate the project at an earlier date with written notice to participating providers if data reports indicate poor outcomes;

(b) A provider may terminate participation in the pilot project at any time with written notice to MAA. The provider must offer to make a good faith effort to transfer ongoing cases to other participating providers.

(c) MAA may terminate a provider's participation immediately if:

(i) The provider fails to comply with project requirements;

(ii) The provider's enrollment as a MAA provider is suspended or terminated (see WAC 388-502-0030); or

(iii) The MAA medical director determines the quality of care provided endangers the health and safety of one or more clients.

[Statutory Authority: RCW 74.08.090. 00-24-054, § 388-533-0500, filed 11/30/00, effective 12/31/00.]

WAC 388-533-0600 Births in birthing centers. (1) MAA covers births in birthing centers for its clients when the client and the maternity care provider choose an MAA-approved birthing center and the client:

(a) Is eligible for CN or MN scope of care (see WAC 388-533-400(2));

(b) Has a MAA-approved medical provider who has accepted responsibility for the birthing center birth as provided in this section;

(c) Is expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and

(d) Passes MAA's risk screening criteria. MAA provides these risk-screening criteria to qualified medical services providers.

(2) Each participating birthing center must:

(a) Be licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC;

(b) Have a valid core provider agreement with MAA;

(c) Be specifically approved by MAA to provide birthing center services; and

(d) Maintain standards of care required by DOH for licensure.

(3) MAA suspends or terminates the core provider agreement of a birthing center if it fails to maintain DOH standards cited in subsection (2) of this section.

(4) MAA approves only the following provider types to provide MAA covered births in birthing centers:

(a) Physicians licensed under chapters 18.57 or 18.71 RCW;

(b) Nurse midwives licensed under chapter 18.79 RCW; and

(c) Midwives licensed under chapter 18.50 RCW.

(5) Each provider using a birthing center must:

(a) Obtain from the client a signed consent form in advance of the birthing center birth;

(b) Follow MAA's risk screening criteria and consult with and/or refer the client or newborn to a physician or hospital when medically appropriate;

(c) Have current, written, and appropriate plans for consultation, emergency transfer and transport of a client and/or newborn to a hospital;

(d) Make appropriate referral of the newborn for screening and medically necessary follow-up care; and

(e) Inform parents of the benefits of a newborn screening test and offer to send the newborn's blood sample to the department of health for testing.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, § 388-533-0600, filed 11/13/00, effective 12/14/00.]

Chapter 388-534 WAC
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

WAC

388-534-0100 Healthy kids/EPSDT.

WAC 388-534-0100 Healthy kids/EPSDT. (1) Persons who are eligible for Medicaid are eligible for healthy kids (HK) coverage up through the day before their twenty-first birthday. This coverage is called early and periodic screening, diagnosis and treatment (EPSDT) in federal rule.

(2) Access and services for healthy kids are governed by federal rules at 42 CFR, Part 441, Subpart B which were in effect as of January 1, 1998.

(a) The standard for coverage for healthy kids is that the services, treatment or other measures are:

(i) Medically necessary;

(ii) Safe and effective; and

(iii) Not experimental.

(b) Healthy kids services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program. Examples of service limits which do not apply to the healthy kids program are the specific numerical limits in WAC 388-545-300, 388-545-500, and 388-545-700, etc.

(c) Services not otherwise covered under the Medicaid program are available to children under healthy kids. The services, treatments and other measures which are available include but are not limited to:

(i) Nutritional counseling;

(ii) Chiropractic care;

(iii) Orthodontics; and

(iv) Occupational therapy (not otherwise covered under the MN program).

(d) Prior authorization and referral requirements are imposed on medical service providers under healthy kids. Such requirements are designed as tools for determining that a service, treatment or other measure meets the standards in subsection (2)(a) of this section.

(3) Transportation requirements of 42 CFR 441, Subpart B are met through a contract with transportation brokers throughout the state.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-534-0100, filed 12/29/00, effective 1/29/01; 00-11-183, recodified as § 388-534-0100, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-86-027, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 90-12-061 (Order 3019), § 388-86-027, filed 5/31/90, effective 7/1/90; 82-01-001 (Order 1725), § 388-86-027, filed 12/3/81; 81-10-015 (Order 1647), § 388-86-027, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-027, filed 10/9/80; 79-12-047 (Order 1457), § 388-86-027, filed 11/26/79; Order 1112, § 388-86-027, filed 4/15/76; Order 738, § 388-86-027, filed 11/22/72.]

Chapter 388-535 WAC
DENTAL-RELATED SERVICES

WAC

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388-535-1000 Dental-related services—Scope of coverage. [Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1000, filed 12/6/95, effective 1/6/96.] Repealed by 99-07-023, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225.

GENERAL

WAC 388-535-1010 Dental-related program introduction. This chapter describes:

(1) The dental-related services that the medical assistance administration (MAA) offers to its eligible clients;

(2) Limitations to those services;

(3) Provider requirements, including prior authorizations; and

(4) MAA's methods for paying providers for dental-related services.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1010, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1050 Dental-related definitions. This section contains definitions of words and phrases in bold that the department uses in this chapter. See also chapter 388-500 WAC for other definitions and abbreviations. Further dental definitions used by the department may be found in the Current Dental Terminology (**CDT-2**) and the Current Procedural Terminology (**CPT**). Where there is any discrepancy between the **CDT-2** or **CPT**and this section, this section prevails.

"Access to baby and child dentistry (ABCD)" is a demonstration project to increase access to dental services in targeted areas for Medicaid eligible infants, toddlers, and preschoolers up through the age of five. See WAC 388-535-1300 for specific information.

"Adult" means a client nineteen years of age or older.

"Anterior" means teeth in the front of the mouth. In relation to crowns, only these permanent teeth are considered anterior for laboratory processed crowns:

(1) **"Lower anterior,"** teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven; and

(2) **"Upper anterior,"** teeth six, seven, eight, nine, ten, and eleven.

"Arch" means the curving structure formed by the crowns of the teeth in their normal position, or by the residual ridge after loss of the teeth.

"Asymptomatic" means having no symptoms.

"Banding" means the application of **orthodontic** brackets to the teeth for the purpose of correcting dentofacial abnormalities.

"Base metal" means dental alloy containing little or no precious metals.

"Behavior management" means managing the behavior of a client during treatment using the assistance of additional professional staff, and professionally accepted restraints or sedative agent, to protect the client from self-injury.

"Bicuspid" means teeth four, five, twelve, thirteen, twenty, twenty-one, twenty-eight, and twenty-nine.

"By report" - a method of payment for a covered service, supply, or equipment which:

(1) Has no maximum allowable established by MAA,

(2) Is a variation on a standard practice, or

(3) Is rarely provided.

"Caries" means tooth decay.

"Child" means a client eighteen years of age or younger.

"Cleft" means an opening or fissure involving significant dental processes, especially one occurring in the embryo. These can be:

(1) Cleft lip,

(2) Cleft palate (at the roof of the mouth), or

(3) Transverse facial cleft (macrostomia).

"Comprehensive oral evaluation" means a thorough evaluation and recording of the hard and soft tissues in and around the mouth, including the evaluation and recording of the patient's dental and medical history and a general health assessment.

"Corona" is the portion of a tooth that is covered by **enamel**, and is separated from the root or roots by a slightly constricted region, known as the cemento-**enamel** junction.

"Craniofacial anomalies" means abnormalities of the head and face, either congenital or acquired, involving significant dental processes.

"Craniofacial team" means a department of health and MAA recognized cleft palate/maxillofacial team which is: Responsible for management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provide integrated case management, promote parent-professional partnership, making appropriate referrals to implement and coordinate treatment plans.

"Current dental terminology (CDT), second edition (CDT-2)," a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

"Current procedural terminology (CPT)," means a description of medical procedures and is available from the American Medical Association of Chicago, Illinois.

"Dental general anesthesia" means the use of agents to induce loss of feeling or sensation, a controlled state of unconsciousness, in order to allow dental services to be rendered to the client.

"Dentally necessary" means diagnostic, preventive, or corrective services that are accepted dental procedures appropriate for the age and development of the client to prevent the incidence or worsening of conditions that endanger teeth or periodontium (tissues around the teeth) or cause significant malfunction or impede reasonable development or homeostatis (health) in the stomatognathic (mouth and jaw) system:

(1) Which may include simple observation with no treatment, if appropriate; and

(2) Includes use of less costly, equally effective services.

"Dentin" is the mineralized tissue of the teeth, which surrounds the tooth pulp and is covered by **enamel** on the crown and by cementum on the roots of the teeth.

"Dentures" are a set of prosthetic artificial teeth. See WAC 388-535-1240 for specific information.

"Dysplasia" means an abnormality in the development of the teeth.

"Enamel" is the white, compact, and very hard substance that covers and protects the dentin of the crown of a tooth.

"Endodontic" means a root canal treatment and related follow-up.

"EPSDT/healthy kids" means the department's early periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in chapter 388-534 WAC.

"Fluoride varnish" means a substance containing dental fluoride, for painting onto teeth. When painted onto teeth, it sticks to tooth surfaces.

"Gingiva" means the gums.

"Hemifacial microsomia" means half or part of the face is smaller-sized.

"High noble metal" means dental alloy containing at least sixty percent pure gold.

"High risk child" means any **child** who has been identified through an oral evaluation or assessment as being at a high risk for developing dental disease because of **caries** in the **child's** dentin; or a **child** identified by the department as developmentally disabled.

"Hypoplasia" means the incomplete or defective development of the **enamel** of the teeth.

"Low risk child" means any **child** who has been identified through an oral evaluation or assessment as being at a low risk for dental disease because of the absence of white spots or **caries** in the **enamel** or **dentin**. This category includes **children** with restorations who are otherwise without disease.

"Major bone grafts" means a transplant of solid bone tissue(s), such as buttons or plugs.

"Malocclusion" means the contact between the upper and lower teeth that interferes with the highest efficiency during the movements of the jaw that are essential to chewing. The abnormality is categorized into four classes, graded by Angle's classification. For coverage, see WAC 388-535-1250.

"Maxillofacial" means relating to the jaws and face.

"Minor bone grafts" means a transplant of nonsolid bone tissue(s), such as powdered bone.

"Moderate risk child" means a **child** who has been identified through an **oral evaluation or assessment** as being at a moderate risk for dental disease, based on presence of white spots, **enamel caries** or **hypoplasia**.

"Molars" means:

(1) Permanent teeth one, two, three, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, thirty, thirty-one, and thirty-two; and

(2) Primary teeth A, B, I, J, K, L, S and T.

"Noble metal" means a dental alloy containing at least twenty-five percent but less than sixty percent pure gold.

"Occlusion" means the relation of the upper and lower teeth when in functional contact during jaw movement.

"Oral evaluation" is a comprehensive oral health and developmental history; an assessment of physical and oral health development and nutritional status; and health education, including anticipatory guidance.

"Oral health assessment or screening" means a screening of the hard and soft tissues in the mouth.

"Oral health status" refers to the client's risk or susceptibility to dental disease at the time an oral evaluation is done by a dental practitioner. This risk is designated as low, moderate or high based on the presence or absence of certain indicators.

"Orthodontic" is a treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues.

"Partials" means a prosthetic appliance replacing one or more missing teeth in one jaw, and receiving its support and retention from both the underlying tissues and some or all of the remaining teeth. See WAC 388-535-1240 for specific information.

"Posterior" means teeth and tissue towards the back of the mouth. Specifically, only these permanent teeth: One, two, three, four, five, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two.

"Prophylaxis" means intervention which includes the **scaling** and polishing of teeth to remove **coronal** plaque, calculus, and stains.

"Reline" means to resurface the tissue side of a denture with new base material in order to achieve a more accurate fit.

"Root planing" is a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased cementum or**dentin** from the teeth's root surfaces and pockets.

"Scaling" means the removal of calculous material from the exposed tooth surfaces and that part of the teeth covered by the marginal gingiva.

"Sealant" is a material applied to teeth to prevent dental caries.

"Sequestrectomy" means removal of dead or dying bone that has separated from healthy bone.

"Therapeutic pulpotomy" means the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

"Usual and customary" means the fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill MAA.

"Wisdom teeth" means teeth one, sixteen, seventeen, and thirty-two.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-535-1050, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1050, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1050, filed 12/6/95, effective 1/6/96.]

COVERAGE

WAC 388-535-1060 Eligible dental-related clients. (1) Subject to the specific limitations described in WAC 388-535-1080, Covered services, clients of the following MAA programs are eligible for the dental-related services described in this chapter:

(a) Categorically needy (CN or CNP), including:

(i) Children's health; and

(ii) Pregnant undocumented aliens.

(b) Medically needy (MN).

(2) Clients with the following state-only funded eligibility programs receive the coverage described in WAC 388-535-1260:

(a) General assistance unemployable (GAU); and

(b) Alcohol and drug abuse treatment and support act (ADATSA).

(3) Clients of the medically indigent (MI) program are limited to emergency hospital-based services only.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1060, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1080 Covered dental-related services. (1) MAA pays only for covered dental and dental-related services, equipment, and supplies listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) **Dentally necessary**;

(c) Within accepted dental or medical practice standards and are:

(i) Consistent with a diagnosis of dental disease or condition; and

(ii) Reasonable in amount and duration of care, treatment, or service.

(2) The following dental-related services are covered:

(a) Oral health evaluations and assessments.

(i) Oral health evaluations no more than once every six months.

(ii) The evaluation services must be documented in the client's dental file.

(iii) These evaluations must include:

(A) A comprehensive oral health and developmental history;

(B) An assessment of physical and oral health development status;

(C) Health education, including anticipatory guidance; and

(D) **Oral health status**.

(b) Dentally necessary services for the identification of dental problems or the prevention of dental disease subject to limitations of this chapter;

(c) Prophylaxis treatment is allowed:

(i) Once every twelve months for **adults** including nursing facility clients.

(ii) Once every six months for **children**.

(iii) Three times a calendar year for clients of the division of developmental disabilities.

(d) Dental services or treatment necessary for the relief of pain and infections, including removal of symptomatic **wisdom teeth**. Routine removal of **asymptomatic wisdom teeth** without justifiable medical indications is not covered;

(e) Restoration of teeth and maintenance of dental health subject to limitations of WAC 388-535-1100, Dental services not covered;

(f) Complex **orthodontic** treatment for severe handicapping dental needs as specified in WAC 388-535-1250, Orthodontic coverage for DSHS clients;

(g) Complete and partial dentures, and necessary modifications, repairs, rebasing, **relining** and adjustments of dentures subject to the limitations of WAC 388-535-1240, Dentures;

(h) **Dentally necessary** oral surgery when coordinated with the client's managed care plan (if any);

(i) **Endodontic** (root canal) therapies for permanent teeth except for **wisdom teeth**;

(j) Nitrous oxide only when medically justified and a component of **behavior management**;

(k) Crowns as described in WAC 388-535-1230, Crowns;

(l) **Therapeutic pulpotomies**, once per tooth; and

(m) Sealants for:

(i) Occlusal surfaces of only these:

(A) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty and thirty-one; and

(B) Primary teeth A, B, I, J, K, L, S and T.

(ii) Lingual pits of teeth seven and ten;

(iii) Teeth with no decay;

(iv) **Children** only; and

(v) Once per tooth in a three-year period.

(3) For clients identified by the department as developmentally disabled, the following preventive services may be allowed more frequently than the limits listed in (3) of this section:

(a) **Fluoride** application, **varnish** or gel;

(b) **Root planing**; and

(c) **Prophylaxis scaling** and **coronal** polishing.

(4) Panoramic radiographs are allowed only for oral surgical or **orthodontic** purposes.

(5) The department covers **dentally necessary** services provided in a hospital under the direction of a physician or dentist for:

(a) The care or treatment of teeth, jaws, or structures directly supporting the teeth if the procedure requires hospitalization; and

(b) Short stays when the procedure cannot be done in an office setting. See WAC 388-550-1100(4), Hospital coverage.

(6) For clients residing in nursing facilities or group homes:

(a) Dental services must be requested by the client or a referral for services made by the attending physician, facility nursing supervisor, or the client's legal guardian;

(b) Mass screening for dental services of clients residing in a facility is not permitted; and

(c) Nursing facilities must provide dental-related necessary services per WAC 388-97-225, Nursing facility care.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1080, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1100 Dental-related services not covered. (1) Dental-related services described in subsection (2) of this section are not covered unless:

(a) Required by a physician as a result of an **EPSDT/Healthy Kids** screen:

(i) Except that all of the orthodontic limitations of WAC 388-535-1250, Orthodontic coverage for DSHS clients, still apply; and

(ii) Such services must be **dentally necessary**

(b) Included in a waivered program; or

(c) Part of one of the Medicare programs for qualified Medicare beneficiaries (QMB) except for QMB-only which is not covered.

(2) MAA does not cover:

(a) Services, procedures, treatment, devices, drugs, or application of associated services which MAA or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the services are provided;

(b) Cosmetic treatment or surgery, except for medically or **dentally necessary** reconstructive surgery to correct defects attributable to an accident, birth defect, or illness;

(c) Teeth whitening;

(d) **Orthodontic** care for **adults**;

(e) **Orthodontic** care for cosmetic reasons and for **children** who do not meet the criteria in WAC 388-535-1250, Orthodontic coverage for DSHS clients;

(f) Any service specifically excluded by statute;

(g) More costly services when less costly equally effective services as determined by the department are available;

(h) Nonmedical equipment, supplies, personal or comfort items and/or services;

(i) **Root planing** for **children** unless clients of the division of developmental disabilities;

(j) Root canal services for primary teeth;

(k) Routine fluoride treatments for **adults**, unless clients of the division of developmental disabilities;

(l) Extraction of asymptomatic teeth:

(i) Except as a necessary part of orthodontic treatment, or (ii) Unless their removal is the most cost effective dental procedure related to dentures;

(m) Crowns for **wisdom teeth**; and

(n) Amalgam or acrylic build-up for **wisdom teeth**.

(3) MAA does not pay for the following services/supplies:

(a) Missed or canceled appointments;

(b) Provider mileage or travel costs;

(c) Take-home drugs;

(d) Dental supplies such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners;

(e) Educational supplies;

(f) Reports, client charts, insurance forms, copying expenses;

(g) Service charges/delinquent payment fees;

(h) Dentist's time writing prescriptions or calling in prescriptions or prescription refills to a pharmacy;

(i) Supplies used in conjunction with an office visit;

(j) Transitional/immediate dentures;

(k) Teeth implants including follow up and maintenance;

(l) Bridges;

(m) Nonemergent oral surgery for **adults** performed in an inpatient setting;

(n) **Minor bone grafts**; or

(o) Temporary crowns.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1100, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1100, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1150 Becoming a DSHS dental provider. (1) The following providers are eligible for enrollment to provide and be paid for dental-related services to eligible clients:

(a) Persons currently licensed by the state of Washington to:

(i) Practice dentistry or specialties of dentistry;

(ii) Practice medicine and osteopathy for:

(A) Oral surgery procedures; or

(B) **Fluoride varnish** under **EPSDT/Healthy Kids**.

(iii) Practice as dental hygienists;

(iv) Provide denture services;

(v) Practice anesthesiology; or

(vi) Provide conscious sedation, when providing that service in dental offices for dental treatments and when certified by the department of health.

(b) Facilities which are:

(i) Hospitals currently licensed by the department of health;

(ii) Federally-qualified health centers;

(iii) Medicare-certified ambulatory surgical centers;

(iv) Medicare-certified rural health clinics; or

(v) Community health centers.

(c) Participating local health jurisdictions; and

(d) Border area or out-of-state providers of dental-related services qualified in their states to provide these services.

(2) Licensed providers participating in the MAA dental program may be paid only for those services that are within their scope of practice.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1150, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1150, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1200 Dental services requiring prior authorization. The following services require prior approval:

(1) Nonemergent inpatient hospital dental admissions as described under WAC 388-550-1100(1) Hospital coverage;

(2) **Orthodontic** treatment as described under WAC 388-535-1250;

(3) Dentures as described in WAC 388-535-1240;

(4) Crowns as described in WAC 388-535-1230; and

(5) Selected procedures identified by MAA, published in its current dental billing instructions, available from MAA at Olympia, Washington.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1200, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1200, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1220 Obtaining prior authorization for dental services. Authorization by MAA only indicates that the specific treatment is **dentally necessary**. Authorization for dental services does not guarantee payment.

(1) When requesting prior authorization, the dental provider must submit to MAA, in writing, sufficient objective clinical information to establish dental necessity including, but not limited to:

(a) Physiological description of the disease, injury, impairment, or other ailment;

(b) X-ray(s);

(c) Treatment plan;

(d) Study model, if requested; and

(e) Photographs, if requested.

(2) When the requested service meets the criteria in WAC 388-535-1080, Covered services, it will be authorized.

(3) A request for dental services will be denied when the requested service is:

(a) Not **dentally necessary**; or

(b) A service, procedure, treatment, device, drug, or application of associated service which MAA or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the service is provided.

(4) Second opinions and/or consultations may be required before the authorization of any elective procedure.

(5) Authorization is valid only if the client is eligible for the date of service.

(6) Miscellaneous or unspecified procedures may require prior authorization at MAA's discretion.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1220, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1230 Crowns. (1) The following crowns do not need authorization and are covered:

(a) Stainless steel, and

(b) Nonlaboratory resin for primary anterior teeth.

(2) The following crowns are limited to single restorations for permanent **anterior** (upper and lower) teeth and require prior authorization by MAA:

(a) Porcelain fused to a **high noble metal**;

(b) Porcelain fused to a predominately **base metal**;

(c) Porcelain fused to a **noble metal**;

(d) Porcelain with ceramic substrate;

(e) Full cast **high noble metal**;

(f) Full cast predominately **base metal**;

(g) Full cast **noble metal**; and

(h) Resin (laboratory).

(3) Criteria for crowns:

(a) Crowns may be authorized when the tooth meets the criteria of **dentally necessary**.

(b) Coverage is based upon a supportable five year prognosis that the client will retain the tooth if crowned. The provider must submit the following information:

(i) The overall condition of the mouth;

(ii) **Oral health status**;

(iii) Patient maintenance of good oral health status;

(iv) **Arch** integrity; and

(v) Prognosis of remaining teeth (that is, no more involved than periodontal case type II).

(c) **Anterior** teeth must show traumatic or pathological destruction to loss of at least one incisal angle.

(4) The laboratory processed crowns described in subsection (2):

(a) Are covered only once per permanent tooth in a five year period;

(b) Are covered for **endodontically** treated **anterior** teeth only after satisfactory completion of the root canal therapy. Post-**endodontic** treatment X-rays must be submitted for prior authorization of these crowns; and

(c) Including tooth and soft tissue preparation, amalgam or acrylic build-ups, temporary restoration, cement base, insulating bases, impressions, and local anesthesia; and

(d) Are covered when a lesser service will not suffice because of extensive **coronal** destruction, and treatment is beyond **intracoronal** restoration.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1230, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1240 Dentures. (1) Initial dentures do not require prior authorization except as described in subsection (4).

(2) Partial dentures are covered under these limits:

(a) Cast base partials only when replacing three or more teeth per **arch** excluding **wisdom teeth**; and

(b) No partials are covered when they replace **wisdom teeth** only.

(3) Prior authorization for replacement dentures or partials is not required when:

(a) The client's existing dentures or partials are:

(i) No longer serviceable and cannot be **relined** or rebased;

(ii) Are lost; or

(iii) Are damaged beyond repair.

(b) The client's health would be adversely affected by absence of dentures;

(c) The client has been able to wear dentures successfully; and

(d) The denture meets the criteria of **dentally necessary**.

(4) Payment (which may be partial) for laboratory and professional fees for dentures and partials requires prior authorization when the client:

(a) Dies;

(b) Moves from the state;

(c) Cannot be located; or

(d) Does not participate in completing the dentures.

(5) The provider must document in the client's medical or dental record:

(a) Justification for replacement of dentures; and

(b) Charts of missing teeth, for replacement of partials.

(6) The impression date may be used as the service date for dentures including partials only when:

(a) Related dental services including laboratory services were provided during a client's eligible period; and

(b) The client is not eligible at the time of delivery.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1240, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1250 Orthodontic coverage for DSHS children. Complex **orthodontic** treatment for severe handicapping dental needs is covered only for categorically needy children subject to the limits of this section.

(1) Prior authorization is not required for **cleft** lip, **cleft**-palate, or craniofacial anomalies when the client is:

(a) Being treated by a department-recognized **cleft** lip, **cleft** palate or **craniofacial anomaly team**; and

(b) Eligible per WAC 388-535-1060.

(2) **Orthodontic** care must be prior authorized for children with severe **malocclusions**.

(3) A client must meet one of the following categories to be eligible for **orthodontic** care:

(a) A child with **clefts** (lip or palate) **craniofacial anomalies** and severe **malocclusions** when followed by an MAA-recognized cleft lip, cleft palate, or **craniofacial** team for:

(i) **Cleft** lip and palate, **cleft** palate, or **cleft** lip with alveolar process involvement;

(ii) **Craniofacial anomalies**, including but not limited to:

(A) Hemifacial microsomia;

(B) Craniosynostosis syndromes;

(C) Cleidocranial dysplasia;

(D) Arthrogryposis;

(E) Marfans syndrome; or

(F) Other syndromes by MAA review;

(iii) Other diseases/**dysplasia** with significant facial growth impact, e.g., juvenile rheumatoid arthritis (JRA); or

(iv) Post traumatic, post radiation, or post burn jaw deformity.

(b) A child with severe **malocclusions** which include one or more of the following:

(i) A severe skeletal disharmony;

(ii) A severe overjet resulting in functional impairment;

(iii) A severe vertical overbite resulting in palatal impingement and/or damage to the mandibular labial tissues.

(c) A child with other dental malformations resulting in severe dental functional impairment. MAA reviews each of these cases for dental **necessity**.

(4) Interceptive **orthodontic** treatment is covered once per client's lifetime for clients with **cleft** palate, **craniofacial anomaly**, or severe **malocclusions**.

(5) Limited transitional **orthodontic** care is covered for a maximum of one year from original placement. Follow up treatment is allowed in three-month increments after the initial placement.

(6) Full **orthodontic** care is limited to a maximum of two years from original **banding**. Six follow up treatments are allowed in three month increments, beginning six months after original banding.

(7) Lost or broken **orthodontics** appliances are not covered.

(8) Orthodontic removal is covered for a client whose appliance was placed by a provider not participating with MAA, or whose payment was not covered by MAA.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1250, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1250, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1260 Dental-related limits of state-only funded programs. (1) Clients with the following state-funded only eligibility programs receive only the limited coverage described in this section:

(a) General assistance unemployable (GAU); and

(b) Alcohol and drug abuse treatment and support act (ADATSA) (GAU-W).

(2) The dental services described and limited in this chapter are covered for clients eligible for GAU or GAU-W only when provided as part of a medical treatment for:

(a) Apical abscess verified by clinical examination, and treated by:

(i) Open and drain palliative treatment;

(ii) Tooth extraction; or

(iii) Root canal;

(b) Radiation therapy for cancer of the mouth, only for a total dental extraction performed prior to and because of that radiation therapy;

(c) Tooth fractures (limited to extraction);

(d) **Maxillofacial** fracture;

(e) Systemic or presystemic cancer, only for oral hygiene related to those conditions;

(f) Cysts or tumor therapies; or

(g) Sequestrectomies.

(3) MAA may require prior authorization for any dental treatment provided to a GAU or GAU-W client.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1260, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1300 Access to baby and child dentistry (ABCD) program. (1) The access to baby and child dentistry (**ABCD**) program is a demonstration project established to increase access to dental services in targeted areas for Medicaid eligible infants, toddlers, and preschoolers.

(2) **Children** eligible for the **ABCD** program must be five years of age or younger and residing in targeted areas selected by MAA.

(3) MAA pays enhanced fees to **ABCD**-certified participating providers for the targeted services. The University of Washington continuing education program certifies dental providers for ABDC services.

(4) In addition to services provided under the MAA dental care program, the following services are provided:

(a) Family oral health education; and

(b) Case management services.

(5) Clients who do not comply with program requirements may be disqualified from the **ABCD** program. The client remains eligible for regular MAA dental coverage.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1300,

filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1300, filed 12/6/95, effective 1/6/96.]

PAYMENT

WAC 388-535-1350 Dental-related services–Payment methodology. The department uses the dental services described in the Current Dental Terminology, 2nd edition (**CDT-2**), and the Current Procedure Terminology (**CPT**). The department uses state-assigned procedure codes to identify services not fully described in the **CDT-2** or **CPT** descriptions.

(1) For covered services provided to eligible clients, MAA pays dentists and related providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC 388-535-1100, Dental services not covered, and WAC 388-535-1400, Dental payment limits.

(2) MAA may pay providers a higher reimbursement rate for selected dental services provided to **children** in order to increase **children's** access to dental services.

(3) Maximum allowable fees for dental services provided to **children** are set as follows:

(a) The department's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) The department consults with and seeks input from representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) The department consults with dental experts and public health professionals to identify and prioritize dental services and procedures in terms of their effectiveness in improving or promoting **children's** dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for **children's** dental services are allocated to specific procedures based on this priority list and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting **children's** dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the department's evaluation of utilization trends, effectiveness of interventions, and access issues.

(4) **Dental general anesthesia** services for all eligible clients are reimbursed on the basis of base anesthesia units plus time. Payment for **dental general anesthesia** is calculated as follows:

(a) Dental procedures are assigned an anesthesia base unit of five;

(b) Twelve minutes constitute one unit of time. When a dental procedure requiring **dental general anesthesia** results in multiple time units and a remainder (less than twelve minutes), the remainder or fraction is considered as one time unit;

(c) Time units are added to the anesthesia base unit of five and multiplied by the anesthesia conversion factor;

(d) The formula for determining payment for **dental general anesthesia** is: (5.0 base anesthesia units + time units) x conversion factor = payment.

(5) Anesthesiologists may be paid for **general dental anesthesia** provided in dental offices. Only anesthesiologists specially contracted by MAA will be paid an additional fee for that service.

(6) Dental hygienists are paid at the same rate as dentists for services allowed under The Dental Hygienist Practice Act available from the department of health, Olympia, Washington.

(7) Licensed denturists or dental laboratories billing independently are paid at MAA's allowance for prosthetics (dentures and partials) services.

(8) Fee schedule changes are made whenever vendor rate increases or decreases are authorized by the legislature.

(9) The department may adjust maximum allowable fees to reflect changes in the services or procedure code descriptions.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1350, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1350, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1400 Dental payment limits. (1) Provision of covered dental services to an eligible client constitutes acceptance by the provider of the department's rules and fees.

(2) Participating providers must bill the department their usual and customary fees.

(3) Payment for dental services is based on the department's schedule of maximum allowances. Fees listed in the MAA fee schedule are the maximum allowable fees.

(4) Payment to the provider will be the lesser of the billed charge (**usual and customary fee**) or the department's maximum allowable fee.

(5) If a covered service is performed for which no fee is listed, the service is paid "**by report**" on a case-by-case basis as determined by MAA

(6) If eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility.

The client is responsible for payment of any dental treatment or service received during any period of ineligibility with the exception described in WAC 388-535-1240(4) even if the treatment was started when the client was eligible.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1400, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1400, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1450 Denture laboratory services–Payment. A dentist using the services of an independent denture laboratory must bill MAA for the services of the laboratory.

No payment will be made to a dentist for services performed and billed by an independent denturist.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1450, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1450, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1500 Dental-related hospital services–Payment. MAA pays for dentally necessary hospital inpatient and outpatient services in accord with WAC 388-550-1100.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1500, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1500, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1550 Dental care provided out-of-state–Payment. (1) Clients, except those receiving medical care services (state-only funding), who are temporarily outside the state receive the same dental care services as clients in the state, subject to the same exceptions and limitations.

(2) Out-of-state dental care received by clients receiving medical care services (state-only funding) is not covered.

(3) Eligible clients in MAA-designated border areas may receive the same dental services as if provided in state.

(4) Dental providers who are out-of-state must meet the same criteria for payment as in-state providers, including the requirements to contract with MAA.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1550, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1550, filed 12/6/95, effective 1/6/96.]

Chapter 388-537 WAC
SCHOOL SERVICES

WAC

WAC 388-537-0100 School medical services for students in special education programs. (1) The medical assistance administration (MAA) pays school districts or educational service districts (ESD) for qualifying medical services provided to an eligible student. To be covered under this section, the student must be eligible for Title XIX (i.e., either the categorically needy or medically needy programs).

(2) To qualify for payment under this section, the medical services must be provided:

(a) By the school district or the ESD; and

(b) To the eligible special education student as part of the student's individualized education program (IEP) or individualized family service plan (IFSP).

(3) To qualify for payment under this section, the medical services must be provided by one of the following service providers:

(a) A qualified Medicaid provider as described under WAC 388-502-0010;

(b) A psychologist, licensed by the state of Washington or granted an educational staff associate (ESA) certificate by the state board of education;

(c) A school guidance counselor, or a school social worker, who has been granted an ESA certificate by the state board of education; or

(d) A person trained and supervised by any of the following:

(i) A licensed registered nurse;

(ii) A licensed physical therapist or physiatrist;

(iii) A licensed occupational therapist; or

(iv) A speech pathologist or audiologist who:

(A) Has been granted a certificate of clinical competence by the American speech, hearing, and language association;

(B) Is a person who completed the equivalent educational and work experience necessary for such a certificate; or

(C) Is a person who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(4) Student service recommendations and referrals must be updated at least annually.

(5) The student does not need a provider prescription to receive services described under this section.

(6) MAA pays for school-based medical services according to the department-established rate or the billed amount, whichever is lower.

(7) MAA does not pay individual school practitioners who provide school-based medical services.

(8) For medical services billed to Medicaid, school districts or ESD, must pursue third-party resources.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-537-0100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-537-0100, filed 12/14/99, effective 1/14/00.]

Chapter 388-538 WAC
MANAGED CARE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-538-001 Purpose. [Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-001, filed 8/11/93, effective 9/11/93. Formerly WAC 388-83-010 (part).] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

388-538-090 Client's choice of primary care provider. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-090, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-090, filed 8/11/93, effective 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

388-538-150 Managed care medical audit. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-150, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-150, filed 8/11/93, effective 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42

U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

WAC 388-538-050 Definitions. The following definitions and abbreviations and those found in chapter 388-500-0005 WAC, Medical definitions, apply to this chapter. Defined words and phrases are bolded in the text.

"Ancillary health services" means health services ordered by a **provider**, including but not limited to, laboratory **services**, radiology **services**, and physical therapy.

"Appeal" means a formal request by a **provider** or covered **enrollee** for reconsideration of a decision such as a utilization review recommendation, a benefit payment, an administrative action, or a quality of care or **service** issue, with the goal of finding a mutually acceptable solution.

"Basic health plan (BHP)" means the health care program authorized by title 70.47 RCW and administered by the health care authority (HCA).

"Children's health insurance program (CHIP)" means the health insurance program authorized by Title XXI of the Social Security Act and administered by the **medical assistance administration (MAA)**

"Client" means an individual eligible for any medical program who is not enrolled with a **managed care plan** or **primary care case management (PCCM) provider**. In this chapter, **client** refers to a person before the person is enrolled in **managed care**, while **enrollee** refers to an individual eligible for any medical program who is enrolled in **managed care**.

"Complaint" means an oral or written expression of dissatisfaction by an **enrollee**.

"Emergency medical condition" means a condition meeting the definition in 42 U.S.C. 1396u-2 (b)(2)(C).

"Emergency services" means services as defined in 42 U.S.C. 1396u-2 (b)(2)(B).

"End enrollment" means an **enrollee** is currently enrolled in **healthy options (HO)** and requests to discontinue enrollment and return to the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-130. This is also referred to as**"disenrollment."**

"Enrollee" means an individual eligible for any medical program who is enrolled in managed care through a **health care plan** or **primary care case management (PCCM) provider** that has a contract with the state.

"Enrollees with chronic conditions" means persons having chronic and disabling conditions, including persons with special health care needs that meet all of the following conditions:

(1) Have a biologic, psychologic, or cognitive basis;

(2) Have lasted or are virtually certain to last for at least one year; and

(3) Produce one or more of the following conditions stemming from a disease:

(a) Significant limitation in areas of physical, cognitive, or emotional function;

(b) Dependency on medical or assistive devices to minimize limitation of function or activities; or

(c) In addition, for children, any of the following:

(i) Significant limitation in social growth or developmental function;

(ii) Need for psychologic, educational, medical, or related **services** over and above the usual for the child's age; or

(iii) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

"Exemption" means a **client** is not currently enrolled in **HO** and makes a pre-enrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-080.

"Health care plan" or **"plan"** means an organization contracted with the department of social and health services (DSHS) to provide **managed care** to **MAA clients**.

"Health care service" or **"service"** or item means a **service** provided for the prevention, cure, or treatment of illness, injury, disease, or condition.

"Healthy options contract or HO contract" means the agreement between the **department** of social and health services and a **health care plan** to provide the contracted **services** to **enrollees**.

"Healthy options program or HO program" means **medical assistance administration's managed care** health program for Medicaid-eligible **clients**.

"Managed care" means a prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and **ancillary health services**.

"Participating provider" means a person or entity with a written agreement with a **plan** to provide **health care services** to **managed care enrollees**.

"Primary care case management (PCCM)" means the health care management activities of a **provider** that contracts with the **department** to provide primary **health care services** and to arrange and coordinate other preventive, specialty, and **ancillary health services**.

"Primary care provider (PCP)" means a person licensed or certified under Title 18 RCW including but not limited to, a **physician**, and advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health **services** to a **client** or an **enrollee**, initiates referrals for specialist and ancillary care, and maintains the **client's** or **enrollee's** continuity of care.

"Timely" - in relation to the provision of **services**, means an **enrollee** has the right to receive medically necessary health care without unreasonable delay.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-050, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-050, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-050, filed 8/11/93, effective 9/11/93.]

WAC 388-538-060 Healthy options and choice. (1) A **client**is required to enroll in **HO** when that **client** meets all of the following conditions:

(a) Is eligible for one of the medical programs for which clients must enroll in **HO** as described in the **HO contract**;

(b) Resides in an area, determined by MAA, where clients must enroll in **HO**;

(c) Is not exempt from **HO** enrollment as determined by **MAA**, consistent with WAC 388-538-080, and any related fair hearing has been held and decided; and

(d) Has not had **HO** enrollment ended by **MAA**, consistent with WAC 388-538-130.

(2) American Indian/Alaska Native (AI/AN) **clients** who meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally-recognized tribal members and their descendants, may choose one of the following:

(a) Enroll with an **HO plan** available in their area;

(b) Enroll with an **HO** Indian or tribal **PCCM provider**-available in their area; or

(c) **MAA's** fee-for-service program.

(3) A **client** may enroll with a **plan** or **PCCM provider** by calling **MAA's** toll-free enrollment line, or by sending a completed **HO** enrollment form to **MAA**.

(a) Except as provided in subsection (2) of this section for AI/AN and in subsection (5) of this section for cross-county enrollment, a **client** required to enroll in **HO** must enroll with a **plan** available in the area where the **client** lives.

(b) Family members must enroll with the same **plan**.

(c) **Enrollees** may request a **plan** change at any time.

(d) When a **client** requests enrollment with a **plan** or **PCCM provider**, MAA enrolls a **client** effective the earliest possible date given the requirements of **MAA's** enrollment system. **MAA** does not enroll **clients** retrospectively.

(4) **MAA** assigns a **client** who does not choose a **plan** or **PCCM provider** as follows:

(a) If the **client** has family members enrolled with a **plan**, the **client** is enrolled with that **plan**;

(b) If the **client** does not have family members enrolled with a **plan**, and the **client** was enrolled in the last six months with a **plan** or **PCCM provider**, the **client** is re-enrolled with the same **plan** or **PCCM provider**;

(c) If a **client** does not choose a plan or **PCCM provider** but chooses a **provider**, **MAA** attempts to contact the **client** by phone to obtain the **client's plan** or **PCCM provider** choice. If **MAA** is not able to contact the **client**, **MAA** attempts to determine whether the **client's** chosen **provider** is with a **plan**, and, if so, assigns the **client** to that **plan**;

(d) If the **client** cannot be assigned according to (a), (b), or (c) of this subsection, **MAA** assigns the **client** as follows:

(i) If an AI/AN **client** does not choose a **plan**, **MAA** assigns the client to a **PCCM provider** if that **client** lives in a zip code served by a **PCCM provider**. If there is no **PCCM provider** in the **client's** area, the **client** will remain fee-for-service. A **client** assigned under this subsection may request to **end enrollment** according to WAC 388-538-130 (2)(b) at any time.

(ii) If a non-AI/AN **client** does not choose a **plan**, **MAA** assigns a **plan** available in the area where the **client** lives. A **plan** must have at least one **PCP** available within twenty-five miles of the zip code in which the **client** lies for the **plan** to be considered available.

(iii) **MAA** sends a written notice to each household of one or more **clients** who are assigned to a **plan** or **PCCM provider**. The notice includes the name of the **plan** or **PCCM provider** to which each **client** has been assigned, toll-free contact phone numbers for the **plan** or **PCCM provider** and **MAA**, the effective date of enrollment, and the date by which the **client** must respond in order to change plan assignment.

(iv) An assigned **client** has at least thirty calendar days to contact **MAA** to change the **plan** or **PCCM provider** before enrollment is effective.

(5) A **client** may enroll with a **plan** in an adjacent county when the **client** lives in an area, designated by **MAA**, where residents historically have traveled a relatively short distance across county lines to the nearest available practitioner.

(6) **PCP** choice or assignment occurs as follows:

(a) **Enrollees** may choose:

(i) A **PCP** or clinic that is in their **plan** and accepting new **enrollees**; or

(ii) Different **PCPs** or clinics participating with the same **plan** for different family members.

(b) The **plan** assigns a **PCP** or clinic within reasonable proximity to the **enrollee's** home if the **enrollee** does not choose one;

(c) **Enrollees** may change **PCPs** or clinics in a **plan** at least once a year for any reason, and at any time for good cause; or

(d) In accordance with this subsection, **enrollees** may file an **appeal** with the **plan** and/or a fair hearing request with DSHS and may change plans if the **plan** denies an **enrollee's** request to change **PCPs** or clinics.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-060, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-060, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-060, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-060, filed 8/11/93, effective 9/11/93.]

WAC 388-538-065 Medicaid eligible basic health plan enrollees. (1) Certain children and pregnant women enrolled through **BHP** (chapter 70.47 RCW) are eligible for Medicaid under pediatric and maternity expansion provisions of the Social Security Act. **MAA** determines Medicaid eligibility for children and pregnant women who enroll through **BHP**.

(2) The administrative rules and regulations that apply to **HO enrollees** also apply to Medicaid eligible clients enrolled through **BHP**, except as follows:

(a) The process for enrolling in **HO** described in WAC 388-538-060(3) does not apply since enrollment is through the health care authority, the state agency that administers **BHP**;

(b) American Indian/Alaska Native (AI/AN) clients cannot choose fee-for-service or **PCCM** as described in WAC 388-538-060(2). They must enroll in a **BHP health care plan**.

(c) If a Medicaid eligible client applying for **BHP** does not choose a **plan** within ninety days, the client is transferred from **BHP** to **HO** and is assigned as described in WAC 388-538-060(4).

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-065, filed 2/1/00, effective 3/3/00.]

WAC 388-538-066 Children's health insurance program (CHIP) enrollees. (1) Children eligible for the **children's health insurance program (CHIP)**, a non-Medicaid medical program, may be enrolled in **managed care** as described in chapter 388-542 WAC.

(2) With the exception of the following sections, the sections in this chapter apply to **CHIP clients** enrolled in **managed care**:

(a) WAC 388-538-060 does not apply to **CHIP**. The enrollment and choice provisions for **CHIP clients** are included in chapter 388-542 WAC.

(b) WAC 388-538-065 does not apply to **CHIP** since **CHIP** eligible **clients** cannot enroll in **managed care** through the **BHP**.

(c) WAC 388-538-080 and 388-538-130 do not apply to **CHIP**. Chapter 388-542 WAC includes the provisions for exceptions to **managed care** enrollment for **CHIP clients**.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-066, filed 2/1/00, effective 3/3/00.]

WAC 388-538-070 Managed care payment. (1) **MAA** pays **plans** a monthly capitated premium according to contracted terms and conditions.

(2) **MAA** pays **PCCM providers** a monthly case management fee according to contracted terms and conditions.

(3) **MAA** does not pay **providers** on a fee-for-service basis for **services** that are the **plan's** responsibility under the **HO contract**, even if the **plan** has not paid for the **service** for any reason.

(4) **MAA** pays an additional monthly amount, known as an enhancement rate, to federally qualified health care centers (FQHC) and rural health clinics (RHC) for each **client** enrolled with **plans** through the FQHC or RHC. **Plans** may contract with FQHCs and RHCs to provide **services** under **HO**. FQHCs and RHCs receive an enhancement rate from **MAA** in addition to the negotiated payments they receive from the **plans** for **services** provided to **enrollees**.

(a) **MAA** pays the enhancement rate only for the categories of **service** provided by the FQHC or RHC under the **HO contact**. **MAA** surveys each FQHC or RHC in order to identify the categories of **services** provided by the FQHC or RHC.

(b) **MAA** bases the enhancement rate on both of the following:

(i) The upper payment limit (UPL) for the county in which the FQHC or RHC is located; and

(ii) An enhancement percentage.

(c) **MAA** determines the UPL for each category of **service** based on **MAA's** historical fee-for-service experience, adjusted for inflation and utilization changes.

(d) **MAA** determines the enhancement percentage for **HO enrollees** as follows:

(i) For FQHCs, the enhancement percentage is equal to the FQHC finalized audit period ratio. The "finalized audit period" is the latest reporting period for which the FQHC has a completed audit approved by and settled with **MAA**.

(A) For a clinic with one finalized audit period, the ratio is equal to:

(FQHC total costs) - (Fee-for-service reimbursements + **HO**reimbursements)/(FFS + **HO** reimbursements).

(B) For a clinic with two finalized audit periods, the ratio is equal to the percentage change in the medical services encounter rate from one finalized audit period to the next. A "medical services encounter" is a face-to-face encounter between a physician or mid-level practitioner and a **client** to provide services for prevention, diagnosis, and/or treatment of illness or injury. A "medical services encounter rate" is the individualized rate **MAA** pays each FQHC to provide such services to clients, or the rate set by Medicare for each RHC for such services.

(C) For FQHCs without a finalized audit, the enhancement percentage is the statewide weighted average of all the FQHCs' finalized audit period ratios. Weighting is based on the number of **enrollees** served by each FQHC.

(ii) For RHCs, **MAA** applies the same enhancement percentage statewide.

(A) On a given month, **MAA** determines the number of **HO enrollees** enrolled with each RHC that is located in the same county as an FQHC. This number is expressed as a percentage of the total number of RHC **enrollees** located in counties that have both FQHCs and RHCs.

(B) For each county that has both an FQHC and an RHC, **MAA** multiplies the FQHC enhancement percentage, as determined under subsection (4)(d)(i) of this section, the by percentage obtained in section (4)(d)(ii)(A) of this section.

(C) The sum of all these products is the weighted statewide RHC enhancement percentage.

(iii) The **HO** enhancement percentage for FQHCs and RHCs is updated once a year.

(e) For each category of service provided by the FQHC or RHC, **MAA** multiplies the UPL, as determined under subsection (4)(c) of this section, by the FQHC's or RHC's enhancement percentage. The sum of all these products is the enhancement rate for the individual FQHC or RHC.

(f) To calculate the enhancement rate for FQHCs and RHCs that provide maternity and newborn delivery services, **MAA** applies each FQHC's or RHC's enhancement percentage to the delivery case rate (DCR), which is a one-time rate paid by **MAA** to the HO plan for each pregnant **enrollee** who gives birth.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-070, filed 2/1/00, effective 3/3/00. Statutory

Authority: RCW 74.08.090. 96-24-073, § 388-538-070, filed 12/2/96, effective 1/2/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-070, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-070, filed 8/11/93, effective 9/11/93.]

WAC 388-538-080 Healthy options exemptions. (1) Only a **client** or a **client's** representative (RCW 7.70.065) may request an exemption from **HO** enrollment. If a **client** asks for an **exemption** prior to the enrollment effective date, the **client** is not enrolled until **MAA** approves or denies the request and any related fair hearing is held and decided.

(2) **MAA** exempts a **client** from mandatory enrollment in a **plan** or with a **PCCM provider** if any of the following apply:

(a) Based on **MAA's** evaluation of objective medical evidence, all of the following are met:

(i) The client has multiple, complex, or severe medical diagnoses;

(ii) The client's established provider is not available through any managed care plan;

(iii) There is a written treatment plan;

(iv) The treatment plan requires frequent change or monitoring; and

(v) Disruption of **client's** care would be harmful; or

(b) Prior to enrollment, the **client** scheduled a surgery with a **provider** not available to the **client** in a **plan** and the surgery is scheduled within the first thirty days of enrollment; or

(c) The **client** is AI/AN as specified in WAC 388-538-060(2) and requests **exemption**; or

(d) The **client** has private insurance under a **managed care**arrangement; or

(e) The **client** has **BHP**; or

(f) The **client** has CHAMPUS; or

(g) The **client** requests enrollment in the same **plan** with which the **client** has private insurance under any arrangement; or

(h) On a case-by-case basis, the **client** presents evidence that the **HO** program does not provide **medically necessary** care that is reasonably available and accessible as offered to the **client**. **MAA** considers that **medically necessary** care is not reasonably available and accessible when any of the following apply:

(i) The **client** is homeless or is expected to live in temporary housing for less than one hundred twenty days from the date the **client** requests the **exemption**;

(ii) The **client** is limited English speaking or hearing impaired and the **client** can communicate with **a provider** who communicates in the **client's** language or in American Sign Language and is not in an **HO plan**;

(iii) The **client** is pregnant and wishes to continue her established course of prenatal care with an obstetrical **provider** who is not available to her through a **plan**;

(iv) The **client** shows that travel to an **HO PCP** is unreasonable when compared to travel to a non-**HO PCP**. This is shown when any of the following transportation situations apply to the **client**:

(A) It is over twenty-five miles one-way to the nearest **HO PCP** who is accepting **enrollees**, and the current **PCP** is closer and not in an available **plan**;

(B) The travel time is over forty-five minutes one-way to the nearest **HO PCP** who is accepting **enrollees**, and the travel time to the current **PCP**, who is not in an available **plan**, is less;

(C) Other transportation difficulties make it unreasonable to get primary medical **services** under **HO**; or

(v) Other evidence is presented that **exemption** is appropriate based on the **client's** circumstances, as evaluated by **MAA**.

(3) **MAA** exempts the **client** for the time period the circumstances or conditions that led to the **exemption** are expected to exist. If the request is approved for a limited time, the client is notified in writing or by telephone of the time limitation, the process for renewing the **exemption**, and their fair hearing rights.

(4) The **client** is not enrolled as provided in subsection (1) of this section and receives timely notice by telephone or in writing when **MAA** approves or denies the **client's exemption** request. If initial denial notice was by telephone, then **MAA** gives the reasons for the denial in writing before requiring the **client** to enroll in **HO**. The written notice to the **client** contains all of the following:

(a) The action **MAA** intends to take, including enrollment information;

(b) The reason(s) for the intended action;

(c) The specific rule or regulation supporting the action;

(d) The **client's** right to request a fair hearing, including the circumstances under which the fee-for-service status continues, if a hearing is requested; and

(e) A translation into the **client's** primary language when the **client** has limited English proficiency.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-080, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 96-24-074, § 388-538-080, filed 12/2/96, effective 1/1/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-080, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-080, filed 8/11/93, effective 9/11/93.]

WAC 388-538-095 Scope of care for managed care enrollees. (1) A **managed care enrollee** is eligible for the **categorically needy** scope of medical care as described in WAC 388-529-0100.

(a) A **client** is entitled to timely access to **medically necessary services** as defined in WAC 388-500-0005.

(b) The **plan** covers the **services** included in the **HO contract** for **plan enrollees**. In addition, **plans** may, at their discretion, cover **services** not required under the **HO contract**.

(c) **MAA** covers the **categorically needy services** not included in the **HO contract** for **plan enrollees**.

(d) **Plan enrollees** may obtain certain **services** from either a **plan provider** or from a medical assistance **provider** with a DSHS core **provider** agreement without needing to obtain a referral from the **PCP** or **plan**. These **services** are described in the **HO contract**, and are communicated to **enrollees** by **MAA** and **plans** as described in (e) of this subsection.

(e) **MAA** sends each **client** written information about covered **services** when the **client** is required to enroll in **managed care**, and any time there is a change in covered **services**. This information describes covered **services**, which **services** are covered by **MAA**, and which **services** are covered by **plans**. In addition, **MAA** requires **plans** to provide new **enrollees** with written information about covered **services**.

(f) **MAA** covers **services** on a fee-for-service basis for **clients** enrolled with a **PCCM provider**. Except for emergencies, a **client's PCCM provider** must refer the client for most services not provided by the **PCCM provider**. The services that require **PCCM provider** referral are described in the **PCCM** contract. **MAA** requires **PCCM providers** to inform **enrollees** about covered **services** and how to obtain them.

(2) For **services** covered by **MAA** for **managed care enrollees**:

(a) **MAA** covers **services** rendered by **providers** with a current DSHS core **provider** agreement to provide the requested **service**;

(b) **MAA** may require the **provider** to obtain authorization from **MAA** for coverage of nonemergency **services**;

(c) **MAA** determines which **services** are **medically necessary**; and

(d) An **enrollee** may request a fair hearing for review of **MAA** coverage decisions.

(3) For **services** covered by **plans**:

(a) **MAA** requires **plans** to contract with a sufficient number of **providers** as determined by **MAA**, to deliver the scope of **services** contracted with the **plan** in a timely fashion, according to the requirements of the HO contract. Except for emergency **services**, **plans** provide covered **services** to **enrollees** through their **participating providers**;

(b) **MAA** requires **plans** to provide new **enrollees** with written information about how **enrollees** may obtain covered **services**;

(c) For nonemergency **services**, **plans** may require the **enrollee** to obtain a referral from the **PCP**, or the **provider** to obtain authorization from the **plan**, according to the requirements of the **HO** contract;

(d) **Plans** and their **providers** determine which **services** are medically necessary given the **enrollee's** condition, according to the requirements included in the **HO** contract;

(e) An **enrollee** may **appeal plan** coverage decisions using the **plan's appeal** process, as described in WAC 388-538-0110. An **enrollee** may also request a hearing for review of a **plan** coverage decision as described in chapter 388-02 WAC;

(f) A managed care enrollee does not need a PCP referral to receive women's health care services, as described in RCW 48.42.100 from any women's health care provider participating with the plan. Any covered services ordered and/or prescribed by the women's health care provider must meet the plan's service authorization requirements for the specific service.

(4) Unless the **plan** chooses to cover these **services**, or an **appeal** or a fair hearing decision reverses a denial, the following **services** are not covered:

(a) For all **managed care enrollees**:

(i) **Services** that are not medically necessary;

(ii) **Services** not included in the **categorically needy** scope of **services**; and

(iii) **Services**, other than a screening exam as described in WAC 388-538-100(3), received in a **hospital** emergency department for nonemergency medical conditions.

(b) For **plan enrollees**:

(i) **Services** received from a participating specialist that require prior authorization from the **plan**, but were not authorized by the **plan**; and

(ii) **Services** received from a nonparticipating **provider** that require prior authorization from the **plan** that were not authorized by the **plan**. All nonemergency **services** covered under the HO contract and received from nonparticipating **providers** require prior authorization from the **plan**.

(c) For **PCCM enrollees, services** that require a referral from the **PCCM provider** as described in the **PCCM** contract, but were not referred by the **PCCM provider**.

(5) A provider may bill an enrollee for noncovered **services** as described in subsection (4) of this section, if the **enrollee** and provider sign an agreement. The provider must give the original agreement to the enrollee and file a copy in the enrollee's record.

(a) The agreement must state all of the following:

(i) The specific **service** to be provided;

(ii) That the **service** is not covered by either **MAA** or the **plan**;

(iii) An explanation of why the **service** is not covered by the **plan** or **MAA**, such as:

(A) The **service** is not medically necessary; or

(B) The **service** is covered only when provided by a participating provider.

(iv) The **enrollee** chooses to receive and pay for the **service**; and

(v) Why the **enrollee** is choosing to pay for the **service**, such as:

(A) The **enrollee** understands that the **service** is available at no cost from a **provider** participating with the **plan**, but the **enrollee** chooses to pay for the **service** from a **provider** not participating with the **plan**;

(B) The **plan** has not authorized emergency department-**services** for nonemergency medical conditions and the **enrollee** chooses to pay for the emergency department's **ser-**

vices rather than wait to receive **services** at no cost in a **participating provider's** office; or

(C) The **plan** has determined that the **service** is not medically necessary and the **enrollee** chooses to pay for the **service**.

(b) For limited English proficient **enrollees**, the agreement must be translated or interpreted into the **enrollee's** primary language to be valid and enforceable.

(c) The agreement is void and unenforceable, and the **enrollee** is under no obligation to pay the **provider**, if the **service** is covered by **MAA** or the **plan** as described in subsection (1) of this section, even if the **provider** is not paid for the covered service because the **provider** did not satisfy the payor's billing requirements.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-538-095, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-095, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-095, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-095, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-095, filed 8/11/93, effective 9/11/93.]

WAC 388-538-100 Managed care emergency services. (1) A **managed care enrollee** may obtain **emergency services**, for **emergency medical conditions** in any hospital emergency department. These definitions differ from the **emergency services** definition that applies to services covered under **MAA's** fee-for-service programs (42 U.S.C. 447.53(4)).

(a) The **plan** covers **emergency services** for **plan enrollees**.

(b) **MAA** covers **emergency services** for **PCCM enrollees**.

(2) **Emergency services** for **emergency medical conditions** do not require prior authorization by the **plan, PCP, PCCM provider,** or **MAA**.

(3) Emergency services received for nonemergency medical conditions must be authorized by the plan for plan enrollees.

(4) An **enrollee** who requests emergency **services** is entitled to receive an exam to determine if the **enrollee** has an emergency medical condition.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-100, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-100, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 95-04-033 (Order 3826), § 388-538-100, filed 1/24/95, effective 2/1/95; 93-17-039 (Order 3621), § 388-538-100, filed 8/11/93, effective 9/11/93.]

WAC 388-538-110 Managed care complaints, appeals, and fair hearings. (1) A **managed care enrollee** has the right to voice a **complaint** or submit an **appeal** of a **plan, PCP** or **provider** decision, action, or inaction. An **enrollee** may do this through the **plan's** complaint and **appeal** process, and through the department's fair hearing process.

(2) To ensure the rights of **enrollees** are protected, **MAA** approves each **plan's complaint** and **appeal** process annually or whenever the **plan** makes a change to the process.

(3) **MAA** requires **plans** to inform **enrollees** in writing within fifteen days of enrollment about their rights and how to use the **plan's complaint** and **appeal** processes. **MAA** requires **plans** to obtain **MAA** approval of all written information sent to **enrollees**.

(4) **Enrollees** may request assistance from the **plan** when using the **plan's complaint** and **appeals** processes.

(5) An **enrollee** who complains to a **plan** is entitled to a written or verbal response from the **plan** within the timeline in the **plan's MAA**-approved **complaint** process.

(6) When an **enrollee** is not satisfied with how the **plan** resolves a complaint, or if the **plan** does not resolve a complaint in a timely fashion, the **enrollee** may submit an appeal to the **plan**. An **enrollee** may also **appeal** a **plan, PCP**, or **provider** decision, or reconsideration of any action or inaction. An **enrollee** who **appeals** a **plan, PCP**, or **provider** decision is entitled to all of the following:

(a) A review of the decision being **appealed**. The review must be conducted by a **plan** representative who was not involved in the decision under appeal;

(b) Continuation of the **service** already being received and which is under **appeal**, until a final decision is made;

(c) A written decision from the **plan**, within the timeline(s) in the **plan** standards, in the **enrollee's** primary language. The **plan** does not need to translate the decision if an **enrollee** with limited English proficiency prefers correspondence in English, and the **plan** documents the **enrollee's** preference. The notice must clearly explain all of the following:

(i) The decision and any action the **plan** intends to take;

(ii) The reason for the decision;

(iii) The specific information that supports the **plan's** decision; and

(iv) Any further **appeal** or fair hearing rights available to the **enrollee**, including the **enrollee's** right to continue receiving the **service** under **appeal** until a final decision is made.

(d) An expedited decision when it is necessary to meet an existing or anticipated acute or urgent medical need.

(7) An **enrollee** may file a fair hearing request without also filing an **appeal** with the **plan** or exhausting the **plan's appeal** process.

(8) The **plan's** medical director or designee reviews all fair hearings requests, and any related **appeals**, when the issues involve medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-110, filed 2/1/00, effective 3/3/00. 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.]

WAC 388-538-120 Enrollee request for a second medical opinion. (1) A **managed care plan enrollee** has the right to a **timely** referral for a second opinion upon request when:

(a) The **enrollee** needs more information about treatment recommended by the **provider** or **plan**; or

(b) The **enrollee** believes the **plan** is not authorizing **medically necessary** care.

(2) A **managed care plan enrollee** has a right to a second opinion from a primary or specialty care **physician** who is participating with the **plan**. At the **plan's** discretion, a clinically appropriate nonparticipating **provider** who is agreed upon by the **plan** and the **enrollee** may provide the second opinion.

(3) **PCCM provider enrollees** have a right to a **timely**referral for a second opinion by another **provider** who has a core **provider** agreement with **MAA**.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-120, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-120, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-120, filed 8/11/93, effective 9/11/93.]

WAC 388-538-130 Ending enrollment in healthy options. (1) An **enrollee**, the **enrollee's** representative as defined in RCW 7.70.065, or plan may request **MAA** to **end enrollment**. Only **MAA** has authority to remove an **enrollee** from the **HO** program. Pending **MAA's** final decision, the **enrollee** remains **enrolled** unless staying in **HO** would adversely affect the **enrollee's** health status.

(2) **MAA** ends enrollment in **HO** when the **enrollee** meets any of the following:

(a) Is no longer eligible for a medical program subject to enrollment; or

(b) Requests to be removed from **HO** according to WAC 388-538-080 (2)(a), (c), or (h), and **MAA** approves the request;

(c) Becomes a **Medicare** beneficiary;

(d) Is scheduled for a surgery with a **provider** not available to the **enrollee** in the **enrollee's** current **plan** and the surgery is scheduled to be performed within the first thirty days of enrollment;

(e) Is pregnant and requests to continue her established course of prenatal care with an obstetrical **provider** who is not available through her current **plan**;

(f) Notifies **MAA** of private insurance under a **managed care** arrangement;

(g) Notifies **MAA** of **BHP** coverage;

(h) Notifies **MAA** of CHAMPUS coverage;

(i) Notifies **MAA** of private insurance with the same **plan** as the **enrollee's** current **HO plan** under any arrangement; or

(j) Asks to be taken out of the current **plan** in order to stay with the **enrollee's** established **provider** but is willing to enroll in the established **provider's plan** for the next enrollment month. **MAA** reviews subsection (2)(b), (d), and (e) in this section when reviewing a request to end a **client's** enrollment per this subsection. **MAA's** decisions on those requests include all of the following:

(i) The decision is given verbally or in writing; and

(ii) Verbal and written notices include the reason for the decision and information on hearings so the **enrollee** may **appeal** the decision; and

(iii) If the request to **end enrollment** is approved, it may be effective back to the beginning of the month the request is made; and

(iv) If the request to **end enrollment** is denied, and the **enrollee** requests a hearing; the **enrollee** remains enrolled in the **plan** until the hearing decision is made as provided in subsection (1) of this section.

(3) **MAA ends enrollment** for the period of time the circumstances or conditions that led to ending the **enrollment** are expected to exist. If the request to **end enrollment** is approved for a limited time, the client is notified in writing or by telephone of the time limitation, the process for renewing the disenrollment, and their fair hearing rights.

(4) **MAA** does not approve an enrollee's request to end enrollment solely to pay for services received but not authorized by the plan.

(5) The **enrollee** remains in **HO** as provided in subsection (1) of this section and receives timely notice by telephone or in writing when **MAA** approves or denies the **enrollee's** request to end enrollment. Except as provided in subsection (2)(j) of this section, **MAA** gives the reasons for a denial in writing. The written denial notice to the **enrollee** contains all of the following:

(a) The action **MAA** intends to take;

(b) The reason(s) for the intended action;

(c) The specific rule or regulation supporting the action;

(d) The **enrollee's** right to request a fair hearing; and

(e) A translation into the **enrollee's** primary language when the **enrollee** has limited English proficiency.

(6) **MAA** may end an **enrollee's** enrollment in a **plan** when the **enrollee's plan** substantiates in writing, to **MAA's** satisfaction, that:

(a) The **enrollee's** behavior is inconsistent with the **plan's** rules and regulations, such as intentional misconduct; and

(b) After the plan has provided:

(i) Clinically appropriate evaluation(s) to determine whether there is a treatable problem contributing to the **enrollee's** behavior; and

(ii) If so, has provided clinically appropriate referral(s) and treatment(s), but the **enrollee's** behavior continues to prevent the **provider** from safely or prudently providing medical care to the **enrollee**; and

(c) The **enrollee** received written notice from the **plan** of the **plan's** intent to request the **enrollee's** removal, unless **MAA** has waived the requirement for the **plan** because the **enrollee's** conduct presents the threat of imminent harm to others. The **plan's** notice to the **enrollee** must include both of the following:

(i) The **enrollee's** right to use the **plan's appeal** process to review the **plan's** request to end the **enrollee's** enrollment; and

(ii) The **enrollee's** right to use the **department** fair hearing process.

(7) **MAA** makes a decision to remove an **enrollee** from enrollment with a plan within thirty days of receiving the **plan's** request to do so. Before making a decision, **MAA** attempts to contact the **enrollee** and learn the **enrollee's** perspective. If **MAA** approves the **plan's** request to remove the **enrollee, MAA** sends a notice at least ten days in advance of the effective date that enrollment will end. The notice includes the reason for MAA's approval to end enrollment and information about the client's fair hearing rights.

(8) **MAA** does not approve a **plan's** request to remove an **enrollee** from **HO** when the request is solely due to an adverse change in the **enrollee's** health or the cost of meeting the **enrollee's** needs.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-130, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-130, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-130, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-130, filed 8/11/93, effective 9/11/93.]

WAC 388-538-140 Quality of care. (1) In order to assure that **managed care enrollees** receive appropriate access to quality health care and **services, MAA** does all of the following:

(a) Requires **plans** to have a fully operational quality assurance system that meets a comprehensive set of quality improvement program (QIP) standards.

(b) Monitors **plan** performance through on-site visits and other audits, and requires corrective action for deficiencies that are found.

(c) Requires **plans** to report annually on standardized clinical performance measures that are specified in the contract with **MAA**, and requires corrective action for substandard performance.

(d) Contracts with a professional review organization to conduct independent external review studies of selected health care and **service** delivery.

(e) Conducts **enrollee** satisfaction surveys.

(f) Annually publishes **plan** performance on certain clinical measures and **enrollee** satisfaction surveys and makes reports of site monitoring visits available upon request.

(2) **MAA** requires **plans** to have a method to assure consideration of the unique needs of **enrollees with chronic conditions**. The method includes:

(a) Early identification;

(b) **Timely** access to health care; and

(c) Coordination of health **service** delivery and community linkages.

[Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-140, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-140, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-140, filed 8/11/93, effective 9/11/93.]

Chapter 388-539 WAC
HIV/AIDS RELATED SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-539-001 Purpose. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-001, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

388-539-050 Definitions. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-050, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

388-539-100 Eligibility. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-100, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

388-539-150 Premium payment. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-150, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

WAC 388-539-0200 AIDS—Health insurance premium payment program. (1) The purpose of the AIDS health insurance premium payment program is to help individuals who are not eligible for MAA's medical programs and who are diagnosed with AIDS, pay their health insurance premiums.

(2) To be eligible for the AIDS health insurance premium payment program, individuals must:

(a) Be diagnosed with AIDS as defined in WAC 246-100-011;

(b) Be a resident of the state of Washington;

(c) Be responsible for all, or part of, the health insurance premium payment (without MAA's help);

(d) Not be eligible for one of MAA's other medical programs;

(e) Not have personal income that exceeds three hundred seventy percent of the federal poverty level; and

(f) Not have personal assets, after exemptions, exceeding fifteen thousand dollars. The following personal assets are exempt from the personal assets calculation:

(i) A home used as the person's primary residence; and

(ii) A vehicle used as personal transportation.

(3) MAA may contract with a not-for-profit community agency to administer the Aids health insurance premium payment program. MAA or its contractor determines an individual's initial eligibility and redetermines eligibility on a periodic basis. To be eligible, individuals must:

(a) Cooperate with MAA's contractor;

(b) Cooperate with eligibility determination and redetermination process; and

(c) Initially meet and continue to meet the eligibility criteria in subsection (2) of this section.

(4) Individuals, diagnosed with AIDS, who are eligible for one of MAA's medical programs may ask MAA to pay their health insurance premiums under a separate process. The client's community services office (CSO) is able to assist the client with this process.

(5) Once an individual is eligible to participate in the AIDS health insurance premium payment program, eligibility would cease only when one of the following occurs. The individual:

(a) Is deceased;

(b) Voluntarily quits the program;

(c) No longer meets the requirements of subsection (2) of this section; or

(d) Has benefits terminated due to the legislature's termination of the funding for this program.

(6) MAA sets a reasonable payment limit for health insurance premiums. MAA sets its limit by tracking the charges billed to MAA for MAA clients who have AIDS. MAA does not pay health insurance premiums that exceed fifty percent of the average of charges billed to MAA for its clients with AIDS.

[Statutory Authority: RCW 74.08.090, 74.09.757. 00-14-070, § 388-539-0200, filed 7/5/00, effective 8/5/00.]

WAC 388-539-0300 Case management for persons living with HIV/AIDS. MAA provides HIV/AIDS case management to assist persons infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

(1) To be eligible for MAA reimbursed HIV/AIDS case management services, the person must:

(a) Have a current medical diagnosis of HIV or AIDS;

(b) Be eligible for Title XIX (Medicaid) coverage under either the categorically needy program (CNP) or the medically needy program (MNP); and

(c) Require:

(i) Assistance to obtain and effectively use necessary medical, social, and educational services; or

(ii) Ninety days of continued monitoring as provided in WAC 388-539-0350(2).

(2) MAA has an interagency agreement with the Washington state department of health (DOH) to administer the HIV/AIDS case management program for MAA's Title XIX (Medicaid) clients.

(3) HIV/AIDS case management agencies who serve MAA's clients must be approved to perform these services by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive persons of their statewide choice of available HIV/AIDS case management providers and document that notification in the client's record. This notification requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services.

(b) Have a current client-signed authorization to release/obtain information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA (see RCW 70.02.030). The fee referenced in RCW 70.02.030 is included in MAA's reimbursement to providers. MAA's clients may not be charged for services or documents related to covered services.

(c) Maintain sufficient contact to ensure the effectiveness of ongoing services per subsection (5) of this section. MAA requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the individual service plan (ISP).

(5) HIV/AIDS case management providers must document services as follows:

(a) Providers must initiate a comprehensive assessment within two working days of the client's referral to HIV/AIDS case management services. Providers must complete the assessment before billing for ongoing case management services. If the assessment does not meet these requirements, the provider must document the reason(s) for failure to do so. The assessment must include the following elements as reported by the client:

(i) Demographic information (e.g., age, gender, education, family composition, housing.);

(ii) Physical status, the identity of the client's primary care provider, and current information on the client's medications/treatments;

(iii) HIV diagnosis (both the documented diagnosis at the time of assessment and historical diagnosis information);

(iv) Psychological/social/cognitive functioning and mental health history;

(v) Ability to perform daily activities;

(vi) Financial and employment status;

(vii) Medical benefits and insurance coverage;

(viii) Informal support systems (e.g., family, friends and spiritual support);

(ix) Legal status, durable power of attorney, and any self-reported criminal history; and

(x) Self-reported behaviors which could lead to HIV transmission or re-infection (e.g., drug/alcohol use).

(b) Providers must develop, monitor, and revise the client's individual service plan (ISP). The ISP identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs. The case manager and the client must develop the ISP within two days of the comprehensive assessment or the provider must document the reason this is not possible. An ISP must be:

(i) Signed by the client, documenting that the client is voluntarily requesting and receiving MAA reimbursed HIV/AIDS case management services; and

(ii) Reviewed monthly by the case manager through in-person or telephone contact with the client. Both the review and any changes must be noted by the case manager:

(A) In the case record narrative; or

(B) By entering notations in, initialing and dating the ISP.

(c) Maintained ongoing narrative records - These records must document case management services provided in each month for which the provider bills MAA. Records must:

(i) Be entered in chronological order and signed by the case manager;

(ii) Document the reason for the case manager's interaction with the client; and

(iii) Describe the plans in place or to be developed to meet unmet client needs.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0300, filed 11/16/00, effective 12/17/00.]

WAC 388-539-0350 HIV/AIDS case management reimbursement information. (1) MAA reimburses HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment - The assessment must cover the areas outlined in WAC 388-539-0300 (1) and (5).

(i) MAA reimburses only one comprehensive assessment unless the client's situation changes as follows:

(A) There is a fifty percent change in need from the initial assessment; or

(B) The client transfers to a new case management provider.

(ii) MAA reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is Medicaid eligible and the ongoing case management has been provided.

(b) HIV/AIDS case management, full-month - Providers may request the full-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. MAA reimburses only one full-month case management fee per client in any one month.

(c) HIV/AIDS case management, partial-month - Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an ISP in place for fewer than twenty days in that month. Using the partial-month reimbursement, MAA may reimburse two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) MAA limits reimbursement to HIV/AIDS case managers when a client becomes stabilized and no longer needs an ISP with active service elements. MAA limits reimbursement for monitoring to ninety days past the time the last active service element of the ISP is completed. Case management providers who are monitoring a stabilized client must meet all of the following criteria in order to bill MAA for up to ninety days of monitoring:

(a) Document the client's history of recurring need;

(b) Assess the client for possible future instability; and

(c) Provide monthly monitoring contacts.

(3) MAA reinstates reimbursement for ongoing case management if a client shifts from monitoring status to active case management status due to documented need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0350, filed 11/16/00, effective 12/17/00.]

WAC 388-539-0500 Coordinated community aids service alternatives (CCASA) program services. (1) For the purpose of this section, "CCASA program services" means a medically directed interdisciplinary program of therapeutic services for a terminally ill patient diagnosed with Acquired Immune Deficiency Syndrome or Disabling Class IV Human Immunodeficiency Virus disease.

(2) Home health, home care or hospice agencies or other agencies meeting applicable state and federal licensure/certification requirements shall furnish CCASA services. Individual contractors meeting the applicable standards and state and federal licensure/certification requirements may provide some CCASA services.

(3) The department may pay for the following Title XIX services to a CCASA client:

(a) Hourly skilled nursing services;

(b) Attendant care;

(c) Respite care;

(d) Nutritional consultation;

(e) Therapeutic home delivered meals;

(f) Transportation; and

(g) Psychosocial services.

(4) For the purpose of this waiver program:

(a) Hourly skilled nursing services means teaching, counseling, supervision, execution, and evaluation of the practice and execution of the medical regimes the physician or case manager prescribes, in consultation with a registered nurse, as outlined in the client's plan of care.

(b) Attendant care services means assisting with medically-oriented tasks necessitated by the medical or mental condition of the client and directly related to the client's medical or mental condition. Attendant care services are limited to assistance with the following: Personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services and essential shopping.

(c) Respite care services means the provision of community or home-based services allowing members or designated significant others who ordinarily care for the client relief from those duties. CCASA shall provide respite care in the home, not in an institution.

(d) Therapeutic home-delivered meals services means nutritionally sound meals delivered to the home when included in a plan of care. These meals shall not replace, nor be a substitute for, a full day's nutritional regimen, but nutritionally supplement the normal three meals a day.

(e) Nutritional consultation services means a nutrition assessment of nutritional care and intervention for a CCASA client. The certified dietitian/nutritionist shall determine the appropriate means of nutrition intervention including the nutrients required, the feeding modality, and the method of nutrition education, counseling and referral in consultation with the client, the client's physician and case manager.

(f) Transportation services means the provision of authorized necessary transportation in order for the client to receive services as included in the client's plan of care.

(g) Psychosocial services means the use of counseling techniques, appraisal skills, including mental status assessment or medication evaluation, consulting abilities and variety of treatment modalities and interventions to help the client and their primary care giver through the multiple stages of this terminal illness.

(5) The department shall provide CCASA services to recipients as described under WAC 388-83-220.

[00-11-183, recodified as § 388-539-0500, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.08.090. 90-21-124 (Order 3088), § 388-86-018, filed 10/23/90, effective 11/23/90.]

WAC 388-539-0550 Payment—Coordinated community aids service alternatives (CCSA) program. (1) The department shall establish payment rates for CCASA program services as defined under WAC 388-539-0500.

(2) The department shall pay for services after the central authorization unit evaluates the recipient's application for medical appropriateness and the department of health has approved a plan of care.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-539-0550, filed 12/29/00, effective 1/29/01; 00-11-183, recodified as § 388-539-0550, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.08.090. 90-21-124 (Order 3088), § 388-87-048, filed 10/23/90, effective 11/23/90.]

Chapter 388-540 WAC
KIDNEY CENTERS

WAC

WAC 388-540-001 Purpose. The department administers state funds to assist eligible clients with medical care costs associated with **end stage renal disease (ESRD)**.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-001, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-001, filed 7/28/93, effective 8/28/93.]

WAC 388-540-005 Definitions. The following definitions and those found in WAC 388-500-0005, Medical definitions, apply to this chapter. Defined words and phrases are bolded in the text.

"Adequate consideration" means that the reasonable value of goods or services received in exchange for transferred property approximates the reasonable value of the property transferred;

"Affiliate" means a facility, hospital, unit, business, or person having an agreement with a **kidney center** to provide specified services to **ESRD** patients;

"Application for kidney disease program (KDP) eligibility"means the form provided by MAA, which the client completes and submits to the contracted **kidney center** to determine **KDP**eligibility;

"Assets" means income, resources, or any real or personal property that a person or the person's spouse owns and could convert to cash to be used for support or maintenance;

"Certification" means the **kidney center** has determined a client eligible for the **KDP** for a defined period of time;

"End stage renal disease (ESRD)" means that stage of renal impairment which is irreversible and permanent, and requires dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life;

"KDP application period" means the time between the date of application and **certification**;

"KDP client" means a resident of the state who has a diagnosis of **ESRD** and meets the financial and medical criteria to be determined eligible by a contracted **kidney center**;

"KDP contract manual" is a set of policies and procedures for contracting **kidney centers**;

"Kidney center" means a facility as defined and certified by the federal government to:

(1) Provide **ESRD** services;

(2) Provide the services specified in this chapter; and

(3) Promote and encourage home dialysis for a client when medically indicated;

"Kidney disease program (KDP)" is a public state program that helps eligible clients with the costs of **ESRD**-related medical care;

"Recertifying client" means a **KDP client** who was determined eligible the previous year for the **KDP** and will continue to qualify under this chapter;

"Substantial financial change" means:

(1) The elimination of a client's required annual deductible amount; or

(2) The increase or decrease of income or **assets** by fifteen hundred dollars.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-005, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-005, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-005, filed 7/28/93, effective 8/28/93.]

WAC 388-540-010 Services. The **kidney center** must provide, directly or through an **affiliate**, all physical facilities, professional consultation, personal instructions, medical treatment and care, drug products, and all supplies necessary for carrying out a medically-sound **ESRD** treatment program, including all of the following:

(1) Dialysis for clients with **ESRD** when medically indicated;

(2) Kidney transplantation treatment, either directly or by referral, for clients with **ESRD** when medically indicated;

(3) Treatment for conditions directly related to **ESRD**;

(4) Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment; and

(5) Supplies and equipment for home dialysis.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-010, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-010, filed 7/28/93, effective 8/28/93.]

WAC 388-540-020 Reimbursement. MAA reimburses **kidney centers** for services according to this chapter and the **kidney center's** contract with the department to the extent the legislature has appropriated funds.

(1) To request reimbursement, the **kidney center** must submit documented evidence, satisfactory to MAA, showing:

(a) The services for which reimbursement is requested; and

(b) The client's financial eligibility for the state **KDP** under this chapter.

(2) MAA limits reimbursement for services provided to a client while visiting out of state to fourteen days per calendar year.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-020, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-020, filed 7/28/93, effective 8/28/93.]

WAC 388-540-030 KDP eligibility requirements. (1) The **kidney center** determines clients' eligibility annually on a case-by-case basis, according to this chapter and the **KDP contract manual**. To be eligible for the **KDP**, a client must:

(a) Be a Washington state resident;

(b) Have countable resources, not exempted under subsection (2) of this section, which are equal to or lower than fifteen thousand dollars;

(c) Have countable income as defined in WAC 388-500-0005, which is equal to or lower than three hundred percent of the federal poverty level (FPL); and

(d) Exhaust or be ineligible for all other resources providing similar benefits to meet the cost of **ESRD**-related medical care, such as:

(i) Government or private disability programs; or

(ii) Local funds raised for the purpose of providing financial support for a specified **ESRD** client.

(2) The following resources are exempt:

(a) A home, defined as real property owned by a client as a principal place of residence, together with surrounding and contiguous property not to exceed five acres;

(b) Household furnishings; and

(c) An automobile.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-030, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-030, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-030, filed 7/28/93, effective 8/28/93.]

WAC 388-540-040 Transfer of resources without adequate consideration. A person may be ineligible for the **KDP** if the person knowingly and willfully assigns or transfers nonexempt resources at less than fair market value within two years preceding the date of application, for the purpose of qualifying or continuing to qualify for the program.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-040, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-040, filed 7/28/93, effective 8/28/93.]

WAC 388-540-050 Fiscal information. The **kidney center** must provide fiscal information upon request by the department, including:

(1) Accounting information and documentation sufficient to establish the basis for fees for services and/or charges;

(2) Sources and amounts of resources allowing an individual client to verify financial eligibility;

(3) Evidence that all other available resources have been depleted before requests for reimbursement from the **KDP** are submitted to MAA; and

(4) Other information as MAA may require.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-050, filed 7/28/93, effective 8/28/93.]

WAC 388-540-060 KDP eligibility determination. The **kidney center** and client must comply with the following rules to determine **KDP** eligibility:

(1) The **kidney center** must:

(a) Inform the client of the requirements for **KDP** eligibility as defined in this chapter;

(b) Provide the client with necessary department forms and instructions in a timely manner;

(c) Review the **KDP application** and documentation;

(d) Determine client eligibility using department policies, rules, and instructions; and

(e) Forward the **KDP application** and documentation to the medical assistance administration (MAA). If necessary, MAA may amend or terminate a client's **certification** period within thirty days of receipt.

(2) A person applying for **KDP** must:

(a) Complete the **KDP application** and submit any documentation necessary to determine eligibility to the **kidney center**; and

(b) Apply for Medicaid, obtain a written Medicaid eligibility determination, and submit a copy to the **kidney center**.

(3) A client applying for recertification must:

(a) Apply for Medicaid forty-five days before the end of the **KDP certification** period, obtain a written Medicaid eligibility determination, and submit a copy to the **kidney center**; or

(b) Have applied for Medicaid within the previous five years and continue to be ineligible because the client:

(i) Was denied Medicaid due to:

(A) Failure to meet Medicaid categorical requirements;

(B) **Assets** which exceed Medicaid resource standards; or

(C) Income which exceeds the categorically needy income standards; or

(ii) Does not meet the medically needy spenddown amount because the cost of medical care is:

(A) Less than the spenddown amount; or

(B) Covered by third-party insurance.

(4) The **KDP application period** is:

(a) One hundred and twenty days for a new client; and

(b) Forty-five days prior to the end of a **certification** period for a client requesting recertification.

(5) The **kidney center** may request an extension of application time limits from MAA when extenuating circumstances prevent the client from completing the application or recertification process within the specified time limits.

(6) The **kidney center** certifies the client as **KDP** eligible for a period of one year from the first day of the month of application, unless the client:

(a) Needs medical coverage for less than one year; or

(b) Has a **substantial financial change**, in which case the client must complete a new **application for KDP eligibility**;

(7) The effective date of **KDP** eligibility is the first day of the month of **KDP** application if the client was eligible at any time during that month. The effective date of **KDP** eligibility may be a maximum of four months before the month of **KDP** application if the:

(a) Medical services received were covered; and

(b) Client would have been eligible had the client applied.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-060, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-060, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-060, filed 7/28/93, effective 8/28/93.]

Chapter 388-542 WAC
CHILDREN'S HEALTH INSURANCE PLAN (CHIP)

WAC

WAC 388-542-0050 Definitions for children's health insurance program (CHIP) terms. The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions apply to this chapter. Defined words and phrases are bolded the first time they are used in the text.

"Age appropriate immunizations" means the recommended childhood immunization schedule as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

"Children's health insurance program (CHIP)" means the health insurance program authorized by Title XXI of the Social Security Act and administered by the department of social and health services (DSHS). Also referred to as state children's health insurance program (S-CHIP).

"Client copay" or **"copay"** means an amount a CHIP client pays to health care providers for specific services.

"Client premium" means a monthly payment a client must make to DSHS for CHIP coverage.

"Creditable coverage" means most types of public and private health coverage, except Indian health services, that provides access to physicians, hospitals, laboratory services, and radiology services. This applies whether or not the coverage is equivalent to that offered under CHIP. "Creditable coverage" is described in 42 U.S.C. Sec. 1397jj.

"Employer-sponsored dependent coverage" means creditable health coverage for dependents offered by a family member's employer or union, for which the employer or union may contribute in whole or part towards the premium.

"Finance division" means the division of the department of social and health services that sends out, monitors, and collects the CHIP client premiums.

[Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0050, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0100 CHIP scope of care. (1) **CHIP** clients are eligible for the same scope of medical care as **Medicaid categorically needy** clients as described in WAC 388-529-0100.

(2) The following WACs apply to CHIP clients enrolled in managed care:

(a) WAC 388-538-095; and

(b) WAC 388-538-100.

(3) Except for American Indian/Alaska Native (AI/AN) clients who have chosen primary care case management (PCCM) or fee-for-service as described in WAC 388-542-0200(3), CHIP clients must receive medical services from managed care plans in counties where two or more managed care plans are available.

[Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0100, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0125 Access to care. (1) MAA provides fee-for-service coverage between the time a client becomes eligible for CHIP services and the time the client is enrolled in managed care.

(2) Not all CHIP clients are required to enroll in managed care. See WAC 388-542-0150 (1)(c).

[Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0125, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0150 Client eligibility requirements for CHIP. (1) To be eligible for CHIP a client must meet all of the following. The client:

(a) Cannot have other creditable coverage. If MAA finds out after eligibility determination that a CHIP client had **creditable coverage** at the time of application, MAA ends the client's eligibility the first of the following month.

(b) Must agree to pay both of the following:

(i) A monthly **client premium** as described in WAC 388-542-250(1); and

(ii) A service **copay** as described in WAC 388-542-250(3).

(c) Must make a choice concerning how to receive services. The choices vary depending on where the client lives (except as provided for AI/AN in WAC 388-542-0200). In counties with:

(i) Two or more managed care plans, the client must choose a managed care plan;

(ii) One managed care plan, the client must choose between a managed care plan and MAA's fee-for-service program; or

(iii) No managed care plan, the only option is MAA's fee-for-service program.

(2) The following WACs describe additional eligibility requirements and conditions for a CHIP client:

(a) WAC 388-505-0210 describes requirements related to children's medical eligibility;

(b) WACs 388-424-0005 and 388-424-0010 describe requirements related to citizenship and alien status;

(c) WAC 388-478-0075 describes monthly income standards;

(d) WAC 388-416-0015 describes eligibility certification periods; and

(e) WAC 388-418-0025 describes effects of changes on eligibility.

(3) MAA does not require a client to pay the client premium in advance to be eligible for CHIP.

(4) MAA ends a client's eligibility for CHIP when the client owes four months of premiums, based on the due dates listed on the bill for the client premium.

(5) When MAA ends a client's eligibility according to subsection (4) of this section, to become eligible for CHIP again, the client must meet both of the following:

(a) Pay all unforgiven past due premiums; and

(b) Serve a waiting period of four consecutive months as described in WAC 388-542-0300. The client does not have CHIP coverage during the waiting period.

(6) MAA forgives client premiums that are more than twelve months overdue. MAA does not require clients to pay overdue premiums that it has forgiven.

(7) Unless specifically stated in chapter 388-542 WAC, the **department's** administrative rules covering children's medical programs apply to CHIP.

[Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0150, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0200 CHIP managed care enrollment. (1) MAA enrolls clients in managed care prospectively only.

(2) American Indian/Alaska Native (AI/AN) clients who meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally-recognized tribal members and their descendants, may choose one of the following:

(a) Enroll with a CHIP plan available in their area;

(b) Enroll with a CHIP Indian or tribal PCCM provider by calling MAA's toll-free enrollment line, or sending a completed CHIP enrollment form to MAA; or

(c) MAA's fee-for-service program.

(3) Clients who are required to enroll in managed care may change plans during the two-month period after enrollment and during an annual open enrollment period. Clients may not change plans otherwise, unless they have "good cause." The "good cause" reasons are any of the following:

(a) The client is American Indian/Alaska Native (AI/AN);

(b) The client moves out of the plan's service area;

(c) To assure all family members are in the same plan;

(d) To protect the client from a perpetrator of domestic violence, abuse or neglect;

(e) To rectify a documented department error;

(f) An administrative law judge orders MAA to disenroll the client; or

(g) The client's plan stops offering service in the client's county.

[Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0200, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0250 CHIP client costs. (1) The finance division charges ten dollars per covered child, per month, for the client premium. The family maximum for CHIP premiums is thirty dollars per month.

(2) The finance division sends bills for client premiums at the beginning of each month of coverage. Client premiums begin the first of the month in which the bill was sent, not the date that the client became eligible for services.

(3) MAA requires a copay for certain services, as follows:

(a) Five dollars for office visits with **physicians**, physician assistants, or advanced registered nurse practitioners (ARNP) (i.e., CPT codes 99201 - 99215);

(b) Five dollars for nongeneric (i.e., brand name, whether single or multiple source) drugs; and

(c) Twenty-five dollars for emergency department visits that do not result in **hospital** admission.

(4) MAA does not require a copay for the following services:

(a) Consultations (i.e., CPT codes 99241 - 99275);

(b) Deliveries (births);

(c) Dental;

(d) Drug and alcohol treatment;

(e) Generic drugs;

(f) Inpatient and **outpatient** surgery;

(g) Mental health services (including services with psychiatrists or psychologists);

(h) Occupational, physical, or speech therapy;

(i) Office visits with age appropriate immunizations or exams for an **EPSDT** (well-child check) screening;

(j) Radiology; or

(k) Visits to the emergency room that result in an inpatient hospital admission.

(5) Clients are responsible for client copays from the first day the client is eligible for CHIP.

(6) For clients who are required to make copays, clients make copays to the health care provider, not MAA. A provider may refuse service to CHIP clients when the copay is not paid at the time of service.

(7) Client out-of-pocket expenses are subject to a twelve-month maximum. All of the following apply to twelve-month, out-of-pocket expenses for CHIP clients:

(a) Only client premiums and copays for covered services count towards the twelve-month maximum;

(b) For those children who incur client premiums and copays, the twelve-month maximums are as follows:

(i) For one child, three hundred dollars;

(ii) For two children, six hundred dollars; and

(iii) For three or more children, nine hundred dollars. The family maximum is nine hundred dollars.

(c) The client and/or family must do the following:

(i) Track and document out-of-pocket expenses;

(ii) Notify MAA when the maximum has been reached; and

(iii) Provide receipts as proof of payment.

(8) MAA's starting date for determining twelve-month, out-of-pocket maximum expenses is the date that the first child in a family became eligible for CHIP services. For example, if a family has:

(a) One child, and that child became eligible for services on April first, the twelve-month period starts on April first;

(b) Two children, and first child became eligible for services on April first and the second child started three months later on July first, the twelve-month period for both children starts on April first;

(c) Three or more children, and the first child became eligible for services on April first, and the last child became eligible on November first (within the same twelve-month period), the twelve-month period starts on April first for all the children.

(9) MAA exempts American Indian/Alaska Native (AI/AN) clients from paying client premiums or service copays.

[Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0250, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0275 Reimbursement. (1) MAA deducts the twenty-five dollar copay from hospitals' outpatient reimbursement for emergency services provided to CHIP clients, unless the emergency department visit results in a hospital admission.

(2) MAA does not deduct the five dollar copay from providers' reimbursement.

[Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0275, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0300 Waiting period for CHIP coverage following employer coverage. (1) If the client or family chooses to end employer sponsored dependent coverage, the client must serve a waiting period of four, full, consecutive months before becoming eligible to enroll in CHIP. The waiting period begins the day after the coverage ends, and ends on the last day of the fourth full month of noncoverage by the employer.

(2) MAA does not require a waiting period prior to CHIP coverage when:

(a) The client or family member has a medical condition that, without treatment would be life-threatening or cause serious disability or loss of function; or

(b) The loss of employer sponsored dependent coverage is due to any of the following;

(i) Loss of employment;

(ii) Death of the employee;

(iii) The employer discontinues employer-sponsored dependent coverage;

(iv) The family's total out-of-pocket maximum for employer-sponsored dependent coverage is fifty dollars per month or more;

(v) The plan terminates employer-sponsored dependent coverage for the client because the client reached the maximum lifetime coverage amount;

(vi) Coverage under a COBRA extension period expired;

(vii) Employer-sponsored dependent coverage is not reasonably available (e.g., client would have to travel to another city or state to access care); or

(viii) Domestic violence that leads to loss of coverage for the victim.

[Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0300, filed 3/17/00, effective 4/17/00.]

Chapter 388-543 WAC

DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES

WAC

WAC 388-543-1000 Definitions for durable medical equipment (DME) and related supplies, prosthetics, and orthotics, medical supplies and related services. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter. Defined words and phrases are bolded the first time they are used in the text.

"Artificial limb" - See "prosthetic device."

"Augmentative communication device (ACD)" means a medical device that transmits or produces messages or symbols, either by voice output or in writing, in a manner that compensates for the impairment or disability of a client with severe expressive or language communication and comprehension disorders. The communication device may use mechanical or electrical impulses to produce messages or symbols that supplement or replace speech.

"Base year" means the year of the data source used in calculating prices.

"By report (BR)" means a method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees.

"Date of delivery" means the date the client actually took physical possession of an item or equipment.

"Disposable supplies" means supplies which may be used once, or more than once, but are time limited.

"Durable medical equipment (DME)" means equipment that: (1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(4) Is appropriate for use in the client's place of residence.

"EPSDT/healthy kids" - see WAC 388-500-0005.

"Expedited prior authorization (EPA)" means the process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization.

"Fee-for-service (FFS)," means the general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's managed care programs.

"Health care financing administration common procedure coding system (HCPCS)" means a coding system established by the Health Care Financing Administration to define services and procedures.

"House wheelchair" means a nursing facility wheelchair that is included in the nursing facility's per-patient-day rate under chapter 74.46 RCW.

"Limitation extension" means an authorization process to exceed a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization.

"Nonreusable supplies" are disposable supplies, which are used once and discarded.

"Manual wheelchair" - see "wheelchair - manual."

"Medical supplies" means supplies that are:

(1) Primarily and customarily used to service a medical purpose; and

(2) Generally not useful to a person in the absence of illness or injury.

"Orthotic device" or **"orthotic"** means a corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Personal or comfort item" means an item or service which primarily serves the comfort or convenience of the client.

"Personal computer (PC)" means any of a variety of electronic devices that are capable of accepting data and instructions, executing the instructions to process the data, and presenting the results. A PC has a central processing unit (CPU), internal and external memory storage, and various input/output devices such as a keyboard, display screen, and printer. A computer system consists of hardware (the physical components of the system) and software (the programs used by the computer to carry out its operations).

"Power-drive wheelchair" - see "wheelchair - power."

"Prior authorization" means a process by which clients or providers must request and receive MAA approval for certain medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are types of prior authorization. Also see WAC 388-501-0165.

"Prosthetic device" or **"prosthetic"** means a replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

"Resource based relative value scale (RBRVS)" means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involve.

"Reusable supplies" are supplies which are to be used more than once.

"Scooter" means a federally-approved, motor-powered vehicle that:

(1) Has a seat on a long platform;

(2) Moves on either three or four wheels;

(3) Is controlled by a steering handle; and

(4) Can be independently driven by a client.

"Specialty bed" means a pressure reducing support surface, such as foam, air, water, or gel mattress or overlay.

"Three- or four-wheeled scooter" means a three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

(1) Rear drive;

(2) A twenty-four volt system;

(3) Electronic or dynamic braking;

(4) A high to low speed setting; and

(5) Tires designed for indoor/outdoor use.

"Trendelenburg position" means a position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"Usual and customary charge" means the amount the provider typically charges to fifty percent or more of his or her non-Medicaid clients, including clients with other third-party coverage.

"Warranty-wheelchair" means a warranty, according to manufacturers' guidelines, of not less than one year from the date of purchase.

"Wheelchair - manual" means a federally-approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

(1) Standard:

(a) Usually is not capable of being modified;

(b) Accommodates a person weighing up to two hundred fifty pounds; and

(c) Has a warranty period of at least one year.

(2) Lightweight:

(a) Composed of lightweight materials;

(b) Capable of being modified;

(c) Accommodates a person weighing up to two hundred fifty pounds; and

(d) Usually has a warranty period of at least three years.

(3) High strength lightweight:

(a) Is usually made of a composite material;

(b) Is capable of being modified;

(c) Accommodates a person weighing up to two hundred fifty pounds;

(d) Has an extended warranty period of over three years; and

(e) Accommodates the very active person.

(4) Hemi:

(a) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and

(b) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

(5) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

(6) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

(7) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

(8) Heavy Duty:

(a) Specifically manufactured to support a person weighing up to three hundred pounds; or

(b) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(9) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

(10) Custom heavy duty:

(a) Specifically manufactured to support a person weighing over three hundred pounds; or

(b) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(11) Custom manufactured specially built:

(a) Ordered for a specific client from custom measurements; and

(b) Is assembled primarily at the manufacturer's factory.

"Wheelchair - power" means a federally-approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

(1) Custom power adaptable to:

(a) Alternative driving controls; and

(b) Power recline and tilt-in-space systems.

(2) Noncustom power: Does not need special positioning or controls and has a standard frame.

(3) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1000, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1100 Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services. The federal government deems **durable medical equipment (DME)** and related supplies, **prosthetics**, **orthotics**, and **medical supplies** as optional services under the **Medicaid** program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment **(EPSDT)/healthy kids** program. The **department** may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(1) The medical assistance administration (MAA) covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when all of the following apply. They must be:

(a) Within the scope of an eligible client's medical care program (see chapter 388-529 WAC);

(b) Within accepted medical or physical medicine community standards of practice;

(c) Prior authorized as described in WAC 388-543-1600, 388-543-1800, and 388-543-1900;

(d) Prescribed by a qualified **provider**, acting within the scope of the provider's practice. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity;

(e) Billed to the department as the payor of last resort only. MAA does not pay first and then collect from Medicare;

(f) **Medically necessary** as defined in WAC 388-500-0005. The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:

(i) A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; or

(ii) Video and/or photograph(s) of the client demonstrating the impairments as well and client's ability to use the requested equipment, when applicable.

(2) MAA evaluates a request for any equipment or devices that are listed as noncovered in WAC 388-543-1300 under the provisions of WAC 388-501-0165.

(3) MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0050, under the provisions of WAC 388-501-0165 which relate to medical necessity.

(4) MAA evaluates requests for covered services that are subject to limitations or other restrictions and approves such

services beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165.

(5) MAA does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under **fee-for-service (FFS)** when the client is any of the following:

(a) An inpatient hospital client;

(b) Eligible for both **Medicare** and Medicaid, and is staying in a **nursing facility** in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(6) MAA covers medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, repairs, and labor charges listed in MAA's published issuances, including Washington Administrative Code (WAC), billing instructions, and numbered memoranda.

(7) An interested party may request MAA to include new equipment/supplies in the billing instructions by sending a written request plus all of the following:

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

(c) Clinical research/case studies (including FDA approval, if required); and

(d) Any additional information the requester feels is important.

(8) MAA bases the decision to purchase or rent DME for a client, or to pay for repairs to client-owned equipment on medical necessity.

(9) MAA covers replacement batteries for purchased medically necessary DME equipment covered within this chapter.

(10) MAA covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician or other licensed practitioner of the healing arts, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;

(b) Wheelchairs and other DME;

(c) Prosthetic/orthotic devices;

(d) Surgical/ostomy appliances and urological supplies;

(e) Bandages, dressings, and tapes;

(f) Equipment and supplies for the management of diabetes; and

(g) Other medical equipment and supplies, as listed in MAA published issuances.

(11) MAA evaluates a **BR** item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.

(12) For a client in a **nursing facility**, MAA covers only the following when medically necessary. All other DME and supplies identified in MAA billing instructions are the responsibility of the nursing facility, in accordance with chapters 388-96 and 388-97 WAC. See also WAC 388-543-2900 (3) and (4). MAA covers:

(a) The purchase and repair of an **augmentative communication device (ACD)**, a wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate, or a **specialty bed**; and

(b) The rental of a speciality bed.

(13) Vendors must provide instructions for use of equipment; therefore, instructional materials such as pamphlets and video tapes are not covered.

(14) Bilirubin lights are limited to rentals, for at-home newborns with jaundice.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1100, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1200 Providers who are eligible to provide services. (1) MAA requires a provider who supplies DME and related supplies, prosthetics, orthotics, medical supplies and related services to an MAA client to meet all of the following. The provider must:

(a) Have the proper business license;

(b) Have appropriately trained qualified staff; and

(c) Be certified, licensed and/or bonded if required, to perform the services billed to the department. Out-of-state prosthetic and orthotics providers must meet their state regulatory requirements.

(2) MAA may reimburse qualified providers for DME and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:

(a) DME providers for DME and related repair services;

(b) Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this section;

(c) Licensed prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. This does not apply to medical equipment dealers and pharmacies that do not require licensure to provide selected prosthetics and orthotics;

(d) Physicians who provide medical equipment and supplies in the physician's office. MAA may pay separately for medical supplies, subject to the provisions in MAA's **resource based relative value scale (RBRVS)** fee schedule; and

(e) Out of state orthotics and prosthetics providers who meet their state regulations.

(3) MAA terminates from Medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0020.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1200, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1300 Equipment, related supplies, or other nonmedical supplies, and devices that are not covered. MAA pays only for DME and related supplies, medical supplies and related services that are medically necessary, listed as covered, and meet the definition of DME and medical supplies as defined in WAC 388-543-1000 and prescribed per WAC 388-543-1100 and 388-543-1200. MAA pays only for prosthetics or orthotics that are listed as such by HCFA,

meet the definition of prosthetic and orthotic as defined in WAC 388-543-1000 and prescribed per WAC 388-543-1100 and 388-543-1200. MAA considers all requests for covered DME, related supplies and services, medical supplies, prosthetics, orthotics, and related services and noncovered equipment, related supplies and services, supplies and devices, under the provisions of WAC 388-501-0165 which relate to medical necessity. When MAA considers that a request does not meet the requirement for medical necessity, the definition(s) of covered item(s), or is not covered, the client may appeal that decision under the provisions of WAC 388-501-0165. MAA specifically excludes services and equipment in this chapter from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are required under the EPSDT/healthy kids program, included as part of a managed care plan service package, included in a waivered program, or part of one of the Medicare programs for qualified Medicare beneficiaries. Excluded services and equipment include, but are not limited to:

(1) Services, procedures, treatment, devices, drugs, or the application of associated services that the department of the Food and Drug Administration (FDA) and/or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the services are provided;

(2) Any service specifically excluded by statute;

(3) A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by MAA for the client contributes to an increased utility bill (refer to the aging and adult services administration's (AASA) COPES program for potential coverage);

(4) Hairpieces or wigs;

(5) Material or services covered under manufacturers' warranties;

(6) Shoe lifts less than one inch, arch supports for flat feet, and nonorthopedic shoes;

(7) Outpatient office visit supplies, such as tongue depressors and surgical gloves;

(8) Prosthetic devices dispensed solely for cosmetic reasons (refer to WAC 388-531-0150 (1)(d);

(9) Home improvements and structural modifications, including but not limited to the following:

(a) Automatic door openers for the house or garage;

(b) Saunas;

(c) Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;

(d) Swimming pools;

(e) Whirlpool systems, such as jacuzzies, hot tubs, or spas; or

(f) Electrical rewiring for any reason;

(g) Elevator systems and elevators; and

(h) Lifts or ramps for the home; or

(i) Installation of bathtubs or shower stalls.

(10) Nonmedical equipment, supplies, and related services, including but not limited to, the following:

(a) Back-packs, pouches, bags, baskets, or other carrying containers;

(b) Bed boards/conversion kits, and blanket lifters (e.g., for feet);

(c) Car seats for children under five, except for positioning car seats that are prior authorized. Refer to WAC 388-543-1700(13) for car seats;

(d) Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;

(e) Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;

(f) Electronic communication equipment, installation services, or service rates, including but not limited to, the following:

(i) Devices intended for amplifying voices (e.g., microphones);

(ii) Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to AASA COPES or outpatient hospital programs for emergency response systems and services);

(iii) Two-way radios; and

(iv) Rental of related equipment or services;

(g) Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads;

(h) Ergonomic equipment;

(i) Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, trampolines;

(j) Generators;

(k) Personal computers including laptops, computer software, printers, computer accessories (such as anti-glare shields, backup memory cards), and computer equipment other than specified in WAC 388-543-2200;

(l) Racing strollers/wheelchairs and purely recreational equipment;

(m) Room fresheners/deodorizers;

(n) Bidet or hygiene systems, paraffin bath units, and shampoo rings;

(o) Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;

(p) Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or

(q) Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

(11) Personal and **comfort items** that do not meet the DME definition, including but not limited to the following:

(a) Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizer, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;

(b) Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers and sheets;

(c) Bedside items, such as bed trays, carafes, and over-the-bed tables;

(d) Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;

(e) Clothing protectors and other protective cloth furniture coverings;

(f) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;

(g) Diverter valves for bathtub;

(h) Eating/feeding utensils;

(i) Emesis basins, enema bags, and diaper wipes;

(j) Health club memberships;

(k) Hot or cold temperature food and drink containers/holders;

(l) Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;

(m) Impotence devices;

(n) Insect repellants;

(o) Massage equipment;

(p) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 388-530 WAC;

(q) Medicine cabinet and first aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;

(r) Page turners;

(s) Radio and television;

(t) Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and

(u) Toothettes and toothbrushes, waterpics, and peridontal devices whether manual, battery-operated, or electric.

(12) Certain wheelchair features and options are not considered by MAA to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

(a) Attendant controls (remote control devices);

(b) Canopies, including those for strollers and other equipment;

(c) Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);

(d) Identification devices (such as labels, license plates, name plates);

(e) Lighting systems;

(f) Speed conversion kits; and

(g) Tie-down restraints, except where medically necessary for client-owned vehicles.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1300, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1400 General reimbursement for DME and related services, prosthetics, orthotics, medical supplies and related services. (1) MAA reimburses a qualified provider who serves a client who is not enrolled in a department-contracted managed care plan only when all of the following apply:

(a) The provider meets all of the conditions in WAC 388-502-0100; and

(b) MAA does not include the item/service for which the provider is requesting reimbursement in other reimbursement rate methodologies. Other methodologies include, but are not limited to, the following:

(i) Hospice providers' per diem reimbursement;

(ii) Hospitals' diagnosis related group (DRG) reimbursement;

(iii) Managed care plans' capitation rate; and

(iv) Nursing facilities' per diem rate.

(2) MAA sets maximum allowable fees for DME and related supplies, prosthetics, orthotics, medical supplies and related services using available published information, such as:

(a) Commercial databases for price comparisons;

(b) Manufacturers' catalogs;

(c) Medicare fee schedules; and

(d) Wholesale prices.

(3) MAA may adopt policies, procedure codes, and/or rates that are inconsistent with those set by Medicare if MAA determines that such actions are in the best interest of its clients.

(4) MAA updates the maximum allowable fees for DME and supplies and prosthetic/orthotic devices no more than once per year, unless otherwise directed by the legislature. MAA may update the rates for different categories of medical equipment and prosthetic/orthotic devices at different times during the year.

(5) A provider must not bill MAA for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(6) MAA's maximum payment for medical equipment and supplies is the lesser of either of the following:

(a) Providers' **usual and customary charges**; or

(b) Established rates, except as provided in subsection (7)(a) of this section.

(7) If a client is eligible for both Medicare and Medicaid, the following apply:

(a) MAA requires a provider to accept Medicare assignment before any Medicaid reimbursement;

(b) If the service provided is covered by Medicare and Medicaid, MAA pays:

(i) The deductible and coinsurance up to Medicare's allowed amount or MAA's allowed amount, whichever is less; or

(ii) For services that are not covered by Medicare but are covered by MAA, if medically necessary.

(8) MAA may pay for medical services rendered to a client only when MAA is the payor of last resort.

(9) MAA does not cover medical equipment and/or services provided to a client who is enrolled in a MAA-contracted managed care plan, but did not use one of the plan's participating provider.

(10) See WAC 388-543-2100, 388-543-2500, 388-543-2700, and 388-543-2900 for other reimbursement methodologies.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1400, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1500 When MAA purchases DME and related supplies, prosthetics, and orthotics. (1) Durable medical equipment (DME) and related supplies, prosthetics, and orthotics purchased by MAA for a client is the client's property.

(2) MAA's reimbursement for covered DME and related supplies, prosthetics, and orthotics includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the **date of delivery**. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Fitting and set-up; and

(c) Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

(3) MAA requires a provider to furnish to MAA clients only new equipment that includes full manufacturer and dealer warranties.

(4) MAA requires a dispensing provider to include a warranty on equipment for one year after the date MAA considers rented equipment to be purchased, as provided under WAC 388-543-1700(3).

(5) MAA charges the dispensing provider for any costs it incurs to have another provider repair equipment if all of the following apply:

(a) Any DME that MAA considers purchased according to WAC 388-543-1700 requires repair during the applicable warranty period;

(b) The dispensing provider is unwilling or unable to fulfill the warranty; and

(c) The client still needs the equipment.

(6) MAA charges the dispensing provider fifty percent of the total amount MAA paid toward rental and eventual purchase of the first equipment if the rental equipment must be replaced during the warranty period. All of the following must apply:

(a) Any medical equipment that MAA considers purchased according to WAC 388-543-1700 requires replacement during the applicable warranty period;

(b) The dispensing provider is unwilling or unable to fulfill the warranty; and

(c) The client still needs the equipment.

(7) Purchase orders:

(a) MAA rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(i) Dies;

(ii) Loses medical eligibility;

(iii) Becomes covered by a hospice agency; or

(iv) Becomes covered by an MAA managed care plan. Refer to subsection (7)(c) of this section.

(b) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded per (a) of this subsection, MAA may pay the provider an amount it considers appropriate to help defray these extra costs. MAA requires the provider to submit justification sufficient to support such a claim.

(c) A client may become a managed care plan client before MAA completes the purchase of prescribed medical equipment. If this occurs:

(i) MAA rescinds the purchase order until the managed care primary care provider (PCP) evaluates the client; then

(ii) MAA requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 388-500-0005; then

(iii) The managed care plan's applicable reimbursement policies apply to the purchase or rental of the equipment.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1500, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1600 Items and services which require prior authorization. (1) MAA bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require **prior authorization (PA)** or **expedited prior authorization (EPA)** on utilization criteria. (See WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA.) MAA considers all of the following when establishing utilization criteria:

(a) High cost;

(b) Potential for utilization abuse;

(c) Narrow therapeutic indication; and

(d) Safety.

(2) MAA requires providers to obtain prior authorization for certain items and services. This includes, but is not limited to, the following:

(a) Augmentative communication devices (ACDs);

(b) Certain by report (BR) DME and supplies as specified in MAA's published issuances, including billing instructions and numbered memoranda;

(c) Blood glucose monitors requiring special features;

(d) Certain equipment rentals and certain prosthetic limbs, as specified in MAA's published issuances, including billing instructions and numbered memoranda;

(e) Decubitus care products and supplies;

(g) Decubitus care mattresses, including flotation or gel mattress, if the provider fails to meet the criteria in WAC 388-543-1900;

(g) Equipment parts and labor charges for repairs or modifications and related services;

(h) Hospital beds, if the provider fails to meet the requirements in WAC 388-543-1900;

(i) Low air loss flotation system, if the provider fails to meet the requirements in WAC 388-543-1900;

(j) Orthopedic shoes and selected orthotics;

(k) Osteogenic stimulator, noninvasive, if the provider fails to meet the requirements in WAC 388-543-1900;

(l) Positioning car seats for children under five years of age;

(m) Transcutaneous electrical nerve stimulators, if the provider fails to meet the requirements in WAC 388-543-1900;

(n) Wheelchairs, wheelchair accessories, wheelchair modifications, air, foam, and gel cushions, and repairs;

(o) Wheelchair-style shower/commode chairs;

(p) Other DME not specifically listed in MAA's published issuances, including billing instructions and numbered memoranda, and submitted as a miscellaneous procedure code; and

(q) Limitation extensions.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1600, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1700 When MAA covers rented DME. (1) MAA's reimbursement amount for rented durable medical equipment (DME) includes all of the following:

(a) Delivery to the client;

(b) Fitting, set-up, and adjustments;

(c) Maintenance, repair and/or replacement of the equipment; and

(d) Return pickup by the provider.

(2) MAA requires a dispensing provider to ensure the DME rented to a MAA client is both of the following:

(a) In good working order; and

(b) Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.

(3) MAA considers rented equipment to be purchased after twelve months' rental unless one of the following apply:

(a) The equipment is restricted as rental only; or

(b) Other MAA published issuances state otherwise.

(4) MAA rents, but does not purchase, certain medically necessary equipment for clients. This includes, but is not limited to, the following:

(a) Bilirubin lights for newborns at home with jaundice; and

(b) Electric breast pumps.

(5) MAA's minimum rental period for covered DME is one day.

(6) If a fee-for-service (FFS) client becomes a managed care plan client, both of the following apply:

(a) MAA stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan; and

(b) The plan determines the client's continuing need for the equipment and is responsible for reimbursing the provider.

(7) MAA stops paying for any rented equipment effective the date of a client's death. MAA prorates monthly rentals as appropriate.

(8) For a client who is eligible for both Medicaid and Medicare, MAA pays only the client's coinsurance and deductibles. MAA discontinues paying client's coinsurance and deductibles for rental equipment when either of the following applies:

(a) The reimbursement amount reaches Medicare's reimbursement cap for the equipment; or

(b) Medicare considers the equipment purchased.

(9) MAA does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a MAA client.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1700, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1800 Prior authorization—General policies for DME and related supplies, prosthetics, orthotics, medical supplies and related services. (1) A provider/vendor may obtain **expedited prior authorization (EPA)** from MAA according to WAC 388-543-1900.

(2) For prior authorization requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

(3) When MAA receives an initial request for prior authorization, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

(4) MAA authorizes BR items that require prior authorization and are listed in MAA's published issuances, including billing instructions and numbered memoranda, only if medical necessity is established and the provider furnishes all of the following information to MAA:

(a) A detailed description of the item or service to be provided;

(b) The cost or charge for the item;

(c) A copy of the manufacturer's invoice, price-list or catalog with the product description for the item being provided; and

(d) A detailed explanation of how the requested item differs from an already existing code description.

(5) MAA requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

(a) The manufacturer's name;

(b) The equipment model and serial number;

(c) A detailed description of the item; and

(d) Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

(6) MAA prior authorizes payment for repair and modification of client-owned equipment only when the criteria in subsection (1) of this section are met. Requests for repairs must include the information listed in subsection (5) of this section.

(7) MAA does not reimburse for purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the requesting provider makes such a request, MAA requires the provider to submit for prior authorization and explain the following:

(a) Why the existing equipment no longer meets the client's medical needs; or

(b) Why the existing equipment could not be repaired or modified to meet those medical needs.

(8) MAA informs the provider and the client of a less costly alternative from MAA's manufacturers' literature on file when an MAA denial of a request is based on a less costly, equally effective alternative.

(9) A provider may resubmit a request for prior authorization for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

(10) MAA authorizes rental equipment for a specific period of time. The provider must request authorization from MAA for any extension of the rental period.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1800, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1900 Expedited prior authorization criteria for DME and related supplies, prosthetics, orthotics, medical supplies, and related services. (1) The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected DME procedure codes. MAA allows payment during a continuous twelve-month period for this process.

(2) MAA requires a provider to create an authorization number for EPA for selected DME procedure codes. The process and criteria used to create the authorization number is explained in MAA published DME-related billing instructions. The authorization number must be used when the provider bills MAA.

(3) The written or telephonic request for prior authorization process must be used when a situation does not meet the criteria for a selected DME code or a requested rental exceeds the limited rental period indicated.

(4) Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA in subsection (2) of this section.

(5) MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1900, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2000 Wheelchairs. (1) MAA bases its decisions regarding requests for wheelchairs on medically necessity and on a case-by-case basis.

(2) The following apply when MAA determines that a wheelchair is medically necessary for six months or less:

(a) If the client lives at home, MAA rents a wheelchair for the client; or

(b) If the client lives in a nursing facility, the nursing facility must provide a **house wheelchair** as part of the per diem rate paid by AASA.

(3) MAA considers rental or purchase of a **manual wheelchair** for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. MAA determines the type of manual wheelchair based on the following:

(a) A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities;

(b) A standard lightweight wheelchair if the client's medical condition is such that the client:

(i) Cannot self-propel a standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight wheelchair.

(c) A high-strength lightweight wheelchair for a client:

(i) Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.

(d) A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing up to three hundred pounds; or

(ii) Accommodate a seat width up to twenty-two inches wide (not to be confused with custom heavy duty wheelchairs).

(e) A custom heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing over three hundred pounds; or

(ii) Accommodate a seat width over twenty-two inches wide.

(f) A rigid wheelchair for a client:

(i) With a medical condition that involves severe upper extremity weakness;

(ii) Who has a high level of activity; and

(iii) Who is unable to self-propel any of the above categories of wheelchair.

(g) A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the above categories of wheelchairs.

(4) MAA considers a **power-drive wheelchair** when the client's medical needs cannot be met by a less costly means of mobility. The prescribing physician must certify that the client can safely and effectively operate a power-drive wheelchair and that the client meets all of the following conditions:

(a) The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category; and

(b) A power-drive wheelchair will provide the client the only means of independent mobility; or

(c) A power-drive wheelchair will enable a child to achieve age-appropriate independence and developmental milestones.

(d) All other circumstances will be considered based on medical necessity and on a case-by-case basis.

(e) The following additional information is required for a three or four-wheeled power-drive scooter/cart:

(i) The prescribing physician certifies that the client's condition is stable; and

(ii) The client is unlikely to require a standard power-drive wheelchair within the next two years.

(5) MAA considers the power-drive wheelchair to be the client's primary chair when the client has both a power-drive wheelchair and a manual wheelchair.

(6) In order to consider purchasing a wheelchair, MAA requires the provider to submit the following information from the prescribing physician, physical therapist, or occupational therapist:

(a) Specific medical justification for the make and model of wheelchair requested;

(b) Define the degree and extent of the client's impairment (such as stage of decubitus, severity of spasticity or flaccidity, degree of kyphosis or scoliosis); and

(c) Documented outcomes of less expensive alternatives (aids to mobility) that have been tried by the client.

(7) In addition to the basic wheelchair, MAA may consider wheelchair accessories or modifications that are specifically identified by the manufacturer as separate line item charges. The provider must submit specific medical justification for each line item, with the modification request.

(8) MAA considers wheelchair modifications to a medically necessary wheelchair when the provider submits all of the following with the modification request:

(a) The make, model, and serial number of the wheelchair to be modified;

(b) The modification requested; and

(c) Specific information regarding the client's medical condition that necessitates the modification.

(9) MAA may consider wheelchair repairs to a medically necessary wheelchair; the provider must submit to MAA the make, model, and serial number of the wheelchair for which the repairs are requested.

(10) MAA may cover two wheelchairs, a manual wheelchair and a power-drive wheelchair, for a noninstitutionalized client in certain situations. One of the following must apply:

(a) The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radii;

(b) The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness;

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities; the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. In these cases, MAA requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home; and

(ii) Cabulance, public buses, or personal transit are neither available, practical, nor possible for financial or other reasons.

(iii) All other circumstances will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2000, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2100 Wheelchairs—Reimbursement methodology. (1) MAA reimburses a DME provider for purchased wheelchairs for a home or nursing facility client based on the specific brand and model of wheelchair dispensed. MAA decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:

(a) The client's medical needs;

(b) Product quality;

(c) Cost; and

(d) Available alternatives.

(2) For **HCPCS** codes for wheelchair rentals and wheelchair accessories (e.g., cushions and backs), MAA uses the Medicare fees that are current on April 1 of each year.

(3) For state-assigned procedure codes, including those listed as BR, for wheelchairs and wheelchair accessories, MAA's maximum allowable reimbursement is based on a percentage of the manufacturer's list price in effect on January 31 of the **base year**, or the invoice for the specific item. This applies to the following:

(a) For basic standard wheelchairs, sixty-five percent;

(b) For add-on accessories and parts, eighty-four percent;

(c) For upcharge modifications and cushions, eighty percent;

(d) For all other manual wheelchairs, eighty percent; and

(e) For all other power-drive wheelchairs, eighty-five percent.

(4) MAA determines rental reimbursement for categories of manual and power-driven wheelchairs based on average market rental rates or Medicare rates.

(5) MAA evaluates and updates the wheelchair fee schedule once per year.

(6) MAA implements wheelchair rate changes on April 1 of the base year, and the rates are effective until the next rate change.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2100, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2200 Augmentative communication devices (ACD). (1) MAA considers all requests on a case-by-case basis for augmentative communication devices (ACDs) for the purpose of appropriately relaying medical information.

(2) MAA requires a provider to submit a prior authorization request for ACDs. The request must be in writing and contain all of the following information:

(a) A detailed description of the client's therapeutic history;

(b) An assessment by a licensed speech pathologist of the client's verbal capabilities. The pathologist must be knowledgeable about selecting ACDs that meet the client's needs;

(c) If the client has a physical disability, condition, or impairment that requires equipment, such as a wheelchair, or a device to be specially adapted to accommodate an ACD, an assessment by the prescribing physician, licensed occupational therapist or physical therapist; and

(d) Documented evaluations and/or trials of each ACD that the client has tried. This includes less costly types/models, and the effectiveness of each device in promoting the client's ability to communicate with health care providers, caregivers, and others.

(3) MAA requires the provider to show or the client to demonstrate all of the following:

(a) The client has reliable and consistent motor response, which can be used to communicate with the help of an ACD;

(b) The client has the cognitive ability to effectively and independently utilize the equipment; and

(c) With the ADC, the client will be able to do all of the following:

(i) Communicate with the personal physician about the medical condition, complaint, ailment, or symptoms;

(ii) Communicate with the personal caregiver about both urgent medical needs and routine personal care needs; and

(iii) Communicate with medical personnel who provide emergency services, rehabilitative care, and other therapeutic treatment.

(4) MAA covers ACDs only once every two years for a client who meets the criteria in subsection (3) of this section. MAA does not approve a new or updated component, modification, or replacement model for a client whose ACD is less than two years old. MAA may make exceptions to the criteria in this subsection based strictly on a finding of unforeseeable and significant changes to the client's medical condition. The

prescribing physician is responsible for justifying why the changes in the client's medical condition were unforeseeable.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2200, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2300 Bathroom/shower equipment. (1) MAA considers a caster-style shower commode chair as the primary option for clients.

(2) MAA considers a wheelchair-style shower commode chair only if the client meets both of the following:

(a) Is able to propel the equipment; and

(b) Has special positioning needs that cannot be met by a caster-style chair.

(3) All other circumstances will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2300, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2400 Hospital beds. (1) Beds covered by MAA are limited to hospital beds for rental or purchase. MAA bases the decision to rent or purchase a manual, semi-electric, or full electric hospital bed on the length of time the client needs the bed, as follows:

(a) MAA initially authorizes a maximum of two months rental for a short-term need. Upon request, MAA may allow limitation extensions as medically necessary;

(b) MAA determines rental on a month-to-month basis if a client's prognosis is poor;

(c) MAA considers a purchase if the need is for more than six months;

(d) If the client continues to have a medical need for a hospital bed after six months, MAA may approve rental for up to an additional six months. MAA considers the equipment to be purchased after a total of twelve months' rental.

(2) MAA considers a manual hospital bed the primary option when the client has full-time caregivers.

(3) MAA considers a full electric hospital bed only if the client meets all of the following criteria:

(a) The client's medical need requires the client to be positioned in a way that is not possible in a regular bed;

(b) The position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);

(c) The client's medical condition requires immediate position changes;

(d) The client is able to operate the controls independently; and

(e) The client needs to be in the **Trendelenburg position**.

(4) All other circumstances for hospital beds will be considered on a case-by-case basic, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2400, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2500 Reimbursement methodology for other durable medical equipment. (1) For the purposes of this section, MAA uses the following terms:

(a) **"Other durable medical equipment (other DME)"** means all durable medical equipment, excluding wheelchairs and related items.

(b) **"Pricing cluster"** means a group of discounted manufacturers' list prices and/or dealer's costs for brands/models of other DME that MAA uses to calculate the reimbursement rate for a procedure code that does not have a fee established by Medicare. MAA uses the discounted manufacturer list price for a brand/model unless that price is not available.

(2) MAA establishes reimbursement rates for purchased other DME.

(a) For HCPCS procedure codes that have a Medicare rate established for a new purchase, MAA uses the rate that is in effect on January first of the year in which MAA sets the reimbursement.

(b) For all other procedure codes, MAA uses a pricing cluster to establish the rate.

(3) Establishing a pricing cluster and reimbursement rates.

(a) In order to make up a pricing cluster for a procedure code, MAA determines which brands/models of other DME its clients most frequently use. MAA obtains prices for these brands/models from manufacturer catalogs or commercial databases. MAA may change or otherwise limit the number of brands/models included in the pricing cluster, based on the following:

(i) Client medical needs;

(ii) Product quality;

(iii) Introduction of new brands/models;

(iv) A manufacturer discontinuing or substituting a brand/model; and/or

(v) Cost.

(b) If a manufacturer list price is not available for any of the brands/models used in the pricing cluster, MAA calculates the reimbursement rate at the manufacturer's published cost to providers plus a thirty-five percent mark-up.

(c) For each brand used in the pricing cluster, MAA discounts the manufacturer's list price by twenty percent.

(i) If six or more brands/models are used in the pricing cluster, MAA calculates the reimbursement rate at the seventieth percentile of the pricing cluster.

(ii) If five brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the fourth highest discounted list price, as described in (b) of this subsection.

(iii) If four brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in (b) of this subsection.

(iv) If three brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in (b) of this subsection.

(v) If two or fewer brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the highest discounted list price, as described in (b) of this subsection.

(4) Rental reimbursement rates for other DME.

(a) MAA sets monthly rental rates at one-tenth of the purchase reimbursement rate as it would be calculated as described in subsections (2) and (3) of this section.

(b) MAA sets daily rental rates at one-three hundredth of the purchase reimbursement rate as it would be calculated as described in subsections (2) and (3) of this section.

(5) MAA annually evaluates and updates reimbursement rates for other DME.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2500, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2600 Prosthetics and orthotics. (1) MAA reimburses for prosthetics and orthotics to licensed prosthetic and orthotic providers only. This does not apply to:

(a) Selected prosthetics and orthotics that do not require specialized skills to provide; and

(b) Out of state providers, who must meet the licensure requirements of that state.

(2) MAA does not cover prosthetics dispensed for purely cosmetic reasons.

(3) MAA covers a replacement prosthesis only when the purchase of a replacement prosthesis is less costly than repairing or modifying a client's current prosthesis.

(4) MAA requires the client to take responsibility for routine maintenance of a prosthetic or orthotic. If the client does not have the physical or mental ability to perform the task, MAA requires the client's caregiver to be responsible. MAA authorizes extensive maintenance that the manufacturer recommends be performed by an authorized dealer.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2600, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2700 Prosthetics and orthotics—Reimbursement. (1) MAA determines reimbursement for prosthetics and orthotics according to a set fee schedule. MAA considers Medicare's current fee schedule when determining maximum allowable fees. For BR codes, MAA reimburses eighty-five percent of the agreed upon fee.

(2) MAA's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds.

(3) MAA's hospital reimbursement rate includes any prosthetics and/or orthotics required for surgery and/or placed during the hospital stay.

(4) MAA evaluates and updates the maximum allowable fees for prosthetics and orthotics at least once per year, independent of scheduled legislatively authorized vendor rate increases. Rates remain effective until the next rate change.

(5) Reimbursement for prosthetics and orthotics is limited to HCPC/National Codes with the same level of coverage as Medicare.

(6) Reimbursement for gender dyphoria surgery includes payment for all related prosthetics and supplies.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2700, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2800 Reusable and disposable medical supplies. (1) MAA requires that a physician prescribe reusable and disposable medical supplies. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being re-evaluated), and quantity.

(2) MAA bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA). MAA considers all of the following when establishing utilization criteria:

(a) High cost;

(b) The potential for utilization abuse;

(c) A narrow therapeutic indication; and

(d) Safety.

(3) MAA requires a provider to obtain a limitation extension in order to exceed the stated limits for nondurable medical equipment and medical supplies. See WAC 388-501-0165.

(4) MAA categorizes medical supplies and non-DME (MSE) as follows (see MAA's billing instructions for specific limitations):

(a) Antiseptics and germicides;

(b) Bandages, dressings, and tapes;

(c) Blood monitoring supplies;

(d) Braces, belts, and supportive devices;

(e) Decubitus care products;

(f) Ostomy supplies;

(g) Pregnancy-related testing kits and nursing equipment;

(h) Supplies associated with osteogenesis stimulators;

(i) Supplies associated with transcutaneous electrical nerve stimulators (TENS);

(j) Syringes and needles;

(k) Urological supplies (e.g., diapers, urinary retention catheters, pant liners, and doublers); and

(l) Miscellaneous supplies.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2800, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2900 Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology. (1) MAA determines rates for each category of medical supplies and non-DME (MSE) using either the:

(a) Medicare fee schedule; or

(b) Manufacturers' catalogs and commercial databases for price comparisons.

(2) MAA evaluates and updates the maximum allowable fees for MSE as follows:

(a) For HCPCS MSE codes, MAA considers the current Medicare fee schedule;

(b) For all MSE with state-assigned procedure codes, when the legislature mandates a vendor rate increase or decrease.

(c) MAA sets the maximum allowable fees for new MSE using one of the following:

(i) Medicare's fee schedule; or

(ii) For those items without a Medicare fee, commercial databases to obtain all brands to make up MAA's pricing cluster. MAA establishes the fee for products in the pricing cluster by using the lesser of either:

(A) Eighty-five percent of the average manufacturer's list price; or

(B) One hundred twenty-five percent of the average dealer cost.

(d) All the brands for which MAA obtains pricing information make up MAA's pricing cluster. However, MAA may limit the number of brands included in the pricing cluster if

doing so is in the best interests of its clients. MAA considers all of the following:

(i) A client's medical needs;

(ii) Product quality;

(iii) Cost; and

(iv) Available alternatives.

(3) MAA's nursing facility per diem rate includes any reusable and disposable medical supplies that may be required for a nursing facility client. MAA may reimburse the following medical supplies separately for a client in a nursing facility:

(a) Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to the following:

(i) Colostomy and other ostomy bags and necessary supplies; and

(ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies;

(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony; and

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks after surgery.

(4) MAA considers decubitus care products to be included in the nursing facility per diem rate and does not reimburse for these separately.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2900, filed 12/13/00, effective 1/13/01.]

WAC 388-543-3000 DME and supplies provided in physician's office. MAA does not pay a DME provider for medical supplies used in conjunction with a physician office visit. MAA pays the office physician for these supplies, as stated in the RBRVS, when it is appropriate.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-3000, filed 12/13/00, effective 1/13/01.]

Chapter 388-544 WAC
VISION AND HEARING AID SERVICES

WAC

VISION CARE

WAC 388-544-0050 Definitions for vision care services. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter. Defined words and phrases are bolded the first time they are used in the text. Unless otherwise defined in this chapter, medical terms are used as commonly defined within the scope of professional medical practice in the state of Washington.

"Stable visual condition" means that a client's eye condition has no acute disease or injury; or the client has reached a point after any acute disease or injury where the variation in need for refractive correction has diminished or steadied. The client's vision condition has stabilized to the extent that eyeglasses or contact lenses are appropriate and that any prescription for refractive correction is likely to be sufficient for one year or more.

"Visual field exams or testing" means a process to determine defects in the field of vision and tests the function of the retina, optic nerve and optic pathways. The process may include simple confrontation to increasingly complex studies with sophisticated equipment.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0050, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0100 Client eligibility for vision care services. (1) The **medical assistance administration (MAA)** covers vision care services for clients eligible for the following "scope-of-care" designations (see WAC 388-529-0100):

(a) **Categorically needy** (e.g., CNP, CHIP, children's health);

(b) **Medically needy** (MNP); and

(c) Medical care services (MCS or GAU/ADATSA).

(2) MAA does not cover vision care services for clients with the following program designations:

(a) **Medically indigent** (MIP) unless the qualifying emergency medical condition is related to the eye(s);

(b) Family planning only;

(c) Any program designated "emergency medical only"; or

(d) Any other program that does not meet the conditions of subsection (1) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0100, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0150 Requirements for vision care providers. (1) The following providers are eligible to enroll/contract with MAA to provide and bill for vision care services furnished to eligible clients:

(a) Ophthalmologists/MD or DO.

(b) Optometrists; and

(c) Opticians.

(2) Enrolled/contracted eye care providers must:

(a) Meet the requirements in chapter 388-502 WAC;

(b) Provide only those services that are within the scope of the provider's license; and

(c) Obtain all hardware and contact lenses from MAA's contract suppliers.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0150, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0200 Vision care services MAA covers without MAA's prior authorization. (1) MAA covers **medically necessary**eye examinations, refractions, eyeglasses (frames and/or lenses), and fitting fees as follows:

(a) For clients who are asymptomatic and are twenty-one years of age or older, once every twenty-four months;

(b) For clients who are asymptomatic and are twenty years of age or younger, once every twelve months;

(c) For adults or children who are identified on the medical assistance identification card (MAID) as being developmentally disabled, once every twelve months;

(d) For clients on medication that affects vision, as often as is medically necessary as documented by the provider;

(e) For clients for whom the provider is diagnosing or treating a medical condition that has symptoms of vision problems or disease, as often as medically necessary. The provider must document the diagnosis and/or treatment in the client's record to justify the frequency of examinations and other services.

(2) MAA covers medically necessary **visual field exams** for the diagnosis and treatment of abnormal signs, symptoms or injuries. MAA does not reimburse visual field exams that are done by simple confrontation. Documentation in the record must show all of the following:

(a) The extent of the testing;

(b) Why the testing was reasonable and necessary for the client; and

(c) The medical basis for the frequency of testing.

(3) MAA covers medically necessary eyeglasses (frames and/or lenses as needed) according to the following:

(a) When the client's condition in both eyes is **stable** as defined in WAC 388-544-0050, Stable visual condition, and when the minimum correction need is documented and meets one of the following:

(i) Sphere power equal to or greater than plus or minus 0.50 diopters;

(ii) Astigmatism power equal to or greater than plus or minus 0.50 diopters; or

(iii) A combination of spherical power and astigmatic power that is equal to or greater than a spherical equivalent of plus or minus 0.75 diopters (the spherical equivalent means one half cylinder added algebraically to the sphere correction).

(b) MAA covers one pair of back-up eyeglasses when contact lenses are medically necessary and they are the client's primary visual correction aid as described in WAC 388-544-0400. MAA limits back-up eye glasses as follows (also see WAC 388-544-0250 (1)(e)):

(i) For clients twenty years of age or younger, once every two years;

(ii) For clients twenty-one years of age and older, once every six years; or

(iii) When MAA agrees in advance to the medical necessity and the service is provided consistent with the limitations included in MAA's authorization.

(4) MAA covers medically necessary gas permeable or daily-wear-soft contact lenses per WAC 388-544-0400.

(5) MAA covers medically necessary therapeutic contact bandage lenses per WAC 388-544-0450.

(6) MAA covers all hyperopic prescriptions for clients who are twenty years of age or younger and who have a diagnosis of "accommodative esotropia" or any strabismus correction. These clients are not subject to the requirements in subsection (3)(a) of this section (stable eye condition and minimum correction need).

(7) MAA covers medically necessary ocular orthotics/prosthetics per WAC 388-544-0500.

(8) MAA covers the following surgeries:

(a) Strabismus surgery for clients seventeen years of age and younger; and

(b) Cataract surgery per WAC 388-544-0550.

(9) MAA considers all requests for vision care services not listed as covered in this section or where requested services exceed stated limitations. MAA considers such requests under WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0200, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0250 Vision care services MAA does not cover without MAA's prior authorization. (1) MAA evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0165.

(2) MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165 which relate to medical necessity.

(3) MAA evaluates a request for a covered service that is subject to limitation(s) or other restriction(s), and approves such a service beyond those specific limitations or restrictions when the service is medically necessary, under the standards for covered services in WAC 388-501-0165.

(4) The vision care services that MAA does not cover without MAA's prior authorization include, but are not limited to:

(a) Any of the following types of contact lenses:

(i) Disposable lenses;

(ii) Extended wear soft lenses; or

(iii) Extended wear soft toric lenses.

(b) Any eye service or hardware that MAA considers not to be medically necessary;

(c) Any eyeglasses (frames and/or lenses) or contact lenses upgraded at private expense to avoid MAA's contract limitations (e.g., frames that are not available through MAA's contract or noncontract frames or lenses for which the client or other person pays the difference between MAA's payment and the total cost) (see WAC 388-544-0300(7) and 388-544-0350(3));

(d) Bifocal additions to eyeglasses with bifocal correction of less than 1.0 diopter;

(e) Both eyeglasses and contact lenses in a two-year period for any client (see WAC 388-544-0200 (3)(b) for backup eyeglass exceptions);

(f) Eyeglasses or contact lenses when the prescribed need does not meet the minimum corrections described in this chapter;

(g) Eyeglasses or contact lenses when the prescription is over two years old;

(h) Group vision screening for eyeglasses;

(i) Lens replacements for a refractive change when the client does not have a stable visual condition as defined in WAC 388-544-0050 (see WAC 388-544-0350(1));

(j) Other vision services or hardware for persons enrolled in MAA's managed care program (Healthy Options) when the requirements of that program have not been met;

(k) Orthoptics and visual training therapy;

(l) Plano lenses (no refractive correction) for both eyes, except as provided in WAC 388-544-0350 (12)(a));

(m) Progressive additions lenses, including blended bifocals;

(n) Refractive surgery of any type (e.g., Radial Keratotomy or laser resurfacing);

(o) Separate charges for eye exams conducted in combination with emergency or operating room procedures;

(p) Strabismus surgery for a client eighteen years of age or older, unless the client meets MAA's established prior authorization criteria for correctable double vision;

(q) Sunglasses or colored/tinted lenses requested for cosmetic or other nonmedical reasons;

(r) Two pairs of eyeglasses (e.g., instead of one pair of multifocals); and

(s) Other services or hardware that do not meet the requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0250, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0300 Eyeglass frames and service. (1) The medical assistance administration (MAA) covers preapproved eyeglass frames through MAA's contracted supplier.

(2) MAA covers eyeglass frames, with specific time limits, for eligible clients who:

(a) Are twenty-one years of age and older, once every twenty-four months;

(b) Are twenty years of age and younger, once every twelve months;

(c) Are identified on the MAID card as being developmentally disabled (adults or children), once every twelve months;

(d) Have been unable to adjust to contact lenses after thirty days. The provider must document the client's inability to adjust and the client must return the contact lenses to the provider.

(3) MAA covers preapproved special frames called "durable and flexible frames" through MAA's contracted supplier when a client:

(a) Is diagnosed with a seizure disorder that results in frequent falls; or

(b) Has a medical condition that has resulted in two or more broken eyeglass frames in a twelve-month period (e.g., Tourette's syndrome).

(4) MAA covers replacement eyeglass frames that have been lost, broken, or stolen:

(a) For adults, only with MAA's prior authorization (see WAC 388-501-0165); and

(b) Without MAA's prior authorization for clients who are either:

(i) Twenty years of age or younger; or

(ii) Identified on the MAID care as being developmentally disabled, regardless of the client's age.

(5) MAA covers incidental repairs to a client's eyeglass frames when both of the following apply:

(a) The repair or adjustment is not typically provided to the public at no cost; and

(b) The cost of the repair does not exceed MAA's cost for replacement frames. MAA's reimbursement for repairs does not exceed its payment level for replacement frames.

(6) If the client has a medically diagnosed allergy to the materials in the available eyeglass frames, MAA covers the cost of coating the contract eyeglass frames to make the frames nonallergenic.

(7) MAA does not allow clients to upgrade eyeglass frames and pay only the upgrade costs in order to avoid MAA's contract limitations (see WAC 388-544-0250 (1)(c) and 388-544-0350(3)).

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0300, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0350 Eyeglass lenses and service. (1) The medical assistance administration (MAA) covers medically necessary eyeglass lenses to correct a client's vision if both of the following apply:

(a) The condition requiring correction is a stable visual condition as defined in WAC 388-544-0050; and

(b) The prescription is less than two years old.

(2) MAA covers the following types of medically necessary eyeglass lenses:

(a) Single vision lenses;

(b) Round or flat top D-style bifocals;

(c) Trifocals that are twenty-five or twenty-eight millimeters;

(d) Slab-off and prism lenses (including Fresnel lenses); and

(e) Glass lenses fifty-four millimeters and smaller.

(3) For clients who own their own serviceable eyeglass frames and request lenses only, MAA covers these requests if the lenses are medically necessary and the size and style of the required lens(es) meet MAA's contract requirements.

(4) MAA covers medically necessary lens replacements without regard to time limits when (a), (b), and (c) of this subsection apply:

(a) One of the following caused the vision change:

(i) Eye surgery;

(ii) The effect(s) of prescribed medication; or

(iii) One or more diseases;

(b) Both the eye condition and the treatment have stabilized as defined in WAC 388-544-0050, Stable visual condition; and

(c) The lens correction has at least one diopter difference between the old and new prescriptions.

(5) MAA covers lens replacement for lost or broken lenses according to the same standards as frames in WAC 388-544-0300 (2) and (4).

(6) MAA allows bifocal lenses to be replaced with single vision lenses or trifocal lenses to be replaced with bifocals or single vision lenses when all of the following apply:

(a) A client has attempted to adjust to the bifocals or trifocals for at least sixty days;

(b) The client is unable to make the adjustment; and

(c) The bifocal or trifocal lenses being replaced are returned to the provider.

(7) MAA covers plastic executive bifocals or trifocals only for clients who are diagnosed with:

(a) Accommodative esotropia; or

(b) Strabismus.

(8) MAA covers high index lenses when the client requires a refractive correction of plus or minus eight diopters or greater.

(9) MAA covers the tinting of plastic lenses when:

(a) The client's medical need is diagnosed and documented as a chronic eye condition causing photophobia; and

(b) The tinting is done by MAA's contracted lens supplier.

(10) MAA covers glass photochromatic lenses when the client's medical need is diagnosed and documented as related to either (a) or (b) of this subsection:

(a) Ocular albinism; or

(b) Blindness, defined as:

(i) Visual acuity for distance vision of twenty/two hundred or worse in the better eye with best correction; or

(ii) A limitation of the client's visual field (widest diameter) subtending an angle of less than twenty degrees from central.

(11) MAA covers treating plastic lenses for scratch resistance only when the client is either:

(a) Twenty years or age or younger; or

(b) Identified on the MAID card as being developmentally disabled.

(12) MAA covers polycarbonate lenses when a client is any of the following:

(a) Blind in one eye as defined in subsection (10) of this section and the client needs protection for the other eye, regardless of whether a vision correction is required;

(b) Twenty years of age or younger and diagnosed with strabismus or amblyopia; or

(c) Identified on the MAID card as being developmentally disabled.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0350, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0400 Contact lenses and services. (1) The medical assistance administration (MAA) covers gas permeable or daily wear soft contact lenses as the client's primary refractive correction method if a client has a vision correction of plus or minus 6.0 diopters or greater.

(2) MAA does not cover contact lenses if the client's ocular condition makes it medically inadvisable (contraindicated) for the client to use contact lenses.

(3) MAA covers contact lens replacements:

(a) Once every twelve months for normal replacement; or

(b) When the contact lenses are lost or damaged, with the following limitations:

(i) The prescription must not be over seventeen months old; and

(ii) The date of dispensing for the lost or damaged lenses must not be within the past eleven months.

(4) MAA does not cover contact lenses for a patient who has received MAA-covered eyeglasses within the past two years unless the provider:

(a) Documents the medical necessity to MAA's satisfaction; and

(b) Receives prior authorization from MAA.

(5) MAA covers soft toric contact lenses (daily wear) for clients with astigmatism requiring a correction equal to or greater than one diopter (plus or minus).

(6) MAA covers lenticular, aspheric and myodisc contact lenses when the client has one or more of the following:

(a) Multiple cataract surgeries on the same eye;

(b) Aphakia;

(c) Keratoconus with refractive error of plus or minus ten diopters; or

(d) Corneal softening (e.g., bullous keratopathy).

(7) MAA covers contact lenses when:

(a) The client has high anisometropia (the eyes have refractive errors that differ, left to right, by plus or minus three diopters or greater); and

(b) Eyeglasses cannot reasonably correct the refractive errors.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0400, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0450 Therapeutic contact bandage lenses. The medical assistance administration (MAA) covers therapeutic contact bandage lenses only when needed immediately after:

(1) Eye injury; or

(2) Eye surgery.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0450, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0500 Ocular prosthetics. The medical assistance administration (MAA) covers ocular prosthetics which are medically necessary and provided by any of the following:

(1) An ophthalmologist;

(2) An ocularist; or

(3) An optometrist who specializes in orthotics.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0550 Cataract surgery. (1) MAA covers cataract surgery when:

(a) It is included in the scope of care for the client's medical program;

(b) It is medically necessary; and

(c) The provider clearly documents the need in the client's record.

(2) MAA considers the surgery medically necessary when the client has:

(a) Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or

(b) One or more of the following conditions:

(i) Dislocated or subluxated lens;

(ii) Intraocular foreign body;

(iii) Ocular trauma;

(iv) Phacogenic glaucoma;

(v) Phacogenic uveitis; or

(vi) Phacoanaphylactic endopthalmitis.

(3) MAA covers cataract surgery as a nonemergent procedure under any of its medical coverage programs, unless the client is diagnosed as being statutorily blind as defined in WAC 388-544-0350 (10)(b). If the client is blind, the need for cataract surgery is emergent and the cataract surgery is covered by MAA, even if the client is eligible only for medically indigent coverage (MIP).

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0550, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0600 Payment methodology. (1) The medical assistance administration (MAA) covers one hundred percent of the MAA contract price for eyeglass frames, lenses, and contact lenses when these items are obtained through MAA's approved contract(s).

(2) See WAC 388-531-1850 for professional fee payment methodology.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0600, filed 12/6/00, effective 1/6/01.]

HEARING AID SERVICES

WAC 388-544-1010 Definitions. "Expedited prior authorization" (EPA) means a process designed by MAA to eliminate the need for written prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies these criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

"FM systems" means a hearing device that uses a frequency modulated radio signal. FM systems are sometimes referred to as radio frequency (RF) aids.

"Limitation extension" (LE) means prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in MAA billing instructions.

"Maximum allowable fee" means the maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

"Prior authorization" means MAA and/or department of health approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1010, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1100 Hearing aid services—General. (1) MAA covers only the hearing aid services listed in this chapter, subject to the exceptions, restrictions, and limitations listed in this chapter.

(2) MAA evaluates requests for services listed as noncovered or subject to limitations or restrictions according to the provisions in WAC 388-501-0165.

(3) MAA reimburses providers at the maximum allowable rates established by MAA.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1100, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1200 Hearing aid services—For adults. This section applies to medical assistance clients eighteen years of age or older:

(1) MAA covers the purchase of one new, nonrefurbished hearing aid for an adult client every five years if all of the following conditions are met:

(a) The client must be:

(i) Eighteen years of age or older; and

(ii) Eligible for the categorically needy program or the medical care services program.

(b) The client must either:

(i) Have an average hearing of fifty decibel hearing level (dBHL) in the better ear based on auditory screening by a certified audiologist or licensed hearing instrument fitter/dispenser at one thousand, two thousand, three thousand, and four thousand Hertz (Hz) with effective masking as indicated; or

(ii) Be referred by a screening provider under the Healthy Kids/early and periodic screening, diagnosis, and treatment (EPSDT) program (only for clients eighteen to twenty years old).

(c) The client's current hearing aid, if the client has one, is not sufficient for the hearing loss in the better ear.

(d) The hearing aid must be:

(i) Medically necessary as defined in WAC 388-500-0005; and

(ii) Warranted for one year.

(2) Reimbursement for hearing aids includes:

(a) A prefitting evaluation;

(b) An ear mold; and

(c) A minimum of three post-fitting consultations.

(3) MAA covers the repair of a hearing aid when the:

(a) Initial one-year warranty has expired;

(b) Client continues to meet the criteria in subsection (1) of this section;

(c) Cost of repair is less than fifty percent of the cost of a new hearing aid;

(d) Provider has documented the repair and replacement costs; and

(e) Repair is warranted for ninety days.

(4) MAA covers the cost of renting a hearing aid for up to two months while the client's own hearing aid is being repaired.

(5) MAA covers one replacement hearing aid in a five year period when the:

(a) Hearing aid is lost or broken beyond repair;

(b) Client continues to meet the criteria in subsection (1) of this section; and

(c) Provider has documented the necessity for the replacement.

(6) MAA covers replacement of ear molds as follows:

(a) Once a year for soft ear molds; and

(b) Once every three years for hard ear molds.

(7) Prior MAA authorization is required for the following services for adults:

(a) Bone conduction hearing aids; and

(b) Binaural hearing aids.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1200, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1300 Hearing aid services—For children. This section applies to medical assistance clients seventeen years of age or younger:

(1) MAA covers the purchase of new, nonrefurbished hearing aids for children if all of the following conditions in subsections (1)(a) and (1)(b) are met:

(a) The child must:

(i) Be seventeen years of age or under;

(ii) Be eligible for any MAA medical program, except medically indigent program (MIP) and family planning only program; and

(iii) Have prior authorization from the child's local department of health's (DOH) children with special health care needs (CSHCN) coordinator to receive a hearing aid.

(b) The hearing aid must be:

(i) Medically necessary as defined in WAC 388-500-0005; and

(ii) Warranted for one year.

(2) Reimbursement for hearing aids includes:

(a) A prefitting evaluation;

(b) An ear mold for in-the-ear (ITE) hearing aids; and

(c) A minimum of three post-fitting consultations.

(3) MAA covers the repair of a hearing aid when the:

(a) Client's local CSHCN coordinator authorizes the repair;

(b) Initial one-year warranty has expired;

(c) Client continues to meet the criteria in subsection (1) of this section;

(d) Cost of repair is less than fifty percent of the cost of a new hearing aid;

(e) Provider has documented the repair and replacement costs; and

(f) Repair is warranted for ninety days.

(4) MAA covers the cost of renting a hearing aid while the client's own hearing aid is being repaired when the rental is authorized for ninety days.

(5) MAA covers replacement of a hearing aid when the:

(a) Client's local CSHCN coordinator authorizes the replacement;

(b) Client continues to meet the criteria in subsection (1) of this section;

(c) Hearing aid is lost or broken beyond repair; and

(d) Provider has documented the necessity for the replacement.

(6) MAA covers replacement of hard and soft ear molds when the replacement is authorized by the client's local CSHCN coordinator.

(7) All hearing aid equipment and services for children require prior authorization from the client's local CSHCN coordinator, except FM systems which require prior authorization from MAA.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1300, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1400 Hearing aid services—Noncovered services. (1) MAA does not cover any of the following:

(a) The purchase of batteries, ear trumpets, or tinnitus maskers;

(b) Group screenings for hearing loss, except as provided under the Healthy Kids/EPSDT program under WAC 388-534-0100;

(c) Computer-aided hearing devices used in school;

(d) Hearing aid charges reimbursed by insurance or other payer source;

(e) Digital hearing aids; or

(f) FM systems or programmable hearing aids for:

(i) Adults;

(ii) Children when the device is used in school; or

(iii) Children whose hearing loss is adequately improved with hearing aids.

(2) MAA evaluates a request for any service listed in this section according to the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1400, filed 11/15/00, effective 12/16/00.]

Chapter 388-545 WAC
THERAPIES

WAC

WAC 388-545-300 Occupational therapy. (1) The following providers are eligible to enroll with medical assistance administration (MAA) to provide occupational therapy services:

(a) A licensed occupational therapist;

(b) A licensed occupational therapy assistant supervised by a licensed occupational therapist; and

(c) An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

(2) Clients in the following MAA programs are eligible to receive occupational therapy services described in this chapter:

(a) Categorically needy;

(b) Children's health;

(c) General assistance unemployable (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program for emergency hospital-based services only; or

(f) Medically needy program only when the client is either:

(i) Twenty years of age or younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program (healthy kids program) as described in chapter 388-534 WAC; or

(ii) Receiving home health care services as described in chapter 388-551 WAC, subchapter II.

(3) Occupational therapy services received by MAA eligible clients must be provided:

(a) As part of an outpatient treatment program for adults and children;

(b) By a home health agency as described under chapter 388-551 WAC, subchapter II;

(c) As part of the physical medicine and rehabilitation (PM&R) program as described in WAC 388-550-2551;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education program or individualized family service plan as described in WAC 388-537-0100; or

(f) When prescribed by a provider for clients age twenty-one or older. The therapy must:

(i) Prevent the need for hospitalization or nursing home care;

(ii) Assist a client in becoming employable;

(iii) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(iv) Be a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(4) MAA pays only for covered occupational therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary, when prescribed by a provider; and

(c) Begun within thirty days of the date prescribed.

(5) MAA covers the following occupational therapy services per client, per calendar year:

(a) Unlimited occupational therapy program visits for clients twenty years of age or younger;

(b) One occupational therapy evaluation. The evaluation is in addition to the twelve program visits allowed per year;

(c) Two durable medical equipment needs assessments. The assessments are in addition to the twelve program visits allowed per year;

(d) Twelve occupational therapy program visits;

(e) Twenty-four additional outpatient occupational therapy program visits when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement;

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(f) Twenty-four additional occupational therapy program visits following a completed and approved inpatient PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of function due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quads only;

(ix) Bilateral limb loss; or

(x) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(g) Additional medically necessary occupational therapy services, regardless of the diagnosis, must be approved by MAA.

(6) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS), per client, per lifetime.

(7) MAA does not cover occupational therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-545-300, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-16-068, § 388-545-300, filed 8/2/99, effective 9/2/99.]

WAC 388-545-500 Physical therapy. (1) The following providers are eligible to provide physical therapy services:

(a) A licensed physical therapist or physiatrist; or

(b) A physical therapist assistant supervised by a licensed physical therapist.

(2) Clients in the following MAA programs are eligible to receive physical therapy services described in this chapter:

(a) Categorically needy (CN);

(b) Children's health;

(c) General assistance-unemployable (GA-U) (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program (MIP) for emergency hospital-based services only; or

(f) Medically needy program (MNP) only when the client is either:

(i) Twenty years of age or younger and referred under the early and periodic screening, diagnosis and treatment program (EPSDT/healthy kids program) as described in WAC 388-86-027; or

(ii) Receiving home health care services as described in chapter 388-551 WAC.

(3) Physical therapy services that MAA eligible clients receive must be provided as part of an outpatient treatment program:

(a) In an office, home, or outpatient hospital setting;

(b) By a home health agency as described in chapter 388-551 WAC;

(c) As part of the acute physical medicine and rehabilitation (acute PM&R) program as described in the acute PM&R subchapter under chapter 388-550 WAC;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-537-0100; or

(f) For disabled children, age two and younger, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(4) MAA pays only for covered physical therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary and ordered by a physician, physician's assistant (PA), or an advanced registered nurse practitioner (ARNP);

(c) Begun within thirty days of the date ordered;

(d) For conditions which are the result of injuries and/or medically recognized diseases and defects; and

(e) Within accepted physical therapy standards.

(5) Providers must document in a client's medical file that physical therapy services provided to clients age twenty-one and older are medically necessary. Such documentation may include justification that physical therapy services:

(a) Prevent the need for hospitalization or nursing home care;

(b) Assist a client in becoming employable;

(c) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(d) Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(6) MAA determines physical therapy program units as follows:

(a) Each fifteen minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(7) MAA does not limit coverage for physical therapy services listed in subsections (8) through (10) of this section if the client is twenty years of age or younger.

(8) MAA covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year, for clients twenty-one years of age and older:

(a) One physical therapy evaluation. The evaluation is in addition to the forty-eight program units allowed per year;

(b) Forty-eight physical therapy program units;

(c) Ninety-six additional outpatient physical therapy program units when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement.

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(vi) Meningomyelocele;

(vii) Down's syndrome;

(viii) Cerebral palsy; or

(ix) Symptoms involving nervous and musculoskeletal systems and lack of coordination;

(d) Two durable medical equipment (DME) needs assessments. The assessments are in addition to the forty-eight physical therapy program units allowed per year. Two program units are allowed per DME needs assessment; and

(e) One wheelchair needs assessment in addition to the two durable medical needs assessments. The assessment is in addition to the forty-eight physical therapy program units allowed per year. Four program units are allowed per wheelchair needs assessment.

(f) The following services are allowed, per day, in addition to the forty-eight physical therapy program units allowed per year:

(i) Two program units for orthotics fitting and training of upper and/or lower extremities.

(ii) Two program units for checkout for orthotic/prosthetic use.

(iii) One muscle testing procedure. Muscle testing procedures cannot be billed in combination with each other.

(g) Ninety-six additional physical therapy program units are allowed following a completed and approved inpatient acute PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient physical therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of functions due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quadriplegics only;

(ix) Bilateral limb loss;

(x) Open wound of lower limb; or

(xi) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(9) For clients age twenty-one and older, MAA covers physical therapy services which exceed the limitations established in subsection (8) of this section if the provider requests prior authorization and MAA approves the request.

(10) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS) per client, per lifetime.

(11) Duplicate services for occupational therapy and physical therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).

(12) MAA does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(13) MAA does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be billed by the hospital.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-545-500, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 00-04-019, § 388-545-500, filed 1/24/00, effective 2/24/00.]

WAC 388-545-700 Speech/audiology services. (1) The following providers are eligible to enroll with medical assistance administration (MAA) to provide, and be reimbursed for, speech/audiology services:

(a) A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association;

(b) A speech-language pathologist who has completed the equivalent educational and work experience necessary for such a certificate;

(c) An audiologist who is appropriately licensed or registered to perform audiology services within their state of residence; and

(d) School districts or educational service districts. Services must be noted in the client's individual educational program or individualized family service plan as described under WAC 388-537-0100.

(2) Clients in the following MAA programs are eligible to receive speech/audiology services described in this chapter:

(a) Categorically needy, children's health, general assistance unemployable, and alcoholism and drug addiction treatment and support act (ADATSA) programs within Washington state or border areas only; or

(b) Medically needy program only when the client is either:

(i) Twenty years of age or under; or

(ii) Receiving home health care services as described under chapter 388-551 WAC, subchapter II;

(c) Medically indigent program only for emergency hospital-based services.

(3) MAA pays only for covered speech/audiology services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) For conditions which are the result of medically recognized diseases and defects; and

(c) Medically necessary, as determined by a health professional.

(4) The following speech/audiology services are covered per client, per calendar year, per provider:

(a) Unlimited speech/audiology program visits for clients twenty years of age and younger;

(b) One medical diagnostic evaluation for clients twenty-one years of age and older. The medical diagnostic evaluation is in addition to the twelve program visits allowed per year;

(c) One second medical diagnostic evaluation at the time of discharge for any of the following:

(i) Anoxic brain damage;

(ii) Acute, ill-defined, cerebrovascular disease;

(iii) Subarachnoid, subdural, and extradural hemorrhage following injury; or

(iv) Intracranial injury of other and unspecified nature;

(d) Twelve speech/audiology program visits for clients twenty-one years of age and older;

(e) Twenty-four additional speech/audiology visits if the speech/audiology service is for any of the following:

(i) Medically necessary conditions for developmentally delayed clients;

(ii) Neurofibromatosis;

(iii) Severe oral or motor dyspraxia;

(iv) Amyotrophic lateral sclerosis (ALS);

(v) Multiple sclerosis;

(vi) Cerebral palsy;

(vii) Quadriplegia;

(viii) Acute, infective polyneuritis (Guillain-Barre' syndrome);

(ix) Acute, but ill-defined, cerebrovascular disease;

(x) Meningomyelocele;

(xi) Cleft palate and cleft lip;

(xii) Down's syndrome;

(xiii) Lack of coordination;

(xiv) Severe aphasia;

(xv) Severe dysphagia;

(xvi) Fracture of the:

(A) Vault or base of the skull;

(B) Multiple fracture involving skull or face with other bones;

(C) Cervical column;

(D) Larynx and trachea; or

(E) Other and unqualified skull fractures;

(xvii) Head injuries as follows:

(A) Cerebral laceration and contusion;

(B) Subarachnoid, subdural, and extradural hemorrhage following injury;

(C) Other and unspecified intracranial hemorrhage following injury;

(D) Injury to blood vessels of the head and neck; or

(E) Intracranial injury of other second unspecified nature;

(xvii) Burns of:

(A) The face, head, and neck, when severe;

(B) Multiple, specified sites; or

(C) Internal organs;

(xix) Cervical spinal cord injury without evidence of spinal bone injury; or

(xx) Other speech disturbances (e.g., severe dysarthria).

(f) Additional medically necessary speech/audiology program visits beyond the initial twelve visits and additional twenty-four visits for clients twenty-one years of age and older if approved by MAA.

(5) MAA limits:

(a) Caloric vestibular testing to four units for each ear, and

(b) Sinusoidal vertical axis rotational testing to three units for each direction.

(6) MAA does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-545-700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-16-071, § 388-545-700, filed 8/2/99, effective 9/2/99.]

Chapter 388-550 WAC
HOSPITAL SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-550-2300 Payment—PM&R. [Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2300, filed 12/18/97, effective 1/18/98.] Repealed by 99-17-111, filed 8/18/99, effective 9/18/99. Statutory Authority: RCW 74.08.090 and 74.09.520.

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. See also chapter 388-500 WAC for other definitions and abbreviations used by MAA. Unless otherwise specified, the terms used in this chapter have the following meaning:

"Accommodation costs" means the expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made, such as, but not limited to, a regular hospital room, special care hospital room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Acute" means a medical condition of severe intensity with sudden onset.

"Acute care" means care provided by an agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015).

"Acute physical medicine and rehabilitation (Acute PM&R)" means a comprehensive inpatient rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense

level of therapy for a diagnostic category for which the client shows significant potential functional improvement.

"ADATSA/DASA assessment center" means an agency contracted by the division of alcohol and substance abuse (DASA) to provide chemical dependency assessment for clients and pregnant women in accordance with the alcohol and drug addiction treatment and support act (ADATSA). Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

"Add-on procedure" means a secondary procedure that is performed in addition to another procedure.

"Administrative day" means a day of a hospital stay in which an acute inpatient level of care is no longer necessary, and noninpatient hospital placement is appropriate.

"Admitting diagnosis" means the diagnosis, coded according to the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM), indicating the medical condition which precipitated the client's admission to an inpatient hospital facility.

"Advance directive" means a document, such as a living will, executed by a client, that tells the client's health care providers and others the client's decisions regarding his or her medical care, particularly whether the client wishes to accept or refuse extraordinary measures to prolong his or her life.

"Aggregate capital cost" means the total cost or the sum of all capital costs.

"Aggregate cost" means the total cost or the sum of all constituent costs.

"Aggregate operating cost" means the total cost or the sum of all operating costs.

"Alcohol and drug addiction treatment and support act (ADATSA)" means the law and the state-funded program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

"Alcoholism and/or alcohol abuse treatment" means the provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.

"All-patient grouper (AP-DRG)" means a computer program that determines the diagnosis-related group (DRG) assignments.

"Allowed charges" means the maximum amount for any procedure that the department will recognize.

"Ancillary hospital costs" means the expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. See **"ancillary services."**

"Ancillary services" means additional or supporting services, such as, but not limited to, laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services, provided by a hospital to a patient during his or her hospital stay.

"Approved treatment facility" means a treatment facility, either public or private, profit or nonprofit, approved by DSHS.

"Audit" means an assessment, evaluation, examination, or investigation of a health care provider's accounts, books and records, including:

(1) Medical, financial and billing records pertaining to billed services paid by the department through Medicaid or other state programs, by a person not employed or affiliated with the provider, for the purpose of verifying the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical and medical records, including mathematical computations and special studies conducted supporting Medicare cost reports HCFA Form 2552, submitted to the department for the purpose of establishing program rates of reimbursement to hospital providers.

"Audit claims sample" means a subset of the universe of paid claims from which the sample is drawn, whether based upon judgmental factors or random selection. The sample may consist of any number of claims in the population up to one hundred percent. See also **"random claims sample"** and **"stratified random sample."**

"Authorization number" means a nine-digit number assigned by MAA that identifies individual requests for approval of services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

"Authorization requirement" means MAA's requirement that a provider present proof of medical necessity to MAA, prior to providing certain medical services or equipment to a client. This takes the form of a request for authorization of the service(s) and/or equipment, including a complete, detailed description of the client's diagnosis and/or any disabling conditions, justifying the need for the equipment or the level of service being requested.

"Average hospital rate" means the average of hospital rates for any particular type of rate that MAA uses.

"Bad debt" means an operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

"Beneficiary" means a recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.

"Billed charge" - See **"usual and customary charge."**

"Blended rate" means a mathematically weighted average rate.

"Border area hospital" means a hospital located in an area defined by state law as:

(1) Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, or The Dalles; and

(2) Idaho - Coeur d'Alene, Lewiston, Moscow, Priest River or Sandpoint.

"Bundled services" mean interventions which are incidental to the major procedure and are not separately reimbursable.

"Buy-in premium" means a monthly premium the state pays so a client is enrolled in part A and/or part B Medicare.

"By report" means a method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules by requiring the provider to submit a "report" describing the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping physician staff on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services; usually associated with hospital emergency room, surgery, laboratory and radiology services.

"Capital-related costs" mean the component of operating costs related to capital assets, including, but not limited to:

(1) Net adjusted depreciation expenses;

(2) Lease and rentals for the use of depreciable assets;

(3) The costs for betterment and improvements;

(4) The cost of minor equipment;

(5) Insurance expenses on depreciable assets;

(6) Interest expense; and

(7) Capital-related costs of related organizations that provide services to the hospital.

It excludes capital costs due solely to changes in ownership of the provider's capital assets.

"Case mix complexity" means, from the clinical perspective, the condition of the treated patients and the difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution.

"Case mix index" means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using diagnosis-related group weights as a measure of relative cost.

"Charity care" means necessary hospital health care rendered to indigent persons, as defined in this section, to the extent that these persons are unable to pay for the care or to pay the deductibles or coinsurance amounts required by a third-party payer, as determined by the department.

"Chemical dependency" means an alcohol or drug addiction; or dependence on alcohol and one or more other psychoactive chemicals.

"Children's hospital" means a hospital primarily serving children.

"Comorbidity" means of, relating to, or caused by a disease other than the principal disease.

"Complication" means a disease or condition occurring subsequent to or concurrent with another condition and aggravating it.

"Comprehensive hospital abstract reporting system (CHARS)" means the department of health's hospital data collection, tracking and reporting system.

"Contract hospital" means a licensed hospital located in a selective contracting area, which is awarded a contract to participate in the department's selective contracting hospital program.

"Contractual adjustment" means the difference between the amount billed at established charges for the services provided and the amount received or due from a third-party payer under a contract agreement. A contractual adjustment is similar to a trade discount.

"Conversion factor" means a hospital-specific dollar amount that reflects the average cost of treating Medicaid clients in a given hospital. See **"cost-based conversion factor (CBCF)"** and **"negotiated conversion factor (NCF)."**

"Cost proxy" means an average ratio of costs to charges for ancillary charges or per diem for accommodation cost centers used to determine a hospital's cost for the services where the hospital has Medicaid claim charges for the services, but does not report costs in corresponding centers in its Medicare cost report.

"Cost report" means the HCFA Form 2552, Hospital and Hospital Health Care Complex Cost Report, completed and submitted annually by a provider:

(1) To Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and

(2) To Medicaid to establish appropriate DRG and RCC reimbursement.

"Costs" mean MAA-approved operating, medical education, and capital-related costs as reported and identified on the HCFA 2552 form.

"Cost-based conversion factor (CBCF)" means a hospital-specific dollar amount that reflects the average cost of treating Medicaid clients in a given hospital. It is calculated from the hospital's cost report by dividing the hospital's costs for treating Medicaid clients during a base period by the number of Medicaid discharges during that same period and adjusting for the hospital's case mix. See also **"conversion factor"** and **"negotiated conversion factor."**

"County hospital" means a hospital established under the provisions of chapter 36.62 RCW.

"Covered service" means a service that is included in the Medicaid program and is within the scope of the eligible client's medical care program.

"Critical care services" mean services for critically ill or injured patients in a variety of medical emergencies that require the constant attendance of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications). For Medicaid reimbursement purposes, critical care services must be provided in a Medicare qualified critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility, to qualify for reimbursement as a special care level of service.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians; it is published annually by the American Medical Association (AMA).

"Customary charge payment limit" means the limit placed on aggregate diagnosis-related group (DRG) payments to a hospital during a given year to assure that DRG payments do not exceed the hospital's charges to the general public for the same services.

"Day outlier" means a case that requires MAA to make additional payment to the hospital provider but which does

not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."**

"Day outlier payment" means the additional amount paid to a disproportionate share hospital for a client five years old or younger who has a prolonged inpatient stay which exceeds the day outlier threshold but whose charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.

"Day outlier threshold" means the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus twenty days.

"Deductible" means the amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

"Detoxification" means treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Diabetic education program" means a comprehensive, multidisciplinary program of instruction offered by an MAA-approved facility to diabetic clients on dealing with diabetes, including instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" means a set of alphabetic, numeric, or alpha-numeric characters assigned by the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as a shorthand symbol to represent the nature of a disease.

"Diagnosis-related group (DRG)" means a classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or complications, and other relevant criteria.

"Direct medical education costs" means the direct costs of providing an approved medical residency program as recognized by Medicare.

"Discharging hospital" means the institution releasing a client from the acute care hospital setting.

"Disproportionate share payment" means additional payment(s) made by the department to a hospital which serves a disproportionate number of Medicaid and other low-income clients and which qualifies for one or more of the disproportionate share hospital programs identified in the state plan.

"Disproportionate share program" means a program that provides additional payments to hospitals which serve a disproportionate number of Medicaid and other low-income clients.

"Dispute conference" means a hospital rate appeal meeting for deliberation during a provider administrative appeal.

(1) At the first level of appeal it is usually a meeting between auditors and the audited provider and/or staff to resolve disputed audit findings, clarify interpretation of regulations and policies, provide additional supporting information and/or documentation.

(2) At the second level of appeal the dispute conference is an informal administrative hearing conducted by an MAA administrator for the purpose of resolving contractor/provider rate disagreements with any of the department's action at the first level of appeal. The dispute conference in this regard is not a formal adjudicative process held in accordance with the Administrative Procedure Act, chapter 34.05 RCW.

"Distinct unit" means a Medicare-certified distinct area for rehabilitation services within a general acute care hospital or a department-designated unit in a children's hospital.

"DRG" - See **"diagnosis-related group."**

"DRG-exempt services" mean services which are paid for through other methodologies than those using cost-based or negotiated conversion factors.

"DRG payment" means the payment made by MAA for a client's inpatient hospital stay; it is calculated by multiplying the hospital-specific conversion factor by the DRG relative weight for the client's medical diagnosis.

"DRG relative weight" means the average cost or charge of a certain DRG divided by the average cost or charge, respectively, for all cases in the entire data base for all DRGs.

"Drug addiction and/or drug abuse treatment" means the provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families.

"Elective procedure or surgery" means a nonemergent procedure or surgery that can be scheduled at convenience.

"Emergency room" or **"emergency facility"** means an organized, distinct hospital-based facility available twenty-four hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and capable of providing emergency services including trauma.

"Emergency services" mean medical services, including maternity services, required by and provided to a patient after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

"Equivalency factor" means a conversion factor used, in conjunction with two other factors (cost-based conversion factor and the ratable factor), to determine the level of state-only program payment.

"Exempt hospital" means a hospital that is either not located in a selective contracting area or is exempted by the

department and is reimbursed for services to MAA clients through methodologies other than those using cost-based or negotiated conversion factors.

"Experimental treatment" means a course of treatment or procedure that:

(1) Is not generally accepted by the medical profession as effective and proven;

(2) Is not recognized by professional medical organizations as conforming to accepted medical practice;

(3) Has not been approved by the federal Food and Drug Administration (FDA) or other requisite government body;

(4) Is still in clinical trials, or has been judged to need further study;

(5) Is covered by the federal law requiring provider institutional review of patient consent forms, and such review did not occur; or

(6) Is rarely used, novel, or relatively unknown, and lacks authoritative evidence of safety and effectiveness.

"Facility triage fee" means the amount the medical assistance administration will pay a hospital for a medical evaluation or medical screening examination, performed in the hospital's emergency department, of a nonemergent condition of a *healthy options* client covered under the primary care case management (PCCM) program. This amount corresponds to the professional care level A or level B service.

"Fee for service" means the general payment method MAA uses to reimburse for medical services provided to clients other than for those services provided through MAA's per capita *healthy options* program.

"Fiscal intermediary" means Medicare's designated fiscal intermediary for a region and/or category of service.

"Fixed per diem rate" means a contracted nonnegotiated daily amount, used to determine payment to a hospital for specific services.

"Global surgery days" means the number of preoperative and follow-up days that are included in the reimbursement to the physician for the major surgical procedure.

"Graduate medical education costs" means the direct and indirect costs of providing medical education in teaching hospitals.

"Grouper" - See **"all-patient grouper (AP-DRG)."**

"HCFA 2552" - See **"cost report."**

"Health care team" means a team of professionals and/or paraprofessionals involved in the care of a client.

"High-cost outlier" means a case with extraordinarily high costs when compared to other cases in the same DRG, in which the allowed charges prior to July 1, 1999, exceed three times the applicable DRG payment or twenty-eight thousand dollars, whichever is greater. On and after July 1, 1999, to qualify as a high-cost outlier, the allowed charges must exceed three times the applicable DRG payment or thirty-three thousand dollars, whichever is greater.

"Hospice" means a medically-directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington state-licensed and Title XVIII-certified Washington state hospice for terminally ill clients and the clients' families.

"Hospital" means an entity which is licensed as an acute care hospital in accordance with applicable state laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

"Hospital admission" means admission as an inpatient to a hospital, for a stay of twenty-four hours or longer.

"Hospital base period" means, for purposes of establishing a provider rate, a specific period or timespan used as a reference point or basis for comparison.

"Hospital base period costs" mean costs incurred in or associated with a specified base period.

"Hospital cost report" - See **"cost report."**

"Hospital facility fee" - See **"facility triage fee."**

"Hospital market basket index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services, as measured by Data Resources, Inc., (DRI).

"Hospital peer group" means the peer group categories adopted by the former Washington state hospital commission for rate-setting purposes:

(1) Group A - rural hospitals paid under a ratio-of-costs-to-charges (RCC) methodology;

(2) Group B - urban hospitals without medical education programs;

(3) Group C - urban hospitals with medical education programs; and

(4) Group D - specialty hospitals and/or hospitals not easily assignable to the other three peer groups.

"Indigent patient" means a patient who has exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below two hundred percent of the federal poverty standards (adjusted for family size), or is otherwise not sufficient to enable the individual to pay for his or her care, or to pay deductibles or coinsurance amounts required by a third-party payor.

"Indirect medical education costs" means the indirect costs of providing an approved medical residency program as recognized by Medicare.

"Inflation adjustment" means, for cost inflation, the hospital inflation adjustment. This adjustment is determined by using the inflation factor method and guidance indicated by the legislature in the budget notes to the biennium appropriations bill. For charge inflation, it means the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) standard reports three and four.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.

"Inpatient services" means all services provided directly or indirectly by the hospital to a patient subsequent to admission and prior to discharge, and includes, but is not limited to, the following services: Bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and services provided by the hos-

pital within twenty-four hours of the patient's admission as an inpatient.

"Interdisciplinary group (IDG)" means the team, including a physician, a registered nurse, a social worker, and a pastoral or other counselor, which is primarily responsible for the provision or supervision of care and services for a Medicaid client.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into alpha-numerical designations (coding).

"Intervention" means any medical or dental service provided to a client that modifies the medical or dental outcome for that client.

"Length of stay (LOS)" means the number of days of inpatient hospitalization. The phrase more commonly means the average length of hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region.* See also **"professional activity study (PAS)."**

"Length of stay extension request" means a request from a hospital provider for MAA to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

"Lifetime hospitalization reserve" means, under the Medicare Part A benefit, the nonrenewable sixty hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond ninety days per benefit period. See also **"reserve days."**

"Low-cost outlier" means a case with extraordinarily low costs when compared to other cases in the same DRG, in which the allowed charges for the case prior to July 1, 1999, is less than or equal to ten percent of the applicable DRG payment or four hundred dollars, whichever is greater. On and after July 1, 1999, to qualify as a low-cost outlier, the allowed charges must be less than or equal to ten percent of the applicable DRG payment or four hundred and fifty dollars, whichever is greater. Reimbursement in such cases is determined by multiplying the case's allowed charges by the hospital's RCC ratio.

"Low income utilization rate" means a formula represented as (A/B)+(C/D) in which:

(1) The numerator A is the hospital's total patient services revenue under the state plan, plus the amount of cash subsidies for patient services received directly from state and local governments in a period;

(2) The denominator B is the hospital's total patient services revenue (including the amount of such cash subsidies) in the same period as the numerator;

(3) The numerator C is the hospital's total inpatient service charge attributable to charity care in a period, less the portion of cash subsidies described in (1) of this definition in the period reasonably attributable to inpatient hospital services. The amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the state plan); and

(4) The denominator D is the hospital's total charge for inpatient hospital services in the same period as the numerator.

"Major diagnostic category (MDC)" means one of the twenty-five mutually exclusive groupings of principal diagnosis areas in the DRG system. The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

"Market basket index" - See **"hospital market basket index."**

"Medicaid cost proxy" means a figure developed to approximate or represent a missing cost figure.

"Medicaid inpatient utilization rate" means a formula represented as X/Y in which:

(1) The numerator X is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan in a period.

(2) The denominator Y is the hospital's total number of inpatient days in the same period as the numerator's. Inpatient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

"Medical assistance program" means Medicaid and medical care services.

"Medical education costs" means the expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

"Medical screening evaluation" means the service(s) provided by a physician or other practitioner to determine whether an emergent medical condition exists. See also **"facility triage fee."**

"Medical stabilization" means a return to a state of constant and steady function. It is commonly used to mean the client is adequately supported to prevent further deterioration.

"Medically indigent person" means a person certified by the department of social and health services as eligible for the limited casualty program-medically indigent (LCP-MI) program. See also **"indigent patient."**

"Medicare cost report" means the annual cost data reported by a hospital to Medicare on the HCFA form 2552.

"Medicare crossover" means a claim involving a client who is eligible for both Medicare benefits and Medicaid.

"Medicare fee schedule (MFS)" means the official HCFA publication of Medicare policies and relative value units for the resource based relative value scale (RBRVS) reimbursement program.

"Medicare Part A" means that part of the Medicare program that helps pay for inpatient hospital services, which may include, but are not limited to:

(1) A semi-private room;
(2) Meals;
(3) Regular nursing services;
(4) Operating room;
(5) Special care units;
(6) Drugs and medical supplies;
(7) Laboratory services;

(8) X-ray and other imaging services; and

(9) Rehabilitation services.

Medicare hospital insurance also helps pay for post-hospital skilled nursing facility care, some specified home health care, and hospice care for certain terminally ill beneficiaries.

"Medicare Part B" means that part of the Medicare program that helps pay for, but is not limited to:

(1) Physician services;

(2) Outpatient hospital services;

(3) Diagnostic tests and imaging services;

(4) Outpatient physical therapy;

(5) Speech pathology services;

(6) Medical equipment and supplies;

(7) Ambulance;

(8) Mental health services; and

(9) Home health services.

"Medicare buy-in premium" - See **"buy-in premium."**

"Medicare payment principles" means the rules published in the federal register regarding reimbursement for services provided to Medicare clients.

"Mentally incompetent" means a client who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the client has been declared competent for purposes which include the ability to consent to sterilization.

"Multiple occupancy rate" means the rate customarily charged for a hospital room with two or more patient beds.

"Negotiated conversion factor (NCF)" means a negotiated hospital-specific dollar amount which is used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"conversion factor"** and **"cost-based conversion factor."**

"Nonallowed service or charge" means a service or charge that cannot be billed to the department or client.

"Noncontract hospital" means a licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the selective contracting hospital program.

"Noncovered service or charge" means a service or charge that is not covered by medical assistance, including, but not limited to, such services or charges as a private room, circumcision, and video recording of the procedure.

"Nonemergent hospital admission" means any inpatient hospitalization of a client who does not have an emergent condition, as defined in WAC 388-500-0005, Emergency services.

"Nonparticipating hospital" means a noncontract hospital, as defined in this section.

"Operating costs" means all expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

"Orthotic device" means a fitted surgical apparatus designed to activate or supplement a weakened or atrophied limb or bodily function.

"Out-of-state hospital" means any hospital located outside the state of Washington or outside the designated border areas in Oregon and Idaho.

"Outlier set-aside factor" means the amount by which a hospital's cost-based conversion factor is reduced for payments of high cost outlier cases.

"Outlier set-aside pool" means the total amount of payments for high cost outliers which are funded annually based on payments for high cost outliers during the year.

"Outliers" means cases with extraordinarily high or low costs when compared to other cases in the same DRG.

"Outpatient" means a client who is receiving medical services in other than an inpatient hospital setting.

"Outpatient care" means medical care provided other than inpatient services in a hospital setting.

"Outpatient hospital" means a hospital authorized by the department of health to provide outpatient services.

"Outpatient stay" means a hospital stay of less than or approximating twenty-four hours, except that cases involving the death of a client, delivery or initial care of a newborn, or transfer to another acute care facility are not deemed outpatient stays.

"Pain treatment facility" means an MAA-approved inpatient facility for pain management, in which a multidisciplinary approach is used to teach clients various techniques to live with chronic pain.

"Participating hospital" means a licensed hospital that accepts MAA clients.

"PAS length of stay (LOS)" means the average length of hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region.* See also **"professional activity study (PAS)"** and **"length of stay."**

"Patient consent" means the informed consent of the client and/or the client's guardian to the procedure(s) to be performed upon or the treatment provided to the client, evidenced by the client's or guardian's signature on a consent form.

"Peer group" - See **"hospital peer group."**

"Peer group cap" means the reimbursement limit set for hospital peer groups B and C, established at the seventieth percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs.

"Per diem charge" means the daily charge per client that a facility may bill or is allowed to receive as payment for its services.

"Personal comfort items" means items and services which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member.

"PM&R" - See **"Acute PM&R."**

"Physician standby" means physician attendance without direct face-to-face patient contact and does not involve provision of care or services.

"Physician's current procedural terminology (CPT)" - See **"CPT."**

"Plan of treatment" or **"plan of care"** means the written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

"Pregnant and postpartum women (PPW)" means eligible female clients who are pregnant or within the first one hundred sixty days following delivery.

"Principal diagnosis" means the medical condition determined after study of the patient's medical records to be the principal cause of the patient's hospital stay.

"Principal procedure" means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

"Private room rate" means the rate customarily charged by a hospital for a one-bed room.

"Professional activity study (PAS)" means the compilation of inpatient hospital data by diagnosis and age, conducted by the Commission of Professional and Hospital Activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region.*

"Professional component" means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a reimbursement that recognizes the physician's cognitive skill.

"Profitability factor" means a factor used to calculate a hospital's low income disproportionate share (LIDSH) payment. The methods used to determine the profitability factor are:

(1) Determine the net revenue of each LIDSH qualified hospital. The net revenue amount will be the "net revenue" figure identified on the MAA hospital disproportionate share application submitted by the hospital. (Net revenue may be calculated using a three year average net revenue using "net revenue" figures from the most recent three years' MAA hospital disproportionate share applications.);

(2) Add the net revenue figures for all hospitals together to determine one total net revenue figure for all hospitals together to determine one total net revenue figure for all LIDSH qualified hospitals;

(3) Divide the hospital specific net revenue figure by the net revenue total for all hospitals; and

(4) Subtract the resulting amount from 1.00. The outcome is the profitability factor.

"Prognosis" means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.

"Prolonged service" means direct face-to-face patient services provided by a physician, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services.

"Prospective payment system (PPS)" means a system that sets payment rates for a pre-determined period for defined services, before the services are provided. The payment rates are based on economic forecasts and the projected cost of services for the pre-determined period.

"Psychiatric hospitals" means designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals.

"Public hospital district" means a hospital district established under chapter 70.44 RCW.

"Random claims sample" means a sample in which all of the items are selected randomly, using a random number table or computer program, based on a scientific method of assuring that each item has an equal chance of being included in the sample. See also **"audit claims sample"** and **"stratified random sample."**

"Ratable" means a hospital-specific adjustment factor applied to the cost-based conversion factor (CBCF) to determine state-only program payment rates to hospitals.

"Ratio of costs to charges (RCC)" means the methodology used to pay hospitals for services exempt from the DRG payment method. It also refers to the factor applied to a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services.

"Readmission" means the situation in which a client who was admitted as an inpatient and discharged from the hospital is back as an inpatient within seven days as a result of one or more of the following: A new flair of illness, complication(s) from the first admission, a therapeutic admission following a diagnostic admission, a planned readmission following discharge, or a premature hospital discharge.

"Rebasing" means the process of recalculating the hospital cost-based conversion factors using more current data.

"Recalibration" means the process of recalculating DRG relative weights using more current data.

"Regional support network (RSN)" means a county authority or a group of county authorities recognized and certified by the department, that contracts with the department per chapters 38.52, 71.05, 71.24, 71.34, and 74.09 RCW and chapters 275-54, 275-55, and 275-57 WAC.

"Rehabilitation units" means specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals that meet Medicare criteria for distinct part rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

"Remote hospitals" means hospitals located outside selective contracting areas (SCAs), or which:

(1) Are more than ten miles from the nearest contract hospital in the SCA; and

(2) Have fewer than seventy five beds; and

(3) Have fewer than five hundred Medicaid admissions in a two-year period.

"Reserve days" means the days beyond the ninetieth day of hospitalization of a Medicare patient for a benefit period or spell of illness. See also **"lifetime hospitalization reserve."**

"Retrospective payment system" means a system that sets payment rates for defined services according to historic costs. The payment rates reflect economic conditions experienced in the past.

"Revenue code" means a nationally-used three-digit coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" means services provided in a nursing facility, including:

(1) Assistance in the activities of daily living.

(2) Socialization activities.

(3) Administration of medication.

(4) Maintenance of the resident's room.

(5) Supervision and assistance in the use of durable medical equipment and prescribed therapies.

See **"accommodation costs"** for services included in the hospital room and board category.

"Rural health clinic" means a clinic that is located in a rural area designated as a shortage area, and is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

"Rural hospital" means a rural health care facility capable of providing or assuring availability of health services in a rural area.

"Secondary diagnosis" means a diagnosis other than the principal diagnosis for which an inpatient is admitted to a hospital.

"Selective contracting area (SCA)" means an area in which hospitals participate in competitive bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by Medicaid patients.

"Selective hospital contracting program" or **"selective contracting"** means a competitive bidding program for hospitals within a specified geographic area to provide inpatient hospital services to medical assistance clients.

"Semi-private room rate" means a rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Short stay" means a hospital stay of less than or approximating twenty-four hours where an inpatient admission was not appropriate.

"Special care unit" means a Medicare-certified hospital unit where intensive care, coronary care, psychiatric intensive care, burn treatment or other specialized care is provided.

"Specialty hospitals" means children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of clients or diseases.

"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" means the charges by a laboratory for performing a test or tests immediately. "Stat." is the abbreviation for the Latin word "statim" meaning immediately.

"State plan" means the plan filed by the department with the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS), outlining how the state will administer the hospital program.

"Stratified random sample" means a sample consisting of claims drawn randomly, using statistical formulas, from each stratum of a universe of paid claims stratified according to the dollar value of the claims. See also **"audit claims sample"** and **"random claims sample."**

"Subacute care" means care to a patient which is less intrusive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

"Surgery" means the medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.

"Swing-bed days" means a bed day on which an inpatient is receiving skilled nursing services in a swing bed at the hospital's census hour. The hospital bed must be certified by the health care financing administration for both acute care and skilled nursing services.

"Teaching hospital" means, for purposes of the teaching hospital assistance program disproportionate share hospital (THAPDSH), the University of Washington Medical Center and Harborview Medical Center.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a reimbursement that recognizes the equipment cost and technician time.

"Tertiary care hospital" means a specialty care hospital providing highly specialized services to clients with more complex medical needs than acute care services.

"Total patient days" means all patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" means to move a client from one acute care facility to another.

"Transferring hospital" means the hospital transferring a client to another acute care facility.

"Trauma care facility" means a facility certified by the department of health as a level I, II, III, IV or V facility.

"Trauma care service" - See department of health's WAC 246-976-935.

"UB-92" means the uniform billing document intended for use nationally by hospitals, hospital-based skilled nursing facilities, home health, and hospice agencies in billing third party payers for services provided to clients.

"Unbundled services" means services which are excluded from the DRG payment to a hospital, including but not limited to, physician professional services and certain nursing services.

"Uncompensated care" - See **"charity care."**

"Uniform cost reporting requirements" means a standard accounting and reporting format as defined by Medicare.

"Uninsured indigent patient" means an individual who receives hospital inpatient and/or outpatient services and who cannot meet the cost of services provided because the

individual has no or insufficient health insurance or other resources to cover the cost.

"Usual and customary charge (UCC)" means the charge customarily made to the general public for a procedure or service, or the rate charged other contractors for the service if the general public is not served.

"Vendor rate increase" means an inflation adjustment determined by the legislature, used to periodically increase reimbursement to vendors, including health care providers, that do business with the state.

[Statutory Authority: RCW 74.08.090, 74.09.730, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303 and .2652. 99-14-039, § 388-550-1050, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-1050, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1100 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 388-501-0050.

(7) For inpatient psychiatric admissions, whether voluntary or involuntary, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-550-1100, filed 12/29/00, effective 1/29/01. 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 fee for service program is limited for certain eligible clients. This coverage includes, but is not limited to the following:

(1) Medical care clients enrolled with the department's healthy options carriers are subject to the respective carrier's policies and procedures for coverage of hospital services;

(2) Medical care clients covered by primary care case management are subject to the clients' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for clients described in subsection (2) and (3) of this section, see WAC 388-538-100.

(4) Coverage for medically indigent (MI) clients is limited to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter:

(a) Out-of-state care, hospital or other medical, is not covered for clients under the MI program; and

(b) Border areas are considered in-state.

(5) Out-of-state medical care is not covered for clients under the medical care services program.

(6) See WAC 388-550-1100(3) for chemical-dependent pregnant clients.

(7) Only Medicaid categorically needy and medically needy clients under twenty-one years of age, or sixty-five years of age or older may receive care in a state mental institution or approved psychiatric facility.

(8)(a) For clients eligible for both Medicare and Medicaid hospitalization, MAA pays deductibles and coinsurance, unless the client has exhausted his or her Medicare part A benefits.

(i) MAA payment is limited in amount so that when added to the Medicare payment, the total amount is no more than what the department pays for the same service when provided to a Medicaid eligible, non-Medicare client.

(ii) Providers must accept the total Medicare/Medicaid amount as payment in full.

(iii) Beneficiaries are not liable for any additional charges billed by providers or by a managed care entity.

(iv) Providers or managed care entities that charge beneficiaries excess amounts are subject to sanctions.

(b) If such benefits are exhausted, the department pays for hospitalization for such clients subject to MAA rules.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-1200, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1300 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 388-530-1150 (1)(d)(ii). For coverage of nonprescription drugs, see WAC 388-530-110 and 388-530-1150.

(g) The subcategories "renal patient (home)" and "non-routine 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. 01-02-075, § 388-550-1400, filed 12/29/00, effective 1/29/01. 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 388-544-0550;

(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. 01-02-075, § 388-550-1700, filed 12/29/00, effective 1/29/01. 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 transplant 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 388-502-0030;

(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. 01-02-075, § 388-550-2200, filed 12/29/00, effective 1/29/01. 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 388-550-2400 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 388-550-2431 Hospice services—Inpatient payments. See chapter 388-551 WAC, Alternatives to hospital services, subchapter I—Hospice services.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2431, filed 2/26/99, effective 3/29/99.]

WAC 388-550-2500 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.]

ACUTE PHYSICAL MEDICINE AND REHABILITATION (ACUTE PM&R)

WAC 388-550-2501 Acute physical medicine and rehabilitation (acute PM&R) program—General. Acute physical medicine and rehabilitation (acute PM&R) is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services during the acute phase of rehabilitation. It requires prior authorization by medical assistance administration (MAA).

(1) A multidisciplinary team coordinates individualized client **acute PM&R** services at an MAA-approved rehabilitation facility to achieve the following for the client:

(a) Improved health and welfare; and

(b) Maximum physical, social, psychological and vocational potential.

(2) MAA determines the length of stay based on individual cases and community standards of care for **acute PM&R** services.

(3) When MAA's authorized acute period of rehabilitation ends, the provider transfers the client to a more appropriate level of care. Therapies may continue to help the client achieve maximum potential through other covered programs such as:

(a) Home health services (see subchapter II of chapter 388-551 WAC);

(b) Nursing facilities (see chapter 388-97 WAC); or

(c) Outpatient hospital services (see chapter 388-550 WAC).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2501, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2511 Acute PM&R definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to this subchapter. Defined words and phrases are bolded in the text. In case of any conflicts, this section prevails for this subchapter.

"Accredit" (or "Accreditation") is a term used by nationally recognized health organizations, such as CARF, to state a facility meets community standards of medical care.

"Acute" means an intense medical episode, not longer than two months.

"Acute physical medicine and rehabilitation (acute PM&R)" means a comprehensive inpatient rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for a diagnostic category for which the client shows significant potential functional improvement.

"CARF." The official name for 'The Rehabilitation Accreditation Commission' of Tucson, Arizona. **CARF** is a national private agency that develops and maintains current, "field-driven" (community) standards through surveys and **accreditations** of rehabilitation facilities.

"Level A services" mean hospital-based **acute** rehabilitation services for medically stable clients with conditions that require complex nursing, medical and therapy needs as listed in WAC 388-550-2551(2). Such conditions include, but are not limited to, traumatic brain injuries, spinal cord injuries, and complicated bilateral amputations.

"Level B services" mean hospital- or nursing facility-based **acute** rehabilitation services for medically stable clients with new or exacerbated multiple sclerosis, mild head injuries, spinal cord injuries following the removal of the thoracic lumbar sacral orthosis (TLSO), and other medical conditions that require less complex nursing, medical and therapy needs as listed in WAC 388-550-2551(3).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2511, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2521 Client eligibility requirements for acute PM&R services. (1) Clients in any of the following medical programs are eligible to receive acute PM&R Level A and Level B services:

(a) Children's health (V);

(b) Categorically needy program (CNP);

(c) Categorically needy program - qualified Medicare beneficiary (CNP-QMB);

(d) General assistance - determination pending for disability (GAX);

(e) Limited casualty program - medically needy program (LCP-MNP); and

(f) Medically needy program - qualified Medicare beneficiary (MNP-QMB).

(2) Clients in any of the following programs may receive only **Level A** hospital-based services:

(a) Medically indigent program (MIP) - emergency hospital-based and emergency transportation services. These clients may only receive services when:

(i) They are transferred directly from an **acute** hospital stay; and

(ii) The client's **acute PM&R** needs are directly related to the emergency medical need for the hospital stay;

(b) General assistance unemployable (GAU - No out-of-state care);

(c) CNP - emergency medical only;

(d) LCP-MNP - emergency medical only; and

(e) Alcoholism and drug addiction treatment and support act (ADATSA) (GAW).

(3) Clients in programs not listed in this section are not covered for **acute PM&R** services. See WAC 388-529-0100 and 388-529-0200 for scope of medical coverage.

(4) If a client is enrolled in an MAA Healthy Options managed care plan at the time of acute care admission, that plan pays for and coordinates **acute PM&R** services as appropriate.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2521, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2531 Requirements for becoming an MAA Level A or B acute PM&R provider. (1) To provide **acute PM&R** services to medical assistance clients, a provider obtains MAA approval for the faculty. To obtain MAA approval for the facility, the provider must:

(a) Submit a letter of request;

(b) Include evidence that confirms the requirements listed in subsection (2) and (3) of this section are met; and

(c) Send the letter and documentation to:

Acute PM&R Program Manager
Division of Health Services Quality Support
Medical Assistance Administration
PO Box 45506
Olympia WA 98504-5506

(2) In order to be approved by MAA as a **Level A** provider, a hospital must be:

(a) Medicare certified;

(b) **Accredited** by the joint commission on **accreditation** of hospital organizations (JCAHO);

(c) Licensed by department of health (DOH) as an acute care hospital (as defined by DOH in WAC 246-310-010, Definitions);

(d) **CARF accredited** for comprehensive integrated inpatient rehabilitation programs; and

(e) Operating per the standards set by DOH, excluding the certified rehabilitation registered nurse (CRRN) requirement, in either:

(i) WAC 246-976-830, Level I trauma rehabilitation designation; or

(ii) WAC 246-976-840, Level II trauma rehabilitation designation.

(3) In order to be approved by and contracted with MAA as a **Level B** provider, a facility must be:

(a) Medicare certified;

(b) Licensed by DOH as an acute care hospital (as defined by DOH in WAC 246-310-010, Definitions) or nursing facility;

(c) **CARF accredited** for comprehensive integrated inpatient rehabilitation programs;

(d) Contracted under MAA's selective contracting program, if in a selective contracting area, unless exempted from the requirement by MAA; and

(e) Operating per the standards set by DOH in WAC 246-976-840, Level II trauma rehabilitation designation, excluding the CRRN requirement.

(4) To obtain conditional contract approval, the applying facility must meet the criteria in subsections (1), (2) and/or (3) of this section, excluding the **CARF accreditation** requirement listed in section (2)(c) and (3)(c) of this section. The facility must:

(a) Actively operate under **CARF** standards; and

(b) Have begun the process of obtaining full **CARF accreditation**.

(5) MAA will revoke a conditional contract approval if the facility does not obtain full **CARF accreditation** within twelve months of the conditional approval date by MAA.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2531, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2541 Quality of care for acute PM&R clients through audits and reviews. (1) To ensure quality of care, MAA may conduct an on-site review of any MAA-approved **acute PM&R** facility. See WAC 388-501-0130, Administrative controls, for additional information on audits conducted by department staff.

(2) In addition, MAA-approved **Level B** nursing facilities are subject to regular on-site surveys conducted by the department's aging and adult services administration (AASA).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2541, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2551 How MAA determines client placement in Level A or B acute PM&R. (1) At the time of authorization, MAA determines the most appropriate client placement on a case-by-case basis:

(a) In the level of care (level A or B);

(b) In the least restrictive environment; and

(c) At the lowest cost to MAA.

(2) Examples of client conditions suitable for **Level A** placement include:

(a) Cognitive and/or motor deficits;

(b) Brain damage from infectious brain diseases;

(c) Quadriplegia or paraplegia;

(d) Skin flap grafts for decubitus ulcers that need close observation by a surgeon, when the client is ready to mobilize or be upright in a chair;

(e) Extensive burns requiring complex medical care and debridement;

(f) Bilateral limb loss requiring close observation when the client has complex medical needs;

(g) Multiple trauma with complicated orthopedic conditions and neurological deficits; or

(h) Stroke with resulting hemiplegia or severe cognitive deficits, including speech and swallowing deficits requiring close observation with radiological examination.

(3) Examples of client conditions suitable for **Level B** placement include:

(a) New strokes when medically stable;

(b) Newly diagnosed or recently exacerbated multiple sclerosis with new loss of function;

(c) New mild head injury when medically stable; or

(d) Spinal cord injuries following the removal of a thoracic lumbar sacral orthosis after the client's first phase of acute rehabilitation.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2551, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2561 MAA's requirements for authorizing acute PM&R services. (1) The patient care coordinator or the attending physician must call the MAA clinical consultation team before admitting an MAA client.

(2) The patient care coordinator or attending physician must provide to MAA objective information showing that:

(a) **Acute PM&R** treatment would effectively enable the client to obtain a greater degree of self-care, independence, or both;

(b) The client's medical condition requires that intensive twenty-four-hour inpatient comprehensive **acute PM&R** services be provided in an MAA-approved **acute PM&R** facility; and

(c) The client suffers from severe disabilities including, but not limited to, motor and/or cognitive deficits.

(3) Clients must be medically stable and show evidence that they are physically and cognitively ready to participate in the rehabilitation program. They must be willing and capable to participate at least three hours per day, seven days per week, in **acute PM&R** activities.

(4) For extension of authorization, the facility's rehabilitation staff must provide adequate medical justification, including significant observable improvement in the client's condition, to MAA prior to the expiration of the initial approved stay. If MAA denies the extension, the client must be transferred to an appropriate lower level of care as defined in WAC 388-550-2501(3).

(5) MAA may authorize administrative day reimbursement for clients who do not meet requirements described in this section, or who stay in the facility longer than the community standard's length of stay. The administrative day rate is the statewide Medicaid average daily nursing facility rate as determined by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2561, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2600 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 Inpatient payment methods and limits. (1) MAA pays hospitals for inpatient hospital services using the rate setting methods identified in the department's approved state plan that includes:

Method	Used for
Negotiated conversion factor	Hospitals participating in the Medicaid hospital selective contracting program under waiver from the federal government
Cost-based conversion factor	Hospitals not participating in or exempt from the Medicaid hospital selective contracting program (DRG method)
Ratio of costs-to-charges	Hospitals or services exempt from DRG payment methods
Fixed per diem rate	Acute Physical Medicine and Rehabilitation (Acute PM&R) Level B contracted facilities

(2) MAA's annual aggregate Medicaid payments to each hospital for inpatient hospital services provided to Medicaid clients must not exceed the hospital's customary charges to the general public for the services (42 CFR § 447.271). MAA will recoup amounts in excess of annual aggregate Medicaid payments to hospitals.

(3) MAA's annual aggregate payments for inpatient hospital services, including state-operated hospitals, must not exceed estimated amounts that MAA would have paid using Medicare payment principles.

(4) When hospital ownership changes, MAA's payment to the hospital must not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(5) Hospitals participating in the medical assistance program must annually submit to the department:

(a) A copy of the hospital's HCFA 2552 Medicare Cost Report; and

(b) A disproportionate share hospital application.

(6) Reports referred to in subsection (5) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by MAA.

(7) MAA requires hospitals to follow generally accepted accounting principles unless federally or state-regulated.

(8) Participating hospitals must permit MAA to conduct periodic audits of their financial and statistical records.

(9) Payments for trauma services may be enhanced per WAC 246-976-935.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-2800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2900 Payment limits—Inpatient hospital services. (1) The department pays covered inpatient hospital services only to:

(a) General hospitals that meet the definition in RCW 70.41.020;

(b) Inpatient psychiatric facilities and alcohol or drug treatment centers:

(i) Approved by the department; and

(ii) Not paid directly through the RSNs.

(c) Out-of-state hospitals, subject to conditions specified in WAC 388-550-6700.

(2) MAA does not pay for hospital care and/or services provided to an MAA client enrolled with a managed care plan, when the plan covers those services. Plans have the authority to determine the treatment regimen of coverage as long as they cover all the Medicaid services that MAA reimburses them to cover. Plans may also provide coverage of services beyond that for which Medicaid reimburses them.

(3) MAA does not pay a hospital for care or services provided to a client enrolled in the hospice program, except as provided under chapter 388-551 WAC, subchapter I, Hospice services.

(4) MAA does not pay hospitals for inpatient ancillary services in addition to the DRG payment. The DRG payment includes ancillary services that include, but are not limited to, the following:

(a) Laboratory services;

(b) Diagnostic X-ray and other imaging services, including, but not limited to, magnetic resonance imaging, 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 MAA nor the client is responsible for payment for additional days of hospitalization when:

(a) A client exceeds the professional activities study (PAS) length of stay (LOS) limitations; and

(b) The provider has not obtained MAA approval for the LOS extension, as specified in WAC 388-550-1700(4).

(6) The LOS limit for a hospitalization is the seventy-fifth percentile of the PAS length of stay for that diagnosis code or combination of codes, published in the *PAS Length of Stay-Western Region edition*, as periodically updated.

(7) Neither MAA nor the client is responsible for payment of elective or nonemergent inpatient services which are included in MAA's selective contracting program and which a client receives in a nonparticipating hospital in a selective contracting area (SCA) unless the provider received prior approval from MAA as required by WAC 388-550-1700 (2)(a). The client, however, may be held responsible for pay-

ment of such services if the client contracts in writing with the hospital at least seventy-two hours in advance of the hospital admission to be responsible for payment. See WAC 388-550-4600, Selective contracting program.

(8) MAA may consider hospital stays of twenty-four hours or less short stays, and does not pay such stays under the DRG methodology. The exception for stays of twenty-four hours or less involving the following situations are paid under the DRG system:

(a) Death of a client;

(b) Obstetrical delivery;

(c) Initial care of a newborn; or

(d) Transfer of a client to another acute care hospital.

(9)(a) Under the ratio of costs-to-charges (RCC) method, MAA does not pay for inpatient hospital services provided more than one day prior to the date of a scheduled or elective surgery. These services must not be charged to the client.

(b) Under the DRG method, MAA considers all services provided the day before a scheduled or elective surgery to be included in the hospital's DRG payment for the case.

(c) MAA does not count toward the threshold for hospital outlier status:

(i) Any charges for extra days of inpatient stay prior to a scheduled or elective surgery; and

(ii) The associated services provided during those extra days.

(10) MAA applies the following rules to RCC cases and high-cost DRG outlier cases for costs that exceed the high-cost outlier threshold:

(a) MAA covers hospital stat charges only for specific laboratory procedures determined and published by MAA as qualified stat procedures. Tests generated in the emergency room do not automatically justify a stat order.

(b) MAA pays hospitals for special care charges only when:

(i) The hospital has a department of health (DOH) or Medicare-certified special care unit;

(ii) The special care service being billed, such as intensive care, coronary care, burn unit, psychiatric intensive care, or other special care, was provided in the special care unit;

(iii) The special care service provided is the kind of service for which the special care unit has been DOH- or Medicare-certified; and

(iv) The client's medical condition required the care be provided in the special care unit.

(11) MAA determines its actual payment for a hospital admission by deducting from the basic hospital reimbursement amount those charges which are the client's responsibility (referred to as spend-down) and any third party liability.

(12) MAA reduces reimbursement rates to hospitals for services provided to MI/GAU clients according to the hospital specific ratable and/or equivalency factors, as provided in WAC 388-550-4800.

(13) MAA pays for the hospitalization of a client who is eligible for Medicare and Medicaid only when the client has exhausted the Medicare part A benefits, including the nonrenewable lifetime hospitalization reserve of sixty days.

(14) MAA pays in-state and border area hospital accommodation charges by multiplying the hospital's RCC rate to the lesser of the room rate submitted by the hospital to MAA or the accommodation charges billed on the claim.

(15) MAA pays out-of-state accommodation charges at the in-state average RCC rate times the hospital's billed charge.

(16) With regard to room rate submittals to MAA:

(a) A hospital must submit changes on the room rate change form, DSHS 13-687;

(b) Charges must not exceed the hospital's usual and customary charges to the public as required by 42 CFR § 447.271;

(c) New room rates take effect on the effective date stated on the room rate change form, or fourteen calendar days after MAA receives the form, whichever is later;

(d) MAA does not make retroactive room rate changes; and

(e) MAA pays private rooms at the semi-private room rate.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-2900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2900, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3000 DRG payment system. (1) Except where otherwise specified, MAA uses the diagnosis-related group (DRG) system, which categorizes patients into clinically coherent and homogenous groups with respect to resource use, as the reimbursement method for inpatient hospital services.

(2) MAA periodically evaluates which all-patient grouper (AP-DRG) version to use.

(3)(a) MAA calculates the DRG payment for a particular hospital by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, for that admission by the hospital's cost-based conversion factor, as determined in WAC 388-550-3450.

(b) If the hospital is participating in the selective contracting program, the department multiplies the DRG relative weight for the admission by the hospital's negotiated conversion factor, as specified in WAC 388-550-4600(4).

(4)(a) MAA pays for a hospital readmission within seven days of discharge for the same client when department review concludes the readmission did not occur as a result of premature hospital discharge.

(b) When a client is readmitted to the same hospital within seven days of discharge, and MAA review concludes the readmission resulted from premature hospital discharge, MAA treats the previous and subsequent admissions as one hospital stay and pay a single DRG for the combined stay.

(5) If two different DRG assignments are involved in a readmission as described in subsection (4) of this section, MAA reviews the hospital's records to determine the appropriate reimbursement.

(6) MAA recognizes Medicaid's DRG payment for a Medicare-Medicaid dually eligible client to be payment in full.

(a) MAA pays the Medicare deductible and co-insurance related to the inpatient hospital services provided to clients

eligible for Medicare and Medicaid subject to the Medicaid maximum allowable limit set in WAC 388-550-1200(6).

(b) MAA ensures total Medicare and Medicaid payments to a provider for such client does not exceed Medicaid's maximum allowable charges.

(c) MAA pays for those allowed charges beyond the threshold using the outlier policy described in WAC 388-550-3700 in cases where:

(i) Such client's Medicare part A benefits including lifetime reserve days are exhausted; and

(ii) The Medicaid outlier threshold status is reached.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3100 Calculating DRG relative weights. (1) MAA sets Washington Medicaid-specific DRG relative weights, as follows:

(a) Uses the all-patient grouper (AP-DRG) to classify Washington Medicaid hospital admissions data.

(b) Statistically tests each DRG for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(c) Establishes relative weights from Washington Medicaid hospital admissions data. These relative weights may be stable or unstable.

(d) Tests the stability of Washington Medicaid relative weights from subsection (1)(c) of this section using a reasonable statistical test to determine if the weights are stable. MAA accepts as stable and adopts those Washington Medicaid relative weights that pass the reasonable statistical test.

(e) Pays admissions for DRGs having unstable Washington Medicaid relative weights using the RCC method.

(2) When using ratios with a Washington Medicaid relative weight as base, MAA adjusts all stable Medicaid relative weights so that the average weight of the case mix population equals 1.0.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3100, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3150 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 388-550-3381 How MAA pays acute PM&R facilities for Level A services. (1) A **Level A** rehabilitation facility is paid by MAA according to:

(a) The individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500, Payment method—RCC; and

(b) MAA's fee schedule as described in WAC 388-550-6000, Payment—Outpatient hospital services.

(2) **Level A** inpatient **acute PM&R** room and board includes, but is not limited to:

(a) Facility use;

(b) Medical social services;

(c) Bed and standard room furnishings; and

(d) Nursing services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3381, filed 8/18/99, effective 9/18/99.]

WAC 388-550-3400 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 388-550-3401 How MAA pays acute PM&R facilities for Level B services. (1) MAA pays a contracted **Level B** facility for **acute PM&R** services at a fixed daily rate established by MAA.

(2) MAA may make cost inflation adjustments to the maximum daily rate by using the same inflation factor and schedule that MAA uses to pay independent hospitals. This diagnosis-related group (DRG) reimbursement method is described in WAC 388-550-3450 (5)(a).

(3) MAA pays the rate in effect at the time of a client's admission to a facility.

(4) Equipment and services identified in the **Level B** contract as excluded from the fixed daily rate are paid to the MAA provider that directly provides the equipment or services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3401, filed 8/18/99, effective 9/18/99.]

WAC 388-550-3450 Payment method for calculating CBCF rates. (1) For Medicaid accommodation costs, MAA:

(a) Uses each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the nine accommodation categories described in WAC 388-550-3150(5); then

(b) Divides those costs per category by total hospital days per category to arrive at a per day accommodation cost; then

(c) Multiplies the per day accommodation cost for each category by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

(2) For ancillary costs MAA:

(a) Uses the base period cost data to calculate total operating, capital, and direct medical education costs for each of the hospital's twenty-nine ancillary categories; then

(b) Divides these costs by total charges per category to arrive at a ratio of costs-to-charges (RCC) per ancillary category; then

(c) Multiplies these RCCs by Medicaid charges per category, as tracked by the Medicaid Management Information System (MMIS), to arrive at total Medicaid ancillary costs per category for the three components (operating, capital, and medical education).

(3) MAA:

(a) Combines Medicaid accommodation and ancillary costs to derive the hospital's total costs for operating, capital, and direct medical education components for the base year; then

(b) Divides the hospital's combined total cost by the number of Medicaid cases during the base year to arrive at an average Medicaid cost per DRG admission; then

(c) Adjusts, for hospitals with a fiscal year ending different than the common fiscal year end, the Medicaid average cost by a factor determined by MAA to standardize hospital costs to the common fiscal year end. MAA adjust the hospital's Medicaid average cost by the hospital's specific case mix index.

(4) MAA caps the Medicaid average cost per case for peer groups B and C at seventy percent of the peer group average. In calculation of the peer group cap, MAA removes the indirect medical education and outlier costs from the Medicaid average cost per admission.

(a) For hospitals in MAA peer groups B or C, MAA determines aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap; then

(b) To whichever is less, the hospital-specific aggregate cost or the peer group cost cap determined in subsection (4) of this section, MAA adds:

(i) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(ii) An outlier cost adjustment in accordance with WAC 388-550-3350(2).

(5) For an inflation adjustment MAA may:

(a) Multiply the sum obtained in subsection (4) of this section by an inflation factor as determined by the legislature for the period January 1 of the year after the base year through October 31 of the rebase year; then

(b) Reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted CBCF; then

(c) Multiply the hospital's adjusted CBCF by the applicable DRG relative weight to calculate the DRG payment for each admission.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3450, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3500 Hospital inflation adjustment determinations. Effective on November 1 of each year, MAA may adjust all cost-based conversion factors (CBCF) by an inflation factor, as determined by the legislature and as addressed in subsequent budget notes. MAA does not automatically give an inflation increase to negotiated conversion factors for contracted hospitals participating in the hospital selective contracting program.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3500, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3600 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) MAA calculates high-cost diagnosis-related group (DRG) outlier payments for qualifying cases as follows:

(a) To qualify as a DRG high-cost outlier the allowed charges for a case:

(i) With an admission date prior to July 1, 1999, must exceed a threshold of three times the applicable DRG payment or twenty-eight thousand dollars, whichever is greater; and

(ii) For an admission date on and after July 1, 1999, must exceed a threshold of three times the applicable DRG payment or thirty-three thousand dollars, whichever is greater.

(b) Payment for high-cost outlier cases other than those in subsections (1)(c) and (d) of this section is the applicable DRG payment amount, plus seventy-five percent of the hospital's ratio of costs-to-charges (RCC) rate applied to the allowed charges exceeding the outlier threshold.

(c) Payment for psychiatric high-cost outliers for DRGs 424-432 is at the applicable DRG rate plus one hundred percent of the hospital RCC applied to the allowed charges exceeding the outlier threshold.

(d) Payment for high-cost outlier cases at in-state childrens hospitals is the applicable DRG payment amount, plus eighty-five percent of the hospital's RCC applied to the allowed charges exceeding the outlier threshold.

(2) MAA calculates low-cost DRG outlier payments for qualifying cases as follows:

(a) To qualify as a DRG low-cost outlier, the allowed charges for a case:

(i) With an admission date prior to July 1, 1999, must be less than or equal to ten percent of the applicable DRG payment or four hundred dollars, whichever is greater; and

(ii) With an admission date on and after July 1, 1999, must be less than or equal to ten percent of the applicable DRG payment or four hundred fifty dollars, whichever is greater.

(b) MAA's payment for low-cost DRG outlier claims is the allowed charges multiplied by the hospital's RCC.

(3) MAA pays hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client no longer needs an acute inpatient level of care, but is not discharged because an appropriate noninpatient hospital placement is not available.

(a) MAA sets payment for administrative days at the statewide average Medicaid nursing facility per diem rate. The administrative day rate is adjusted annually effective November 1.

(b) Ancillary services are not paid during administrative days.

(c) For a DRG payment case, MAA does not pay administrative days until the case exceeds the high-cost outlier threshold for that case.

(d) For DRG-exempt cases, MAA identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(e) If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, MAA pays the hospital at the administrative day rate from the date of admission.

(4) MAA makes day outlier payments to hospitals, in accordance with section 1923 (a)(2)(C) of the Social Security Act, for exceptionally long-stay clients. A hospital is eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share (DSH) hospital and the client served is under the age of six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The charge for the hospitalization is below the high-cost outlier threshold as defined in subsection (1)(a) of this section; and

(d) The client's length of stay is over the day outlier threshold for the applicable DRG. The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

(5) MAA bases the day outlier payment on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate.

(6) MAA's total payment for day outlier claims is the applicable DRG payment plus the day outlier or administrative days payment.

(7) Day outliers are only paid for cases that do not reach high-cost outlier status. A client's outlier claim is either a day outlier or a high-cost outlier, but not both.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3800 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 Payment method—Border area hospitals. (1) Under the diagnosis-related group (DRG) payment method:

(a) MAA calculates the cost-based conversion factor (CBCF) of a border area hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(b) For a border area hospital with no HCFA 2552 for the rebasing year, MAA assigns the MAA peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(2) MAA calculates:

(a) The ratio of costs-to-charges (RCC) in accordance with WAC 388-550-4500.

(b)For a border area hospital with no HCFA 2552 Medicare cost report, its RCC on the Washington in-state average RCC ratios.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4000 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 Payment method—New hospitals. (1) For rate-setting purposes, MAA considers as new:

(a) A hospital which began services after the most recent rebased cost-based conversion factors (CBCFs), or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) MAA determines a new hospital's CBCF as the average of the CBCF of all hospitals within the same MAA peer group.

(3) MAA determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC rate for all current Washington in-state hospitals.

(4) MAA considers that a change in hospital ownership does not constitute a new hospital.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-4100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4200 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) MAA calculates a hospital's ratio of costs-to-charges (RCC) by dividing allowable operating costs by patient revenues associated with these allowable costs.

(b) MAA bases these figures on the annual Medicare cost report data provided by the hospital.

(c) MAA updates hospitals' RCC rates annually with the submittal of new HCFA 2552 Medicare cost report data. Prior to computing the ratio, MAA excludes increases in operating costs or total rate-setting revenue attributable to a change in ownership.

(2) MAA limits a hospital's RCC to one hundred percent of its allowable charges. MAA recoups payments made to a hospital in excess of its customary charges to the general public.

(3) MAA establishes the basic hospital payment by multiplying the hospital's assigned RCC rate by the allowed charges for medically necessary services. MAA deducts client responsibility (spend-down) or third-party liability (TPL) as identified on the billing invoice or by MAA from the basic payment to determine the actual payment due from MAA for that hospital admission.

(4) MAA uses the RCC payment method to reimburse:

(a) Peer group A hospitals;

(b) Other DRG-exempt hospitals identified in WAC 388-550-4300; and

(c) Any hospital for DRG-exempt services described in WAC 388-550-4400.

(5) MAA deems the RCC for in-state and border area hospitals lacking sufficient HCFA 2552 Medicare cost report data the weighted average of the RCC rates for in-state hospitals.

(6) MAA calculates an outpatient ratio of costs-to-charges by dividing the projected costs by the projected charge multiplied by the average RCC.

(a) In no case may the outpatient adjustment factor exceed 1.0.

(b) The outpatient adjustment factor is updated annually effective November 1.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4600 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), MAA pays any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) MAA pays any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the department to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest contracting hospital exceeds the client's county travel distance standard, as follows:

County	Community Travel Distance Standard
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 may obtain such services from a contracting hospital appropriate to the client's condition.

(3) MAA requires prior authorization for all nonemergent admissions to nonparticipating hospitals in an SCA. See WAC 388-550-1700 (2)(a).

(4) MAA pays a licensed hospital all applicable Medicare deductible and coinsurance amounts for inpatient services provided to Medicaid clients who are also beneficiaries of Medicare part A subject to the Medicaid maximum allowable as established in WAC 388-550-1200 (8)(a).

(5) The department pays any licensed hospital DRG-exempt services as listed in WAC 388-550-4400.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4800 Hospital payment method—State-only programs. (1) The medical assistance administration (MAA):

(a) Calculates payments to hospitals for state-only MI/medical care services to clients according to the:

(i) Diagnosis-related group (DRG); or

(ii) Ratio of costs-to-charges (RCC) methodologies; and

(b) Reduces hospitals' Title XIX rates by their ratable and/or equivalency factors (EQ), as applicable.

(2) MAA calculates ratables by:

(a) Adding together a hospital's Medicare and Medicaid revenues, along with the value of the hospital's charity care and bad debts. MAA deducts the hospital's low-income disproportionate share (LIDSH) revenue from this total to arrive at the hospital's community care dollars; then

(b) Subtracting revenue generated by hospital-based physicians from total hospital revenue. Both revenues are as reported in the hospital's HCFA 2552 cost report; then

(c) Divides the amount derived in step (2)(a) by the amount derived in step (2)(b) to obtain the ratio of community care dollars to total revenue; then

(d) Subtracts the result of step (2)(c) from 1.000 to obtain the hospital's ratable. The hospital's Title XIX cost-based

conversion factor (CBCF) or RCC rate is multiplied by (1-ratable) for a MI or medical care services client.

(e) The payments for MI/medical care services clients are mathematically represented as follows:

MI/medical care services RCC = Title XIX RCC x (1-Ratable)

MI/medical care services CBCF = Title XIX Conversion Factor x (1-Ratable) x EQ

(3) MAA updates each hospital's ratable annually on August 1.

(4) MAA:

(a) Uses the EQ to hold the DRG reimbursement rates for the MI/medical care services programs at their current level prior to any rebasing. MAA applies the EQ only to the Title XIX DRG CBCFs. MAA does not apply the EQ when the DRG rate change is due to the application of an inflation factor.

(b) Calculates a hospital's equivalency factor as follows:

EQ = (Current MI/medical care services conversion factor)/(Title XIX DRG rate x (1-ratable))

(5) Effective for hospital admissions on or after December 1, 1991, MAA reduces its payment for MI (but not medical care services) clients further by multiplying the payment by ninety-seven percent. MAA applies this payment reduction adjustment to the MIDSH methodology in accordance with section 3(b) of the "Medicaid Voluntary Contributions and Provider-Specific Tax Amendment of 1991."

(6) When the MI/medical care services client has a trauma that qualifies under the trauma program, MAA pays the full Medicaid Title XIX amount when care has been provided in a nongovernmental hospital designated by the department of health (DOH) as a trauma services center. MAA gives an annual grant for trauma services to governmental hospitals certified by DOH.

[Statutory Authority: RCW 74.09.080, 74.09.730, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271 and 2652. 99-14-026, § 388-550-4800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4900 Disproportionate share payments. (1) As required by section 1902 (a)(13)(A) of the Social Security Act, the medical assistance administration (MAA) gives consideration to hospitals which serve a disproportionate number of low-income clients with special needs by making a payment adjustment to eligible hospitals. MAA considers this adjustment a disproportionate share payment.

(2) MAA considers a hospital a disproportionate share hospital if both the following apply:

(a) The hospital's Medicaid inpatient utilization rate (MIPUR) is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or its low-income utilization rate (LIUR) exceeds twenty-five percent; and

(b) The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals, This requirement does not apply to a hospital:

(i) The inpatients of which are predominantly individuals under eighteen years of age; or

(ii) Which did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(3) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(4) MAA may consider a hospital a disproportionate share hospital if both of the following apply:

(a) The hospital has a MIPUR of not less than one percent; and

(b) The hospital meets the requirement of subsection (2)(b) of this section.

(5) MAA administers the low-income disproportionate share (LIDSH) program and may administer any of the:

(a) Medically indigent disproportionate share (MIDSH);

(b) General assistance-unemployable disproportionate share (GAUDSH);

(c) Small rural hospital assistance program disproportionate share (SRHAPDSH);

(d) Teaching hospital assistance program disproportionate share (THAPDSH);

(e) State teaching hospital financing program disproportionate share (STHFPDSH);

(f) County teaching hospital financing program disproportionate share (CTHFPDSH); and

(g) Public hospital district disproportionate share (PHDDSH).

(6) MAA allows a hospital to receive any one or all of the disproportionate share hospital (DSH) payment adjustments discussed in subsection (5) of this section when the hospital:

(a) Applies to MAA; and

(b) Meets the eligibility requirements for the particular DSH payment program, as discussed in WAC 388-550-5000 through 388-550-5400.

(7) MAA ensures each hospital's total DSH payments do not exceed the individual hospital's DSH limit, defined as:

(a) The cost to the hospital of providing services to Medicaid clients, including clients served under Medicaid managed care programs;

(b) Less the amount paid by the state under the non-DSH payment provision of the state plan;

(c) Plus the cost to the hospital of providing services to uninsured patients; and

(d) Less any cash payments made by uninsured clients.

(8) MAA's total annual DSH payments must not exceed the state's DSH allotment for the federal fiscal year.

If the DSH statewide allotment is exceeded, MAA recoups overpayments from hospitals in the following program order:

(a) PHDDSH;
(b) THAPDSH;
(c) CTHFPDSH;
(d) STHFPDSH;
(e) SRHAPDSH;
(f) MIDSH;
(g) GAUDSH; and
(h) LIDSH.

[Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5000 Payment method—LIDSH. (1) A hospital serving the department's clients is eligible for a low-income disproportionate share hospital (LIDSH) payment adjustment if the hospital meets the requirements of WAC 388-550-4900(2).

(2) MAA pays hospitals considered eligible under the criteria in subsection (1) of this section. The total LIDSH payment amounts equal the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(3) MAA distributes LIDSH payments to individual hospitals as follows by:

(a) For each LIDSH-eligible hospital, determining the standardized Medicaid inpatient utilization rate (MIPUR). The MIPUR is standardized by dividing the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(b) Multiples the hospital's standardized MIPUR by the hospital's most recent case mix index, and then by the hospital's most recent fiscal year Title XIX admissions, and lastly by the hospital's profitability factor. MAA then multiplies the product by an initial random base amount; then

(c) Compares the sum of all annual LIDSH payments to the appropriated amount. If the amounts differ, MAA progressively selects a new base amount by trial and error until the sum of the LIDSH payments to hospitals equals the appropriated amount.

[Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. 99-14-040, § 388-550-5000, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5100 Payment method—MIDSH. (1) MAA considers a hospital eligible for the medically indigent disproportionate share hospital (MIDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is an in-state or border area hospital;

(c) Provides services to clients under the medically indigent program; and

(d) Has a low-income utilization rate of one percent or more.

(2) MAA determines the MIDSH payment for each eligible hospital in accordance with WAC 388-550-4800.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5150 Payment method—GAUDSH. (1) MAA considers a hospital eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is an in-state or border area hospital;

(c) Provides services to clients under the medical care services program; and

(d) Has a low-income utilization rate (LIUR) of one percent or more.

(2) MAA determines the GAUDSH payment for each eligible hospital in accordance with WAC 388-550-4800, except that the payment is not reduced by the additional three percent specified in WAC 388-550-4800(4).

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5150, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5200 Payment method—SRHAPDSH. (1) MAA considers a hospital eligible for the small rural hospital assistance program disproportionate share hospital (SRHAPDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is an in-state hospital;

(c) Is a small, rural hospital, defined as a hospital with fewer than seventy-five licensed beds and located in a city or town with a nonstudent population of thirteen thousand or less; and

(d) Provides at least one percent of its services to low-income patients in rural areas of the state.

(2)(a) MAA pays hospitals qualifying for SRHAPDSH payments from a legislatively appropriated pool.

(b) MAA determines each individual hospital's SRHAPDSH payment as follows: The total dollars in the pool will be multiplied by the percentage derived from dividing the Medicaid payments to the individual hospital during the fiscal year that is two years previous to the state fiscal year immediately preceded by the total Medicaid payments to all SRHAPDSH hospitals during the same hospital fiscal year.

(3) MAA's SRHAPDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured indigent patients. MAA reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5200, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5250 Payment method—THAPDSH. (1) MAA considers a hospital eligible for the teaching hospital assistance program disproportionate share hospital (THAPDSH) program if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is a Washington State University hospital; and

(c) Has a Medicaid inpatient utilization rate (MIPUR) of twenty percent or more.

(2) MAA funds THAPDSH payments with legislatively appropriated monies. MAA divides the legislatively appro-

priated THAPDSH amount equally between qualifying hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5250, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5300 Payment method—STHFPDSH. (1) MAA considers a hospital eligible for the state teaching hospital financing program disproportionate share hospital (STHFPDSH) program if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is a state-owned university or public corporation hospital (border area hospitals are excluded);

(c) Provides a major medical teaching program, defined as a program in a hospital with more than one hundred residents and/or interns; and

(d) Has a Medicaid inpatient utilization rate (MIPUR) of at least twenty percent.

(2) MAA:

(a) Pays hospitals deemed eligible under the criteria in subsection (1) of this section a STHFPDSH payment from the legislatively appropriated pool specifically designated for DSH payments to state and county teaching hospitals.

(b) Limits STHFPDSH payments to eligible hospitals to seventy percent of the legislatively appropriated pool for DSH payments to state and county teaching hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5300, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5350 Payment method—CTHFPDSH. (1) MAA considers a hospital eligible for the county teaching hospital financing program disproportionate share hospital (CTHFPDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is a county hospital in Washington state (border area hospitals are excluded), so designated by the county in which located;

(c) Provides a major medical teaching program, defined as a program in a hospital with more than one hundred residents and/or interns; and

(d) Has a low-income utilization rate (LIUR) of at least twenty-five percent.

(2) MAA:

(a) Pays hospitals considered eligible under the criteria in subsection (1) of this section a CTHFPDSH payment from the legislatively appropriated pool specifically designated for DSH payments to state and county teaching hospitals.

(b) Limits CTHFPDSH payments to eligible hospitals to thirty percent of the legislatively appropriated pool for DSH payments to state and county teaching hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5350, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5400 Payment method—PHDDSH. (1) MAA considers a hospital eligible for the public hospital district disproportionate share hospital (PHDDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is a public district hospital in Washington state or a border area hospital owned by a public corporation; and

(c) Provides at least one percent of its services to low-income patients.

(2) MAA pays hospitals considered eligible under the criteria in subsection (1) of this section a PHDDSH payment amount from the legislatively appropriated PHDDSH pool.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5400, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5500 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 388-550-5550 Public notice for changes in Medicaid payment rates for hospital services. (1) The purpose and intent of this section is to describe the manner in which the department, pertaining to Medicaid hospital rates, will comply with section 4711(a) of the federal Balanced Budget Act of 1997, Public Law 105-33, as codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For purposes of this section, the term:

(a) "Stakeholders" means providers, beneficiaries, representatives of beneficiaries, and other concerned state residents.

(b) "Rate" means the Medicaid payment amount to a provider for a particular hospital service, except for disproportionate share payments not mandated by federal law.

(c) "Methodology" underlying the establishment of a Medicaid hospital rate means (unless otherwise noted) the principles, procedures, limitations, and formulas detailed in WAC 388-550-2800 through 388-550-5500.

(d) "Justification" means an explanation of why the department is proposing or implementing a Medicaid rate

change based on a change in Medicaid rate-setting methodology.

(e) "Reasonable opportunity to review and provide written comments" means a period of fourteen calendar days in which stakeholders may provide written comments to the department.

(f) "Hospital services" means those services that are performed in a hospital facility for an inpatient client and which are payable only to the hospital entity, not to individual performing providers.

(g) "Web site" means the department's internet home page on the worldwide web: http://www.wa.gov/dshs/maa is the internet address.

(3) The department will notify stakeholders of proposed and final changes in individual Medicaid hospital rates for hospital services, as follows:

(a) Publish the proposed Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates;

(b) Give stakeholders a reasonable opportunity to review and provide written comments on the proposed Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates; and

(c) Publish the final Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates.

(4)(a) Except as otherwise provided in this section, the department will determine the manner of publication of proposed or final Medicaid hospital rates.

(b) Publication of proposed Medicaid hospital rates will occur as follows:

(i) The department will mail each provider's proposed rate to the affected provider via first-class mail at least fifteen calendar days before the proposed date for implementing the rates; and

(ii) For other stakeholders, the department will post proposed rates on the department's web site.

(c) Publication of final Medicaid hospital rates will occur as follows:

(i) The department will mail each provider's final rate to the affected provider via first-class mail at least one calendar day before implementing the rate; and

(ii) For other stakeholders, the department will post final rates on the department's web site.

(d) The publications required by subsections (4)(b) and (c) of this section will refer to the appropriate sections of chapter 388-550 WAC for information on the methodologies underlying the proposed and final rates.

(5) The department, whenever it proposes amendments to the methodologies underlying the establishment of Medicaid hospital rates as described in WAC 388-550-2800 through 388-550-5500, will adhere to the notice and comment provisions of the Administrative Procedure Act (chapter 34.05 RCW).

(6) Stakeholders who wish to receive notice of either proposed and final Medicaid hospital rates or proposed and final amendments to WAC 388-550-2800 through 388-550-5500 must notify the department in writing. The department will send notice of all such actions to such stakeholders postage prepaid by regular mail.

(7)(a) The notice and publication provisions of section 4711(a) of the Balanced Budget Act of 1997 do not apply when a rate change is:

(i) Necessary to conform to Medicare rules, methods, or levels of reimbursement for clients who are eligible for both Medicare and Medicaid;

(ii) Required by Congress, the legislature, or court order, and no further rulemaking is necessary to implement the change; or

(iii) Part of a non-Medicaid program.

(b) Although notice and publication are not required for Medicaid rate changes described in subsection (7)(a) of this section, the department will attempt to timely notify stakeholders of these rate changes.

(8) The following rules apply when the department and an individual hospital negotiate or contractually agree to Medicaid rates for hospital services:

(a) Receipt by the hospital of the contract or contract amendment form for signature constitutes notice to the hospital of proposed Medicaid rates.

(b) Receipt by the hospital of the contract or contract amendment form signed by both parties constitutes notice to the hospital of final Medicaid rates.

(c) Notwithstanding subsection (4)(c) of this section, final Medicaid contract rates are effective on the date contractually agreed to by the department and the individual hospital.

(d) Prior to the execution of the contract, the department will not publish negotiated contract prices that are agreed to between the department and an individual provider to anyone other than the individual provider. Within fifteen calendar days after the execution of any such contract, the department will publish the negotiated contract prices on its web site.

(9) The following rules apply when a hospital provider or other stakeholder wishes to challenge the adequacy of the public notification process followed by the department in proposing or implementing a change to Medicaid hospital rates, the methodologies underlying the establishment of such rates, or the justification for such rates:

(a) If any such challenge is limited solely to the adequacy of the public notification process, then the challenge will:

(i) Not be pursued in any administrative appeal or dispute resolution procedure established in rule by the department; and

(ii) Be pursued only in a court of proper jurisdiction as may be provided by law.

(b) If a hospital provider brings any such challenge in conjunction with an appeal of its Medicaid rate, then the hospital provider may pursue the challenge in an administrative appeal or dispute resolution procedure established in rule by the department under which hospital providers may appeal their Medicaid rates.

[Statutory Authority: RCW 74.09.500 and 42 USC 1396a (a)(13)(A). 98-23-036, § 388-550-5550, filed 11/10/98, effective 12/11/98.]

WAC 388-550-5600 Administrative appeal for hospital rate reimbursement. The hospital appeals and dispute process follows the procedures as stated in WAC 388-502-

0220, Administrative appeal for contractor/provider rate reimbursement.

[Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-550-5600, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5700 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) Excluding nonallowable revenue codes and the services specified in subsection (2) below MAA determines allowable costs for hospital outpatient services by the application of the hospital-specific outpatient ratio of costs to charges (RCC).

(b) MAA does not pay separately for ancillary hospital services which are included in the hospital's RCC reimbursement rate.

(2) MAA pays the lesser of billed charges or MAA's published maximum allowable fees for the following outpatient services:

(a) Laboratory/pathology;

(b) Radiology, diagnostic and therapeutic;

(c) Nuclear medicine;

(d) Computerized tomography scans, magnetic resonance imaging, and other imaging services;

(e) Physical therapy;

(f) Occupational therapy;

(g) Speech/language therapy; and

(h) Other hospital services as identified and published by the department.

(3) MAA is not responsible for payment of hospital care and/or services provided to a client enrolled in a MAA-contracted, prepaid medical plan when the client fails to use:

(a) For a nonemergent condition, a hospital provider under contract with the plan;

(b) In a bona fide emergent situation, a hospital provider under contract with the plan; or

(c) The provider whom MAA has authorized to provide and receive payment for a service not covered by the prepaid plan, but covered under the client's medical assistance program.

(4) Providers or managed care entities that charge Medicare beneficiaries excess amounts are subject to sanctions as listed in 42 U.S.C. 1320A-7b (d)(1). These sanctions include

a fine of up to twenty-five thousand dollars or imprisonment of up to five years, or both.

(5) MAA considers a hospital stay of twenty-four hours or less as an outpatient short stay. MAA does not pay an outpatient short stay under the DRG system except when it involves one of the following situations:

(a) Death of a client;

(b) Obstetrical delivery;

(c) Initial care of a newborn; or

(d) Transfer of a client to another acute care hospital.

(6) MAA does not pay for patient room and ancillary services charges beyond the twenty-four period for outpatient stays.

(7) MAA does not cover short stay unit, emergency room facility, and labor room charges in combination when these billing periods overlap.

(8) MAA requires that the hospital's bill to the department shows the admitting, principal, and secondary diagnoses. Include the attending physician's name and MAA provider number.

(9) Payments for trauma services may be enhanced per WAC 246-976-935.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v), 42 C.F.R. 447.271 and 42 C.F.R. 11303. 99-14-028, § 388-550-6000, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-6000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

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.

(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. 01-02-075, § 388-550-6700, filed 12/29/00, effective 1/29/01. 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.]

Chapter 388-551 WAC
ALTERNATIVES TO HOSPITAL SERVICES

WAC

SUBCHAPTER I—HOSPICE SERVICES

Hospice—General

WAC 388-551-1000 Hospice program. (1) Hospice is a twenty-four hour program coordinated by a **hospice interdisciplinary team**. The hospice program allows the **terminally ill** client to choose physical, pastoral/spiritual, and psychosocial comfort rather than cure. Hospitalization is used only for acute symptom management.

(2) Hospice care is initiated by the choice of client, **family**, or physician. The client's physician must certify a client as appropriate for hospice care.

(3) Hospice care may be in a client's temporary or permanent place of **residence**.

(4) Hospice care is ended by the client or family (**revocation**), the hospice agency (**discharge**), or death.

(5) Bereavement care is provided to the **family** of the client who chooses hospice care. It provides emotional and spiritual comfort associated with the death of a hospice client.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1000, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1010 Hospice definitions. The following definitions and those found in WAC 388-500-0005, Medical definitions have the following meanings for this subchapter. Defined words and phrases are bolded in the text.

"Biologicals" means medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

"Brief period" means six days or less.

"CSO" means the client's community services office of the department's economic services administration.

"Discharge" means an agency ends hospice care for a client. See WAC 388-551-1350 for details.

"Election period" means the time, ninety or sixty days, that the client is certified as eligible for and chooses to receive hospice care. See WAC 388-551-1310 for details.

"Family" means any person(s) important to the client, as defined by the client.

"HCS" means the client's home and community services office of the aging and adult services administration.

"Hospice interdisciplinary team" means the following health professionals who plan and deliver hospice care to a client as appropriate under the direction of a certified physician: home health aides monitored by a registered nurse, therapists (physical, occupational, speech-language), registered nurses, physicians, social workers, counselors, volunteers, and others as necessary.

"Palliative" means medical treatment designed to reduce pain or increase comfort, rather than cure.

"Plan of care." See WAC 388-551-1320 for details.

"Residence" means where the client lives for an extended period of time.

"Revoke" and **"revocation"** mean a client or family member's choice to stop receiving hospice care. See WAC 388-551-1220 for details.

"Terminally ill" means the client has a life expectancy of six months or less, assuming the client's disease process runs its natural course.

"Twenty-four-hour day" means a day beginning and ending at midnight.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1010, filed 4/9/99, effective 5/10/99.]

Hospice—Coverage

WAC 388-551-1200 Client eligibility for hospice care. (1) A client must be eligible for one of the following Medicaid programs to receive hospice care:

(a) Categorically needy program (CNP);

(b) General assistance — disability determination pending (GAX);

(c) Limited casualty program - medically needy program (LCP-MNP); or

(d) Children's health (V).

(2) An eligible Medicaid client who voluntarily chooses hospice care must be certified by a physician as **terminally ill**before MAA pays for hospice care.

(3) Clients enrolled in one of MAA's healthy options managed care plans receive all hospice services directly through their plan. The managed care plan must arrange or provide all hospice services for a managed care client.

(4) Hospice clients attain institutional status as described in WAC 388-513-1320 when they elect and are certified for hospice care. See WAC 388-513-1380 for the client's financial participation requirements.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1200, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1210 Services included in the hospice daily rate. (1) In the client's individual **plan of care**, the **hospice interdisciplinary team** identifies the specific Hospice services and supplies to be provided to the client.

(2) The services must be all of the following:

(a) Medically necessary for **palliative** care;

(b) Related to the client's **terminal illness**;

(c) Prescribed by the client's attending physician, alternate physician, or hospice medical director;

(d) Supplied or arranged for by the hospice provider; and

(e) Included in the client's **plan of care**.

(3) The following intermittent services and supplies, paid by MAA's hospice daily rate, must be available from and offered by the hospice provider for the client as determined by the client's **hospice interdisciplinary team**:

(a) **Medical equipment and supplies** that are medically necessary for **palliative** care;

(b) **Drugs and biologicals** used primarily for the relief of pain and management of symptoms;

(c) **Home health aide services** furnished by qualified aides of the hospice agency. A registered nurse must complete a home-site supervisory visit every two weeks to assess aide services provided;

(d) **Physical therapy, occupational therapy, and speech-language therapy** to manage symptoms or enable the client to safely perform ADLs (activities of daily living) and basic functional skills;

(e) **Physician services** related to administration of the **plan of care**;

(f) **Nursing care** provided through the hospice agency by either:

(i) A registered nurse; or

(ii) A licensed practical nurse under the supervision of a registered nurse;

(g) **Medical social services** provided through the hospice agency by a social worker under the direction of a physician;

(h) **Counseling services** provided through the hospice agency to the client and his or her **family** members or caregivers;

(i) **Medical transportation services**; and

(j) **Short-term, inpatient care,** provided in a Medicare-certified hospice inpatient unit, hospital, or nursing facility.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1210, filed 4/9/99, effective 5/10/99.]

Hospice—Provider Requirements

WAC 388-551-1300 How to become a MAA hospice provider. (1) To be reimbursed by MAA, a hospice agency must be:

(a) Medicare, Title XVIII certified; and

(b) Enrolled with MAA as a provider of hospice care.

(2) All services provided through a hospice agency must be performed by qualified personnel as required through Medicare's certification process in effect as of February 1, 1999. For more information on Medicare certifications, contact:

Department of Health
Hospice Certification Program
Mailstop 47852
Olympia, Washington, 98504-7852.

(3) Freestanding hospice agencies licensed as hospitals by the department of health must sign an additional selective contract with MAA to receive payment from MAA.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1300, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1310 Certifications (election periods) for hospice clients. A client chooses to receive Hospice care through a series of time-limited periods, called **"election periods."** An example of this process is WAC 388-551-1315. Hospice providers are responsible for obtaining physician certifications for these **election periods**.

(1) A client's hospice coverage must be available for two initial ninety-day **election periods** followed by an unlimited number of succeeding sixty-day **election periods**.

(2) The hospice provider must document the client's medical prognosis of a specific **terminal illness** in the client's hospice record. This written certification must be filed in the client's hospice record for each election period. The certification must meet all of the following criteria:

(a) For the **initial election period**, signatures of the hospice medical director and the client's attending physician; and

(b) For **subsequent election periods**:

(i) Signature of the hospice medical director; and

(ii) Verbal certifications by the hospice medical director or the client's attending physician must be documented in writing no later than two calendar days after hospice care is initiated or renewed.

(3) The provider must file election statements in the client's hospice medical record. This election statement must include:

(a) Name and address of the hospice;

(b) Proof that client was fully informed about hospice care and waiver of other services;

(c) Effective date of the election; and

(d) Signature of the client or their representative.

(4) When a client's hospice coverage ends within an **election period**, the remainder of that **election period** is forfeited.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1310, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1315 Example of how hospice client certifications (election periods) work. This is an **example** of how election periods, as described in WAC 388-551-1310, work:

(1) Client chooses hospice care, physician certifies the client;

(2) Client is on hospice care for the first ninety-day period;

(3) Physician recertifies the client for the second ninety-day period;

(4) Client revokes hospice care, on the sixty-third day of the second ninety-day period (one hundred and fifty-three days since original certification);

(5) Hospice care for the client stops on the sixty-third day of the second ninety-day period (one hundred and fifty-three days since original certification);

(6) Client decides to re-elect hospice care, eleven days later, the seventy-fourth day of the second ninety-day period (the one hundred and sixty-fourth day since original certification);

(7) Client forfeits the right to the remaining sixteen days of the second ninety-day period; and

(8) Does the physician re-certify the client for hospice care?:

(a) If yes, the client may immediately begin a new sixty-day election period; or

(b) If no, the client is not currently eligible to receive hospice care.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1315, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1320 Hospice plan of care. (1) The hospice agency must establish the client's hospice **plan of care** in accordance with Medicare requirements before hospice services are delivered. Hospice services delivered must be consistent with that **plan of care**.

(2) A registered nurse or physician must conduct an initial assessment of the client and must develop the **plan of care** with at least one other member of the **hospice interdisciplinary team**.

(3) The **hospice interdisciplinary team** must review in a case planning conference the **plan of care**, no later than two working days after it is developed.

(4) The **plan of care** must be reviewed and updated every two weeks by at least three members of the **hospice interdisciplinary team**, including at least:

(a) A registered nurse;

(b) A social worker; and

(c) One other **hospice interdisciplinary team** member.

(5) Also see WAC 246-331-135 for the department of health's plan of care requirements.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1320, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1330 Hospice coordination of care. (1) Once a client chooses hospice care from a hospice agency, that client gives up the right to:

(a) Covered Medicaid hospice services and supplies received at the same time from another hospice agency; and

(b) Any covered Medicaid services and supplies received from any other provider and which are related to the **terminal illness**.

(2) Services and supplies not covered by the Medicaid hospice benefit are paid separately, if covered under the client's Medicaid eligibility. These services include but are not limited to:

(a) COPES (community options program entry system) as determined and paid by the department's aging and adult services administration (AASA); and

(b) Medically intensive home care program (MIHCP) as determined by the department's division of developmentally disabled.

(3) Clients eligible for coordinated community aids services alternatives (CCASA) are not eligible for hospice coverage.

(4) The hospice provider must coordinate all the client's medical management for the **terminal illness**.

(5) All of the client's providers, including the hospice provider, must coordinate:

(a) The client's health care; and

(b) Services available from other department programs, such as COPES.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1330, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1340 When a client leaves hospice without notice. When a client chooses to leave hospice care or refuses hospice care without giving the hospice provider a **revocation** statement, as required by WAC 388-551-1360, the hospice provider must do all of the following:

(1) Notify MAA's hospice coordinator within **five working days** of becoming aware of the client's decision (see WAC 388-551-1400 for further requirements);

(2) Stop billing MAA for hospice payment;

(3) Notify the client, or the client's representative, that the client's **discharge** has been reported to MAA; and

(4) Document the effective date and details of the **discharge**in the client's hospice record.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1340, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1350 Discharges from hospice care. A hospice provider may **discharge** a client from hospice care when the client:

(1) Is no longer certified for hospice care;

(2) Is no longer appropriate for hospice care; or

(3) Seeks treatment for the **terminal illness** from outside the **plan of care** as defined by the **hospice interdisciplinary team**.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1350, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1360 Ending hospice care (revocations). (1) A client or a **family** member may choose to stop hospice care at any time by signing a **revocation** statement.

(2) The **revocation** statement documents the client's choice to stop Medicaid Hospice care. The **revocation** statement must include all of the following:

(a) Client's signature;

(b) Date the **revocation** was signed; and

(c) Actual date that the client chose to stop receiving hospice care.

(3) The hospice agency must keep any explanation supporting any difference in the signature and **revocation** dates in the client's hospice records.

(4) The hospice agency must keep the **revocation** statement in the client's hospice record.

(5) After a client **revokes** hospice care, the remaining days on the current **election period** are forfeited. The client may enter the next consecutive **election period** immediately. The client does not have to wait for the forfeited days to pass before entering the next consecutive **election period**.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1360, filed 4/9/99, effective 5/10/99.]

Hospice—Notification

WAC 388-551-1400 Hospice providers must notify the department. (1) Notification within five working days avoids duplicative payments for services related to a client's terminal illness. Hospice providers must notify the MAA hospice coordinator, and either the client's CSO or HCS as appropriate.

(2) Hospice providers must report any changes in the client's hospice status within **five working days** from when a MAA client:

(a) Begins the first day of hospice care;

(b) Changes hospice agencies. Clients may change hospice agencies only once per election period. Both the old and new hospice providers must supply the department as described in subsection (1) of this section with:

(i) The effective date of **discharge** from the old agency; and

(ii) The effective date of the admit to, the name of, and the provider number of the new agency;

(c) **Revokes** the hospice benefit (home or institutional);

(d) **Discharges** from hospice care;

(e) Becomes an institutional facility resident;

(f) Leaves an institutional facility as a resident; or

(g) Dies.

(3) A hospice agency must submit a client's assessment to MAA within five working days of MAA's request for that assessment.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1400, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1410 Hospice providers must notify institutional providers. Hospice providers must notify a client's institutional provider of the changes described in WAC 388-551-1400.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1410, filed 4/9/99, effective 5/10/99.]

Hospice—Payment

WAC 388-551-1500 Availability requirements for hospice care. All services related to the client's **terminal illness** are included in the daily rate through one of the following four levels of hospice care:

(1) **Routine care** for each day the client is at their **residence**, with no restriction on length or frequency of visits, dependent on the client's needs.

(2) **Continuous care** is acute episodic care received by the client to maintain the client at home and addresses a **brief** period of medical crisis. Continuous care consists predominately of nursing care. This benefit is limited to:

(a) A minimum of eight hours of care provided during a **twenty-four-hour day**;

(b) Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care; and

(c) Homemaker, home health aide, and attendant services that may be provided as supplements to the nursing care.

(3) **Inpatient respite care** is care received in an approved nursing facility or hospital to relieve the primary caregiver. This benefit is limited to:

(a) No more than five consecutive days; and

(b) A client not residing in a nursing facility.

(4) **General inpatient hospice care** is for pain and symptom management that cannot be provided in other settings.

(a) The services must conform to the client's written **plan of care**.

(b) This benefit is limited to **brief** periods of care in MAA-approved:

(i) Hospitals;

(ii) Nursing facilities; or

(iii) Hospice inpatient facilities.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1500, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1510 Payment method for hospice providers. This section describes payment methods for Hospice care provided under WAC 388-551-1500 to hospice clients.

(1) Prior to submitting a claim to MAA, the hospice provider must file written certification in the client's hospice record per WAC 388-551-1310.

(2) MAA may pay for Hospice care provided to clients in one of the following settings:

(a) A client's **residence**;

(b) Inpatient respite services; or

(c) General inpatient as follows:

DAY OF	PAID AT
Admit	General Inpatient
Brief Period	General Inpatient
Death	General Inpatient
Other Discharge	Routine

(3) To be paid by MAA, the hospice provider must provide and/or coordinate MAA covered:

(a) Medicaid hospice services; and

(b) Services that relate to the client's **terminal illness** at the time of the hospice admit.

(4) MAA does not pay hospice providers for the client's last day, except for the day of death.

(5) Hospice providers must bill MAA for their services using hospice-specific revenue codes.

(6) MAA pays hospice providers for services (not room and board) at a daily rate calculated by one of the following methods and adjusted for current wages:

(a) Payments for services delivered in a client's **residence** (routine and continuous home care) are based on the county location of the client's residence for that particular client; or

(b) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(7) MAA pays nursing facility room and board payments to hospice agencies, not licensed as hospitals, at a day rate as follows:

(a) Directly to the hospice provider at ninety-five percent of the nursing facility's lowest current Medicaid day rate;

(b) The hospice agency pays the nursing facility at a day rate no greater than the nursing facility's lowest current Medicaid daily rate; and

(c) The correct amount of the patient's participation must be:

(i) Collected by the hospice agency as directed by the department each month; and

(ii) Forwarded to the nursing facility.

(8) MAA pays nursing facility room and board payments to free-standing hospice agencies licensed as hospitals by using MAA's administrative statewide average day rate in effect at the time the contract is signed.

(9) The department pays for COPES services clients directly to the COPES provider.

(a) Patient participation in that case is paid separately to the COPES provider.

(b) Hospice providers bill MAA directly for hospice services, not the COPES program.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1510, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1520 Payment method for nonhospice providers. (1) Hospitals which provide inpatient care to cli-

ents in the hospice program for medical conditions not related to their **terminal illness** may be paid according to chapter 388-550 WAC, Hospital services.

(2) MAA pays attending physicians who are not employed by the hospice agency at their usual amount through the resource based relative value scale (RBRVS) fee schedule:

(a) For direct physician care services provided to a hospice client;

(b) When the provided services are not related to the **terminal illness**; and

(c) When the client's providers, including hospice provider, coordinate the health care provided.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1520, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1530 Payment method for Medicaid-Medicare dual eligible clients. (1) MAA does not pay for any hospice care provided to a client covered by part A Medicare (hospital insurance).

(2) MAA may pay for hospice care provided to a client:

(a) Covered by part B Medicaid (medical insurance); and

(b) Not covered by part A Medicare.

(3) Hospice providers must bill Medicare before billing Medicaid, except for hospice nursing facility room and board.

(4) All the limitations and requirements related to hospice care described in this chapter apply to the payments described in this section.

[Statutory Authority: RCW 74.09.520 and 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1530, filed 4/9/99, effective 5/10/99.]

SUBCHAPTER II—HOME HEALTH SERVICES

WAC 388-551-2000 Home health services—General. The purpose of the medical assistance administration (MAA) home health program is to reduce the costs of health care services by providing equally effective, more conservative, and/or less costly treatment in a client's home.

Home health services consist of skilled nursing and **specialized therapies** provided in a client's **residence**. Home health aide services may be provided in addition to these services. The client must be **homebound**, as determined by documentation submitted to MAA during the client's focused program review period. Services provided are for acute, intermittent, short term, and intensive courses of treatment. See chapter 388-515 WAC for clients needing chronic, long-term maintenance care.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2000, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2010 Home health—Definitions. Words and abbreviations in bold have the following definitions for this chapter. See also chapter 388-500 WAC for other definitions and abbreviations used by the department.

"Home health agency" means an agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"Home health services" mean skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on a part-time or intermittent basis by a Title XVIII Medicare and Title XIX Medicaid home health provider. See also WAC 388-551-2000.

"Homebound" means a physician has certified that the client is medically or physically confined to the home, and under normal circumstances, lacks the ability to leave home without a considerable and taxing effort. The client may be considered homebound if absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment.

"Plan of treatment (POT)" (also known as **"plan of care (POC)"**) means a written plan of treatment that is established and periodically reviewed and signed by both a physician and a home health agency provider, that describes the home health care to be provided at the client's **residence**. See WAC 388-551-2210.

"Residence" means a client's home or place of living not including a hospital, skilled nursing facility, or residential facility with skilled nursing services available.

"Specialized therapy" means skilled therapy services provided to **homebound** clients which includes:

(1) Physical;

(2) Occupational; or

(3) Speech/audiology services.

See WAC 388-551-2110.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2010, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2020 Home health services—Eligible clients. (1) Clients in the following MAA programs are eligible to receive **home health services** subject to the limitations described in this chapter. Chapter 388-551 WAC does not apply to clients enrolled in MAA's managed care plans.

(a) Categorically needy program (CNP);

(b) Limited casualty program - medically needy program (LCP-MNP);

(c) General assistance expedited (GA-X) (disability determination pending); and

(d) Medical care services (MCS) programs:

(i) General assistance - unemployable (GA-U); and

(ii) Alcoholism and drug addiction treatment and support act (ADATSA) (GA-W).

(2) Clients in the following emergency-only MAA programs are eligible to receive **home health services** subject to the limitations described in this chapter. Coverage is also limited to two skilled nursing visits per eligibility enrollment period. **Specialized therapy** services and home health aide visits are not covered:

(a) Categorically needy program (CNP) - emergency-only.

(b) Limited casualty program - medically needy program (LCP-MNP)-emergency only.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2020, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2100 Covered home health services—Nursing. (1) Skilled nursing services involve observation,

assessment, treatment, teaching, training, management and/or evaluation requiring the skills of:

(a) A registered nurse; or

(b) A licensed practical nurse under the supervision of a registered nurse.

(2) MAA may pay for up to two skilled nursing visits per day. See WAC 388-551-2220 (3), (4) and (5).

(3) Coverage for home health nursing services is limited to **homebound** clients, except as listed in subsection (4) of this section.

(4) MAA covers home health nursing services for non-homebound clients on a limited basis only when the client is unable to access similar services in a less costly setting, as documented by the provider and approved by MAA.

(5) A brief skilled nursing visit occurs when only one of the following activities is performed during a visit:

(a) An injection or blood draw;

(b) Placement of oral medications in containers (e.g., envelopes, cups, medisets); or

(c) A prefill of insulin syringes.

(6) MAA may cover brief skilled nursing visits for a client with chronic needs, for a short time, until a long term care plan is implemented.

(7) MAA limits services provided to a client enrolled in either of the emergency medical programs listed in WAC 388-551-2020 (2)(a) and (b), to two skilled nursing visits within their eligibility enrollment period.

(8) To receive infusion therapy clients must:

(a) Be willing and capable of learning and managing their infusion care; or

(b) Have a caregiver willing and capable of learning and managing the client's infusion care.

(9) MAA covers infant phototherapy:

(a) For up to five skilled nursing visits per infant;

(b) When provided by a Medicaid approved infant phototherapy agency; and

(c) When the infant is diagnosed with hyperbilirubinemia.

(10) MAA covers limited high risk obstetrical services:

(a) For a medical condition that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;

(b) During the span of home health agency services, if enrollment in or referral to the following providers of First Steps has been verified:

(i) Maternity support services (MSS); or

(ii) Maternity case management (MCM);

(c) When provided by a registered nurse who has either:

(i) National prenatal certification; or

(ii) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years; and

(d) For up to three home health visits per pregnancy.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2100, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2110 Covered home health services—Specialized therapy. (1) MAA may pay for up to one specialized therapy visit per day, per type of specialized therapy.

(2) To receive specialized therapy services, a client must be homebound.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2110, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2120 Home health services—Aides. (1) MAA may pay for up to one home health aide visit per day.

(2) MAA pays for home health aide services only when the services are provided under the supervision of and in conjunction with:

(a) Skilled nursing services; or

(b) Specialized therapy services.

(3) MAA covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2120, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2130 Home health services—Noncovered. (1) MAA does not cover the following **home health services** and expenses:

(a) Medical social work services;

(b) Psychiatric skilled nursing services;

(c) Pre- and postnatal skilled nursing services except as listed under WAC 388-551-2100(10);

(d) Additional administrative costs billed above the visit rate (these costs are included in the visit rate and may not be billed separately);

(e) Well baby follow-up care;

(f) Services performed in hospitals, correctional facilities, skilled nursing facilities or a residential facility with skilled nursing services available;

(g) Home health aide services that are not provided in conjunction with skilled nursing or **specialized therapy** services;

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change);

(i) Home health **specialized therapies** and home health aide visits for clients in the following programs:

(i) CNP - emergency medical only; and

(ii) LCP-MNP - emergency medical only;

(j) Skilled nursing visits for a client when a **home health agency** cannot safely meet the medical needs of that client within **home health services** program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care);

(k) More than one of the same type of specialized therapy and/or home health aide visit per day;

(l) Home health visits made without a written physician order unless the verbal order is:

(i) Written prior to or on the date of the visit; and

(ii) Signed by the physician within forty-five days.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2130, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2200 Home health services—Eligible providers. A home health provider may contract with MAA

to be a Medicaid provider if the provider is Title XVIII (Medicare) certified and licensed by the state as a **home health agency**. Providers must have an active Medicaid provider number to bill MAA.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2200, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2210 Home health providers—Requirements. For any delivered **home health service** to be payable, MAA requires home health providers to develop and implement an individualized **plan of treatment (POT)** for the client.

(1) The **POT** must:

(a) Be documented in writing and be located in the client's home health medical record;

(b) Be developed and supervised by a licensed registered nurse or licensed therapist;

(c) Reflect the physician's orders and client's current health status;

(d) Be reviewed and revised by a physician at least every sixty-two calendar days and signed by a physician within forty-five days of the verbal order;

(e) Contain specific goals and treatment plans; and

(f) Be available to department staff or its designated contractor(s) on request.

(2) The provider must include in the **POT** all of the following:

(a) The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for **home health services**);

(b) The medical diagnoses and prognosis, including date(s) of onset or exacerbation;

(c) A discharge plan;

(d) The type(s) of equipment required;

(e) A description of each planned service and goals related to the services provided;

(f) Specific procedures and modalities;

(g) A description of the client's mental status;

(h) Rehabilitation potential;

(i) A list of permitted activities;

(j) A list of safety measures taken on behalf of the client; and

(k) A list of medications which indicates:

(i) Any new prescription prescribed; and

(ii) Which medications are changed for dosage or route of administration.

(3) The provider must include in or attach to the **POT**:

(a) A description of the client's functional limits and the effects;

(b) Significant clinical findings;

(c) Dates of recent hospitalization; and

(d) If the client is not **homebound**, a description of why **home health services** are necessary. The description must include:

(i) A written statement noting coordination with, or referral to, the client's department of social and health services-assigned case manager; or

(ii) An assessment of the client and the client's access to community resources, including attempts to use appropriate alternatives to meet the client's home health needs.

(4) The individual client medical record must comply with community standards of practice, and must include documentation of:

(a) Supervisory visits for home health aide services per WAC 388-551-2120(3);

(b) All medications administered and treatments provided;

(c) All physician orders and change orders, with notation that the order was received prior to treatment;

(d) Signed physician new orders and change orders;

(e) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;

(f) Interdisciplinary team communications;

(g) Inter-agency and intra-agency referrals;

(h) Medical tests and results; and

(i) Pertinent medical history.

(5) The provider must document at least the following in the client's medical record:

(a) Skilled interventions per the **POT**;

(b) Any clinical change in client status;

(c) Follow-up interventions specific to a change in status with significant clinical findings; and

(d) Any communications with the attending physician.

(6) The provider must include the following documentation in the client's visit notes when appropriate:

(a) Any teaching, assessment, management, evaluation, patient compliance, and client response;

(b) Weekly documentation of wound care, size, drainage, color, odor, and identification of potential complications and interventions provided; and

(c) The client's physical system assessment as identified in the **POT**.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2210, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2220 Home health providers—Payments. (1) Payment to home health providers is:

(a) A set visit rate for each discipline provided to a client;

(b) Based on the county location of the providing **home health agency**; and

(c) Updated by general vendor rate changes.

(2) For clients eligible for Medicaid and Medicare, MAA may pay for services described in this chapter only when Medicare does not cover those services. The maximum payment for each service is Medicaid's maximum payment.

(3) Providers must submit documentation to the department during any MAA focused program review period. Documentation includes, but is not limited to, the requirements listed in WAC 388-551-2210.

(4) After MAA receives the documentation, MAA's medical director or designee reviews the client's medical records for program compliance and quality of care.

(5) MAA may take back payment for any insufficiently documented home health care service when the MAA medical director or designee determines that:

(a) The service was not medically necessary (defined in WAC 388-500-0005) or reasonable;

(b) Clients were able to receive care outside of the home (see definition of **homebound** in this chapter and WAC 388-551-2100(3)); or

(c) The service was not in compliance with program policy.

(6) Covered **home health services** for clients enrolled in a Healthy Options managed care plan are paid for by that plan.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2220, filed 8/2/99, effective 9/2/99.]

Chapter 388-552 WAC
OXYGEN AND RESPIRATORY THERAPY

WAC

WAC 388-552-001 Scope. (1) This chapter applies to:

(a) Medical assistance administration (MAA) clients who require medically necessary **oxygen** and/or respiratory therapy equipment, supplies, and services in their homes and nursing facilities; and

(b) Providers who furnish **oxygen** and respiratory therapy equipment, supplies and services to eligible MAA clients.

(2) Instructions for clients covered by Medicare are located in Medicare's Durable Medical Equipment Regional Carrier (DMERC) Manual.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-001, filed 6/9/99, effective 7/10/99.]

WAC 388-552-005 Definitions. The following definitions and those in WAC 388-500-0005 apply to this chapter. If a definition in WAC 388-500-0005 differs with the definition in this section, the definition in this section applies. Defined words and phrases are bolded in the text.

"Authorized prescriber" means a health care practitioner authorized by law or rule in the state of Washington to prescribe oxygen and respiratory therapy equipment, supplies, and services.

"Base year," as used in this chapter, means the year in which the oxygen and respiratory therapy billing instructions' current fee schedule is adopted.

"Maximum allowable" means the maximum dollar amount MAA reimburses a provider for a specific service, supply, or piece of equipment.

"Oxygen" means United States Pure (USP) medical grade liquid or gaseous oxygen.

"Oxygen and respiratory therapy billing instructions" means a booklet containing procedures for billing, which is available by writing to Medical Assistance Administration, Division of Program Support, PO Box 45562, Olympia, WA, 98504-5562.

"Oxygen system" means all equipment necessary to provide oxygen to a person.

"Portable system" means a small system which allows the client to be independent of the stationary system for several hours, thereby providing mobility outside of the residence.

"Provider" means a person or company with a signed core provider agreement with MAA to furnish **oxygen** and respiratory therapy equipment, supplies, and services to eligible MAA clients.

"Respiratory care practitioner" means a person certified by the department of health according to chapter 18.89 RCW and chapter 246-928 WAC.

"Stationary system" means equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-005, filed 6/9/99, effective 7/10/99.]

CLIENT ELIGIBILITY

WAC 388-552-100 Client eligibility. (1) All MAA fee-for-service clients are eligible for **oxygen** and respiratory therapy equipment, supplies, and services when medically necessary, with the following limitations:

(a) Clients on the medically indigent program are not eligible under this chapter; and

(b) Clients on the categorically needy/qualified Medicare beneficiaries and medically needy/qualified Medicare beneficiaries programs are covered by Medicare and Medicaid as follows:

(i) If Medicare covers the service, MAA will pay the lesser of:

(A) The full co-insurance and deductible amounts due, based upon Medicaid's allowed amount; or

(B) MAA's **maximum allowable** for that service minus the amount paid by Medicare.

(ii) If Medicare does not cover or denies equipment, supplies, or services that MAA covers according to this chapter, MAA reimburses at MAA's **maximum allowable**; except,

MAA does not reimburse for clients on the qualified Medicare beneficiaries (QMB) only program.

(2) Services for clients enrolled in a healthy options managed care plan receive all **oxygen** and respiratory therapy equipment, supplies, and services through their designated plan, subject to the plan's coverages and limitations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-100, filed 6/9/99, effective 7/10/99.]

PROVIDERS

WAC 388-552-200 Providers—General responsibilities. (1) The provider must verify that the client's original prescription is signed and dated by the **authorized prescriber** no more than ninety days prior to the initial date of service. The prescription must include, at a minimum:

(a) The client's medical diagnosis, prognosis, and documentation of the medical necessity for **oxygen** and/or respiratory therapy equipment, supplies, and/or services, and any modifications;

(b) If **oxygen** is prescribed:

(i) Flow rate of **oxygen**;

(ii) Estimated duration of need;

(iii) Frequency and duration of **oxygen** use; and

(iv) Lab values or **oxygen** saturation measurements upon the client's discharge from the hospital.

(2) The provider must provide instructions to the client and/or caregiver on the safe and proper use of equipment provided.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-200, filed 6/9/99, effective 7/10/99.]

WAC 388-552-210 Required records. (1) A provider must maintain legible, accurate, and complete charts and records for each client. These records must support and justify claims that the provider submits to MAA for reimbursement. Records must include, at a minimum the:

(a) Date(s) of service;

(b) Client's name and date of birth;

(c) Name and title of person performing the service, when it is someone other than the billing practitioner;

(d) Chief complaint or reason for each visit;

(e) Pertinent medical history;

(f) Pertinent findings on examination;

(g) **Oxygen**, equipment, supplies, and/or services prescribed or provided;

(h) The original and subsequent prescriptions according to the requirements in WAC 388-552-200 and 388-552-220;

(i) Description of treatment (when applicable);

(j) Recommendations for additional treatments, procedures, or consultations;

(k) X-rays, tests, and results;

(l) Plan of treatment/care/outcome;

(m) Logs of oxygen saturations and lab values taken to substantiate the medical necessity of continuous **oxygen**, as required by WAC 388-552-220;

(n) Logs of oximetry readings if required by WAC 388-552-380 for a client seventeen years of age or younger; and

(o) Recommendations and evaluations if required by WAC 388-552-230 for the infant apnea monitor program.

(2) The provider must make required charts and records available to DSHS or its contractor(s) upon request.

(3) MAA may require additional information in order to process a submitted claim.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-210, filed 6/9/99, effective 7/10/99.]

WAC 388-552-220 Requirements for oxygen providers. Oxygen providers must:

(1) Obtain a renewed prescription every six months if the client's condition warrants continued service;

(2) Verify, at least every six months, that **oxygen** saturations or lab values substantiate the need for continued **oxygen** use for each client. The provider may perform the **oxygen**-saturation measurements. MAA does not accept lifetime certificates of medical need (CMNs).

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-220, filed 6/9/99, effective 7/10/99.]

WAC 388-552-230 Requirements for infant apnea monitors. (1) MAA does not reimburse for apnea monitors unless the provider has a respiratory care practitioner or registered nurse with expertise in pediatric respiratory care who is responsible for their apnea monitor program.

(2) MAA does not require a confirming second opinion for the initial rental period for diagnoses of apnea of prematurity, primary apnea, obstructed airway, or congenital conditions associated with apnea. For other diagnoses, a neonatologist's confirming assessment and recommendation must be maintained as a second opinion in the client's file. The initial rental period must not exceed six months.

(3) Regardless of diagnosis, the provider must maintain in the client's file, a neonatologist's clinical evaluation justifying each subsequent rental period.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-230, filed 6/9/99, effective 7/10/99.]

WAC 388-552-240 Requirements for respiratory care practitioners. (1) A respiratory care practitioner must comply with chapter 18.89 RCW and chapter 246-928 WAC to qualify for reimbursement.

(2) A respiratory care practitioner must complete at least the following in each client visit:

(a) Check equipment and ensure equipment settings continue to meet the client's needs; and

(b) Communicate with the client's physician if there are any concerns or recommendations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-240, filed 6/9/99, effective 7/10/99.]

COVERAGE

WAC 388-552-300 Coverage. (1) MAA covers medically necessary oxygen and respiratory therapy equipment, supplies, and services subject to the limitations in this chapter. MAA approves additional oxygen and respiratory ther-

apy equipment, supplies, and services on a case-by-case basis if medically necessary.

(2) MAA does not reimburse for a service or product if any of the following apply:

(a) The service or product is not covered by MAA;

(b) The service or product is not medically necessary;

(c) The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or

(d) The client and provider do not meet the requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-300, filed 6/9/99, effective 7/10/99.]

WAC 388-552-310 Coverage—Oxygen and oxygen equipment. (1) MAA reimburses for **oxygen** provided to:

(a) Clients eighteen years of age or older with:

(i) PO_2< = fifty-five mm on room air; or

(ii) SaO_2< = eighty-eighty percent on room air; or

(iii) PaO_2< = fifty-five mm on room air.

(b) Clients seventeen years of age or younger to maintain SaO_2 at:

(i) Ninety-two percent; or

(ii) Ninety-four percent in a child with cor pulmonale or pulmonary hypertension.

(2) MAA may cover spare tanks of **oxygen** and other equipment if the provider and attending physician document that travel distance or potential weather conditions could reasonably be expected to interfere with routine delivery of such equipment and supplies.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-310, filed 6/9/99, effective 7/10/99.]

WAC 388-552-320 Coverage—Continuous positive airway pressure (CPAP) and supplies. (1) MAA covers the rental and/or purchase of medically necessary CPAP equipment and related accessories when all of the following apply:

(a) The results of a prior sleep study indicate the client has sleep apnea;

(b) The client's attending physician determines that the client's sleep apnea is chronic;

(c) CPAP is the least costly, most effective treatment modality;

(d) The item is to be used exclusively by the client for whom it is requested;

(e) The item is FDA-approved; and

(f) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA covers the rental of CPAP equipment for a maximum of two months. Thereafter, if the client's primary physician determines the equipment is tolerated and beneficial to the client, MAA reimburses for its purchase.

(3) Refer to **oxygen and respiratory therapy billing instructions** to determine which CPAP accessories are covered.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-320, filed 6/9/99, effective 7/10/99.]

WAC 388-552-330 Coverage—Ventilator therapy, equipment, and supplies. (1) MAA covers medically necessary ventilator equipment rental and related disposable supplies when all of the following apply:

(a) The ventilator is to be used exclusively by the client for whom it is requested;

(b) The ventilator is FDA-approved; and

(c) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA's monthly rental payment includes medically necessary accessories, including, but not limited to: Humidifiers, nebulizers, alarms, temperature probes, adapters, connectors, fittings, and tubing.

(3) MAA covers a secondary (back-up) ventilator at fifty percent of the monthly rental if medically necessary.

(4) MAA covers the purchase of durable accessories for client-owned ventilator systems according to the fee schedule in the current **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-330, filed 6/9/99, effective 7/10/99.]

WAC 388-552-340 Coverage—Infant apnea monitor program. (1) A provider must comply with WAC 388-552-230 to qualify for reimbursement for the infant apnea monitor program.

(2) MAA covers infant apnea monitors on a rental basis.

(3) MAA includes all home visits, follow-up calls, and training in the rental allowance.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-340, filed 6/9/99, effective 7/10/99.]

WAC 388-552-350 Coverage—Respiratory and ventilator therapy. (1) MAA covers prescribed medically necessary respiratory and ventilator therapy services in the home.

(2) Therapy services must be provided by a certified respiratory care practitioner;

(3) MAA does not reimburse separately for respiratory and ventilator therapy services provided to clients residing in nursing facilities. This service is included in the nursing facility's per diem.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-350, filed 6/9/99, effective 7/10/99.]

WAC 388-552-360 Coverage—Suction pumps and supplies. (1) MAA covers suction pumps and supplies when medically necessary for deep oral or tracheostomy suctioning.

(2) MAA may cover one stationary and one portable suction pump for the same client if warranted by the client's condition. The provider and attending physician must document that either:

(a) Travel distance or potential weather conditions could reasonably be expected to interfere with the delivery of medically necessary replacement equipment; or

(b) The client requires suctioning while away from the client's place of residence.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-360, filed 6/9/99, effective 7/10/99.]

WAC 388-552-370 Coverage—Inhalation drugs and solutions. Inhalation drugs and solutions are included in the prescription drug program. Refer to chapter 388-530 WAC.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-370, filed 6/9/99, effective 7/10/99.]

WAC 388-552-380 Coverage—Oximeters. (1) MAA covers oximeters for clients seventeen years of age or younger when the client has one of the following conditions:

(a) Chronic lung disease, is on supplemental **oxygen**, and is at risk for desaturation with sleep, stress, or feeding;

(b) A compromised or artificial airway, and is at risk for major obstructive events or aspiration events; or

(c) Chronic lung disease, requires ventilator or BIPAP support, and may be at risk for atelectasis or pneumonia as well as hypoventilation.

(2) The provider must review oximetry needs and fluctuations in **oxygen** levels monthly, and log results in the client's records.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-380, filed 6/9/99, effective 7/10/99.]

WAC 388-552-390 Coverage—Nursing facilities. (1) MAA reimburses according to this chapter for the chronic use of medically necessary **oxygen**, and **oxygen** and respiratory equipment and supplies to eligible clients who reside in nursing facilities.

(2) Nursing facilities are reimbursed in their per diem rate for:

(a) **Oxygen** and **oxygen** equipment and supplies used in emergency situations; and

(b) Respiratory and ventilator therapy services.

(3) Nursing facilities with a "piped" **oxygen** system may submit a written request to MAA for permission to bill MAA for oxygen. See **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-390, filed 6/9/99, effective 7/10/99.]

REIMBURSEMENT

WAC 388-552-400 Reimbursement for covered services. (1) A provider must bill MAA according to the procedures and codes in the current **oxygen and respiratory therapy billing instructions**.

(2) MAA does not reimburse separately for telephone calls, mileage, or travel time. These services are included in the reimbursement for other equipment and/or services.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-400, filed 6/9/99, effective 7/10/99.]

WAC 388-552-410 Reimbursement methods. MAA bases the decision to rent or purchase medical equipment for a client, or pay for repairs to client-owned equipment, on the least costly and/or equally effective alternative.

(1) **Rental**.

(a) Types of rental equipment:

(i) Equipment that normally requires frequent maintenance (such as ventilators and concentrators) is reimbursed on a rental basis for as long as medically necessary; and

(ii) Equipment with lower maintenance requirements (such as suction pumps and humidifiers) is reimbursed on a rental basis for a specified rental period, after which the equipment is considered purchased and owned by the client. Refer to the **oxygen and respiratory therapy billing instructions** for detailed information.

(b) The monthly rental rate includes, but is not limited to:

(i) A full service warranty covering the rental period;

(ii) Any adjustments, modifications, repairs or replacements required to keep the equipment in good working condition on a continuous basis throughout the total rental period;

(iii) All medically necessary accessories and disposable supplies, unless separately billable according to current **oxygen and respiratory therapy billing instructions**;

(iv) Instructions to the client and/or caregiver for safe and proper use of the equipment; and

(v) Cost of pick-up and delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(2) **Purchase**.

(a) Purchased equipment becomes the property of the client;

(b) MAA reimburses for:

(i) Equipment that is new at the time of purchase, unless otherwise specified in current **oxygen and respiratory therapy billing instructions**; and

(ii) One maintenance and service visit every six months for purchased equipment.

(c) MAA does not reimburse for:

(i) Defective equipment;

(ii) The cost of materials covered under the manufacturer's warranty; or

(iii) Repair or replacement of equipment if evidence indicates malicious damage, culpable neglect, or wrongful disposition.

(d) The reimbursement rate for purchased equipment includes, but is not limited to:

(i) A manufacturer's warranty for a minimum warranty period of one year for medical equipment, not including disposable/ non-reusable supplies;

(ii) Instructions to the client and/or caregiver for safe and proper use of the equipment; and

(iii) The cost of delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(e) The provider must make warranty information, including date of purchase and warranty period, available to MAA upon request.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-410, filed 6/9/99, effective 7/10/99.]

WAC 388-552-420 Reimbursement methodology. MAA, at its discretion, uses the following methods to deter-

mine the **maximum allowable** amount for each purchased and rented item and service:

(1) **Monthly rental reimbursement methodology**.

(a) Medicare's fee as of October 31 of the year prior to the base year; or

(b) A **maximum allowable** equal to:

(i) One-tenth of the purchase **maximum allowable** for that product; or

(ii) If MAA does not reimburse for the purchase of that product, one-tenth of the amount calculated using the methodology in subsection (1) of this section.

(2) **Purchase reimbursement methodology**.

(a) Medicare's fee as of October 31 of the year prior to the **base year**; or

(b) A **maximum allowable** equal to the seventieth percentile price of an array of input prices.

(i) The number of input prices included in each array may be limited by MAA based on consideration of product quality, cost, available alternatives, and client needs.

(ii) An input price used in the **maximum allowable** calculation is the lesser of:

(A) Eighty percent of the manufacturer's list or suggested retail price as of October 31 of the **base year**; or

(B) One hundred thirty-five percent of the wholesale acquisition cost as of October 31 of the **base year**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-420, filed 6/9/99, effective 7/10/99.]

Chapter 388-555 WAC
INTERPRETER SERVICES

WAC

WAC 388-555-1000 Definitions. For the purposes of this chapter, the following definitions apply:

"Client" means any individual who has been determined eligible for medical or health care services for any of the medical assistance administration (MAA) programs.

"Consecutive appointments" means appointments beginning or scheduled to begin within fifteen minutes of the last completed appointment.

"Family member" means any person who is related to the client: a spouse, child, grandmother, grandfather, grandchild, mother, father, sister, brother, cousin, niece, nephew, aunt, uncle, step relations and/or in-laws.

"Federally qualified health center" (FQHC) means:

(1) A facility that is receiving grants under section 329, 330, or 340 of the Public Health Services Act; or

(2) Receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service as determined by the secretary to meet the requirements for receiving such a grant; or

(3) A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (P.L. 93-638). Only Health Care Financing Administration-designated FQHCs will be allowed to participate in MAA's Medicaid program.

"Independent interpreter" means any fluent, bilingual/multilingual person, certified by language interpretation services and translation (LIST) in medical terminology, who provides interpreter services for payment and who is not employed by, or a contractor of, any interpreter agency enrolled with MAA. Independent interpreter also means any person fluent in American Sign Language, certified by the National Association for the Deaf (NAD) or Registry for Interpreters for the Deaf (RID).

"Interpreter" means a person who speaks English and another language fluently or signs American Sign Language fluently. Fluency includes an understanding of nonverbal and cultural patterns necessary to communicate effectively. An interpreter enables clients and medical/health care providers to communicate effectively with each other.

"Interpreter agency" means a business entity, organized under and permitted to operate by the laws of the state of Washington, which offers as one of its main objectives or purposes to procure interpreter services by employing or contracting with bilingual/multilingual persons on a permanent or part-time basis to provide medical interpreter services for payment to MAA clients. For purposes of this chapter, interpreter agency does not include:

(1) A business entity that employs a person exclusively or regularly to perform other duties, or to perform interpreter services solely in connection with the affairs of that employer; or

(2) A person who is self-employed and is the only bilingual/multilingual employee contracting for the purpose of providing interpreter services to others.

"Language interpretation services and translation" (LIST) means the section within the department of social and health services (DSHS) that is responsible for certifying and qualifying spoken language interpreters.

"Limited English proficient (LEP)" means a limited ability or an inability to speak, read, or write English well enough to understand and communicate effectively in normal daily activities. The client decides whether he/she is limited in his/her ability to speak, read, or write English.

"Primary language" means the language identified by the client as the language in which he/she wishes to communicate. This may also be referred to as the preferred language.

"Qualified interpreter for American Sign Language" means a certified NAD, RID, or noncertified interpreter who is determined to be competent, both receptively and expressively by the consumer to be qualified to effectively meet his/her communication needs, both receptively and expressively.

"Qualified interpreter for spoken languages" means an interpreter who has passed DSHS screening tests in languages other than the DSHS certificated languages as specified in RCW 74.04.025.

"Unit" means a billable amount of time for interpreter services equal to fifteen minutes.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1000, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1050 Covered services. Interpreters and/or interpreter agencies shall receive payment for interpreter services that are:

(1) Provided for a client who is:

(a) Deaf;

(b) Deaf-blind;

(c) Hard of hearing; or

(d) Limited English proficient.

(2) Provided during a necessary medical service performed by an eligible provider; and

(3) Covered under a MAA program for which the client is eligible. For exceptions, see WAC 388-555-1100, Noncovered services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1050, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1100 Noncovered services. Interpreters and/or interpreter agencies shall not receive payment from MAA for interpreter services related to:

(1) Inpatient hospital services;

(2) Nursing facility services;

(3) Community mental health center services;

(4) The provision of any noncovered service;

(5) Interpreter services funded or paid for by any other source;

(6) Interpreter services provided by an interpreter to the interpreter's own family members;

(7) Any person other than an eligible MAA client;

(8) Medical assistance client no-shows;

(9) The interpreter's failure to appear for scheduled services;

(10) The interpreter's transportation costs or travel time;

(11) Waiting time before the scheduled appointment; or

(12) Any block of time when interpreter services are not required by the medical provider to communicate with a medical assistance client.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1100, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1150 Eligible providers. (1) To provide services other than at FQHCs, independent interpreters and/or interpreter agencies are considered eligible providers when they:

(a) Are enrolled with MAA to provide interpreter services;

(b) Meet the criteria in WAC 388-502-0020 and 388-502-0100.

(2) To enroll as an independent interpreter for MAA clients, interpreters shall submit the following to the department:

(a) Proof of certification which may be either:

(i) Number and date of medical certificate from LIST; or

(ii) A copy of a RID or NAD certificate for certified sign language interpreters.

(b) A Social Security Number, if the interpreter has one;

(c) A completed interpreter services core provider agreement;

(d) A signed confidentiality pledge;

(e) A completed provider information form; and

(f) Verification of errors and omissions liability insurance at or over one hundred thousand dollars per occurrence.

(3) To enroll with MAA as an interpreter agency, the agency shall submit to the department:

(a) A completed interpreter services core provider agreement;

(b) Verification of errors and omissions liability insurance at or over one million dollars per occurrence;

(c) A completed provider information form; and

(d) A list of interpreters employed/contracted to provide services to MAA clients, including the following information for each interpreter:

(i) A signed confidentiality pledge; and

(ii) Number and date of medical certificate from LIST; or

(iii) A copy of a current RID or NAD certificate for certified sign language interpreters or written description of evaluation process for qualified interpreter status.

(4) To qualify as an eligible provider, an interpreter agency shall have the capacity to provide interpreter services in:

(a) American Sign Language; or

(b) At least three spoken languages; or

(c) Fewer than three spoken languages if the languages provided are reflective of a majority of the LEP clients residing within the county(ies) served by the agency. DSHS reports will be used to identify the languages needed in the demographic area.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-555-1150, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1150, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1200 Provider requirements. (1) An interpreter or interpreter agency shall not determine the need for interpreter services, nor shall the interpreter market interpreter services to MAA clients. See WAC 388-555-1250, Coordination of services.

(2) An interpreter or interpreter agency shall not require a client to obtain interpreter services exclusive of other interpreters or interpreter agencies.

(3) An interpreter or interpreter agency shall adhere to department policies and procedures regarding confidentiality of client records as stated in WAC 388-01-030.

(4) An independent interpreter shall enroll with the department as provided in WAC 388-555-1100 and obtain a current medical assistance provider number.

(5) An interpreter or interpreter agency must participate in an orientation which will be scheduled and given by MAA within their first year of contracting with the department. The department may terminate contracts with any provider who does not participate in the orientation.

(6) Interpreter agencies shall assume full legal and financial liability for interpreter services provided by employees and contractors.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-555-1200, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1200, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1250 Coordination of services. An interpreter and/or interpreter agency shall:

(1) Coordinate appointment dates and times with the medical provider and the client as requested by the medical provider; and

(2) Notify the medical provider of any changes to scheduled appointments at least twenty-four hours in advance.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1250, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1300 Payment. (1) Eligible interpreters and/or interpreter agencies shall only provide services when the following conditions are met:

(a) The client or the medical provider determines that an interpreter is necessary in order for the client to appropriately access necessary medical and health care services covered by the client's medical assistance program;

(b) The medical provider has informed the client that interpreter services are available at no cost to the client; and

(c) The interpreter presents a current identification card with his/her name, such as a driver's license, prior to providing interpreter services.

(2) To the extent permitted under federal law and regulation, the department may provide federal financial participation to match funds expended by public agencies for interpreter services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1300, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1350 Payment methodology. (1) An interpreter and/or interpreter agency providing services at facilities other than FQHCs shall receive payment for interpreter services based on:

(a) Funds legislatively provided for interpreter services;

(b) Department allocation of vendor rate increases appropriated by the legislature;

(c) Billable units of time; and

(d) Submitting claims to the department according to billing instructions provided by MAA. All eligible interpreters will be provided with billing instructions.

(2) An interpreter and/or interpreter agency providing services at an FQHC shall seek payment according to WAC 388-55-1450.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1350, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1400 Recordkeeping and audits. Interpreters and/or interpreter agencies shall maintain legible, accurate, and complete records in order to support and justify interpretation services provided to medical assistance clients. The types of records that must be maintained are described in the billing instructions.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1400, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1450 Services at federally qualified health clinics. (1) A federally qualified health center shall receive payment for interpreter services when the FQHC:

(a) Uses interpreters certified or qualified by LIST; and

(b) Bills MAA fee-for-service.

(2) Interpreters providing services at an FQHC shall:

(a) Be certified and qualified by LIST; and

(b) Meet the requirements described in WAC 388-555-1200 (1), (2) and (3), and 388-555-1250; and

(c) Seek payment from the FQHC.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1450, filed 7/10/98, effective 7/10/98.]

Chapter 388-556 WAC
MEDICAL CARE—OTHER SERVICES PROVIDED

WAC

WAC 388-556-0100 Chemical dependency treatment services. The department covers chemical dependency treatment services, as defined in chapter 388-805 WAC, for Medicaid and children's health clients. Coverage is limited to services performed by providers defined in WAC 388-502-0010.

[Statutory Authority: RCW 74.08.090, 74.09.035, and 74.50.055. 00-18-032, § 388-556-0100, filed 8/29/00, effective 9/29/00.]

WAC 388-556-0200 Chiropractic services for children. (1) MAA will pay only for chiropractic services:

(a) For MAA clients who are:

(i) Under twenty-one years of age; and

(ii) Referred by a screening provider under the healthy kids/early and periodic screening, diagnosis, and treatment (EPSDT) program.

(b) That are:

(i) Medically necessary, safe, effective, and not experimental;

(ii) Provided by a chiropractor licensed in the state where services are provided; and

(iii) Within the scope of the chiropractor's license.

(c) Limited to:

(i) Chiropractic manipulative treatments of the spine; and

(ii) X-rays of the spine.

(2) Chiropractic services are paid according to fees established by MAA using methodology set forth in WAC 388-531-1850.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-16-031, § 388-556-0200, filed 7/24/00, effective 8/24/00.]

WAC 388-556-0300 Personal care services. The department pays for personal care services for a Title XIX categorically needy Medicaid client as provided under chapter 388-71 WAC, Home and community programs.

[Statutory Authority: RCW 74.08.090. 00-17-057, § 388-556-0300, filed 8/9/00, effective 9/9/00.]

WAC 388-556-0400 Limitations on services available to recipients of categorically needy medical assistance. (1) Organ transplants are limited to the cornea, heart, heart-lung, kidney, kidney-pancreas, liver, pancreas, single lung, and bone marrow.

(2) The department shall provide treatment, dialysis, equipment, and supplies for acute and chronic nonfunctioning kidneys when the client is in the home, hospital, or kidney center as described under WAC 388-540-005.

(3) Detoxification and medical stabilization are provided to chemically-using pregnant women in a hospital.

(4) The department shall provide detoxification of acute alcohol or other drug intoxication only in a certified detoxification center or in a general hospital having a detoxification provider agreement with the department.

(5) The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 275-25 WAC and certified under chapter 275-19 WAC or its successor.

(6) The department may require a second opinion and/or consultation before the approval of any elective surgical procedure.

(7) The department designates diagnoses that may require surgical intervention:

(a) Performed in other than a hospital in-patient setting; and

(b) Requiring prior approval by the department for a hospital admission.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-556-0400, filed 12/29/00, effective 1/29/01; 00-11-183, recodified as § 388-556-0400, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-86-005, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-86-005, filed 10/25/95, effective 10/28/95; 93-17-038 (Order 3620), § 388-86-005, filed 8/11/93, effective 9/11/93; 92-03-084 (Order 3309), § 388-86-005, filed 1/15/92, effective 2/15/92; 90-17-122 (Order 3056), § 388-86-005, filed 8/21/90, effective 9/21/90; 90-12-051 (Order 3009), § 388-86-005, filed 5/31/90, effective 7/1/90; 89-18-033 (Order 2860), § 388-86-005, filed 8/29/89, effective 9/29/89; 89-13-005 (Order 2811), § 388-86-005, filed 6/8/89; 88-06-083 (Order 2600), § 388-86-005, filed 3/2/88. Statutory Authority: 1987 1st ex.s. c 7. 88-02-034 (Order 2580), § 388-86-005, filed 12/31/87. Statutory Authority: RCW 74.08.090. 87-12-050 (Order 2495), § 388-86-005, filed 6/1/87; 84-02-052 (Order 2060), § 388-86-005, filed 1/4/84; 83-17-073 (Order 2011), § 388-86-005, filed 8/19/83; 83-01-056 (Order 1923), § 388-86-005, filed 12/15/82; 82-10-062 (Order 1801), § 388-86-005, filed 5/5/82; 82-01-001 (Order 1725), § 388-86-005, filed 12/3/81; 81-16-033 (Order 1685), § 388-86-005, filed 7/29/81; 81-10-015 (Order 1647), § 388-86-005, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-005, filed 10/9/80; 78-06-081 (Order 1299), § 388-86-005, filed 6/1/78; 78-02-024 (Order 1265), § 388-86-005, filed 1/13/78; Order 994, § 388-86-005, filed 12/31/74; Order 970, § 388-86-005, filed 9/13/74; Order 911, § 388-86-005, filed 3/1/74; Order 858, § 388-86-005, filed 9/27/73; Order 781, § 388-86-005, filed 3/16/73; Order 738, § 388-86-005, filed 11/22/72; Order 680, § 388-86-005, filed 5/10/72; Order 630, § 388-86-005, filed 11/24/71; Order 581, § 388-86-005, filed 7/20/71; Order 549, § 388-86-005, filed 3/31/71, effective 5/1/71; Order 453, § 388-86-005, filed 5/20/70, effective 6/20/70; Order 419, § 388-86-005, filed 12/31/69; Order 264 (part); § 388-86-005, filed 11/24/67.]

WAC 388-556-0500 Medical care services under state-administered cash programs. Medical care services (MCS) are state-administered medical care services provided to a client receiving cash benefits under the general assistance-unemployable (GA-U) program or the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program. For a client eligible for MCS:

(1) The department of social and health services (DSHS) covers only the medically necessary services within the notated applicable program limitations listed in the MCS column under WAC 388-529-0200.

(2) DSHS does not cover medical services received outside the state of Washington unless the medical services are provided in a border area listed under WAC 388-501-0175.

[Statutory Authority: RCW 74.08.090 and 74.09.035. 01-01-009, § 388-556-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-556-0600 Mental health services. Mental health-related services are available to eligible clients under chapter 388-862 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.530, 71.24.035. 00-24-053, § 388-556-0600, filed 11/30/00, effective 12/31/00.]

Chapter 388-700 WAC

JUVENILE REHABILITATION ADMINISTRATION—PRACTICES AND PROCEDURES

(Formerly chapter 275-37 WAC)

WAC

WAC 388-700-0005 What definitions apply to this chapter? The following definitions apply to this chapter:

"Assistant secretary" means the assistant secretary of the juvenile rehabilitation administration.

"Community facility" means a group care facility operated for the care of juveniles committed to the department under RCW 13.40.185. A county detention facility that houses juveniles committed to the department under RCW 13.40.185 pursuant to an interagency agreement with the department is not a community facility.

"Contractor" means a department of social and health services (DSHS)/juvenile rehabilitation administration (JRA) contractor and all employees and all subcontractors of that contractor.

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

"JRA" means the juvenile rehabilitation administration, department of social and health services.

"JRA youth" or **"juvenile"** means a juvenile offender under the jurisdiction of JRA or a youthful offender under the jurisdiction of the department of corrections who is placed in a JRA facility.

"Limited access" means supervised access to a juvenile(s) that is the result of the person's regularly scheduled activities or work duties.

"Preponderance of the evidence" means a determination by the secretary that the alleged sexual misconduct more likely than not occurred, or an admission of sexual misconduct has been made.

"Program administrator" means institution superintendent, regional administrator, or their designees.

"Reasonable cause" means a reason that would motivate a person of ordinary intelligence under the circumstances to believe that an act of sexual misconduct may have occurred.

"Regular access" means unsupervised access to a juvenile(s), for more than a nominal amount of time, that is the result of the person's regularly scheduled activities or work duties.

"Secretary" means the secretary of the department of social and health services.

"Sexual contact" means any touching of the sexual or other intimate parts of a person done for the purpose of gratifying sexual desire of either party or a third party.

"Sexual intercourse" has its ordinary meaning and:

(1) Occurs upon any penetration, however slight; and

(2) Also means any penetration of the vagina or anus however slight, by an object, when committed on one person by another, whether such persons are of the same or opposite sex, except when such penetration is accomplished for medically recognized treatment or diagnostic purposes; and

(3) Also means any act of sexual contact between persons involving the sex organs of one person and the mouth or anus of another whether such persons are of the same or opposite sex.

"Suspend" means to remove from unsupervised access to any JRA youth.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0005, filed 11/27/00, effective 12/28/00.]

BACKGROUND CHECKS

WAC 388-700-0010 When are background checks required? JRA must conduct background checks on prospective employees, volunteers, and individual contracted service providers who will have regular access to juveniles. Background checks may be conducted on prospective employees, volunteers, and individual contracted service providers who will have limited access to juveniles.

(1) Procedures must be established in order to investigate and determine suitability of a person in a position who will have regular access or limited access to juveniles.

(2) Employees, volunteers or individual contracted service providers who are authorized for regular access do not require the presence of another person cleared through the designated background check process during the performance of their duties.

(3) The presence of another person cleared through the designated background check process is required for people authorized to have limited access to juveniles.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0010, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0015 What crimes prohibit "regular access" to juveniles? Effective September 1, 1998, potential employees, volunteers, and individual contracted service providers must not be hired, engaged, or authorized in a position which allows regular access if the individual has been convicted of:

(1) Any felony sex offense as defined in RCW 9.94A.030 and 9A.44.130;

(2) Any crime specified in chapter 9A.44 RCW when the victim was a juvenile in the custody of or under the jurisdiction of JRA as stated in RCW 13.40.570; or

(3) Any violent offense as defined in RCW 9.94A.030.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0015, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0020 What are the reporting requirements for criminal convictions? Effective September 1, 1998 employees, volunteers, and individual contracted service providers who are authorized for regular access to a juvenile(s) must report any conviction of a crime identified in WAC 388-700-0015. The report must be made to the person's supervisor within seven days of conviction. Failure to report within seven days constitutes misconduct under Title 50 RCW. Employees, volunteers, and individual contracted service providers who have been convicted of offenses in WAC 388-700-0015 must not have regular access to a juvenile(s).

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0020, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0025 Is a contracting agency required to do background checks? JRA must require background checks to be conducted on prospective employees and volunteers of contracting agencies if the person will have regular access to juveniles.

(1) Requirements of WAC 388-700-0010, 388-700-0015, and 388-700-0020 must be met by contracted service providers.

(2) The contracted service provider or designee of an agency contracting with JRA for the provision of a community facility must ensure background check investigations are conducted according to department licensing requirements.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0025, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA EMPLOYEES

WAC 388-700-0030 What action must be taken if there is a belief that sexual misconduct by a JRA employee has occurred? If there is reasonable cause to believe that sexual intercourse or sexual contact between a JRA employee and a JRA youth has occurred, the secretary must immediately remove the JRA employee from access to JRA youth, and follow reporting requirements in chapter 26.44 RCW, Reporting abuse and neglect of a child.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0030, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0035 What disciplinary action is required if there is evidence that sexual misconduct by a JRA employee has occurred? If the preponderance of the evidence finds that sexual intercourse or sexual contact between a JRA employee and a JRA youth has occurred, or upon a guilty plea or conviction for any crime specified in chapter 9A.44 RCW when the victim was an offender, the secretary must immediately institute proceedings to terminate the employee.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0035, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA CONTRACTORS

WAC 388-700-0040 What action must be taken if there is a belief that sexual misconduct by a JRA contractor has occurred? The secretary requires the individual contractor, or employee of a contractor, when there is reasonable cause to believe he/she has had sexual intercourse or sexual contact with a JRA youth, to be immediately removed from access to any JRA youth, and follow reporting requirements in chapter 26.44 RCW, Reporting abuse and neglect of a child.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0040, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0045 What action is required if there is evidence that sexual misconduct by a JRA contractor has occurred? (1) If there is a preponderance of evidence that sexual intercourse or sexual contact between a JRA contractor and a JRA youth occurred, the secretary must inform the contractor that the individual employee is disqualified from employment with a contractor in any position with access to JRA youth.

(2) A contract with a contractor who has had an employee who has been disqualified for employment based on a preponderance of evidence that he or she has had sexual intercourse or sexual contact with a JRA youth, must not be renewed until the secretary determines that significant progress has been made by the contractor to reduce the likelihood that any of its employees or subcontractors have sexual intercourse or sexual contact with a JRA youth.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0045, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA EMPLOYEES OR CONTRACTORS

WAC 388-700-0050 What action will be taken if an employee or contractor has sexual intercourse or sexual contact against their will? DSHS will not take any action against a person who is employed or contracted by JRA who has sexual intercourse or sexual contact with a JRA youth and it is found to have been against the employed or contracted person's will.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0050, filed 11/27/00, effective 12/28/00.]

Chapter 388-710 WAC
CONSOLIDATED JUVENILE SERVICES PROGRAMS

WAC

WAC 388-710-0005 Definitions. "Administration" means activities and costs necessary for management and support of a consolidated juvenile services program.

"Application" means the document requesting state funds for specific projects under the consolidated juvenile services program.

"Community input" means information received from local entities which must include, unless impracticable: Providers, judges, law enforcement, juvenile court staff, social service agencies, schools, tribes, organizations representing communities of color, as well as other persons with an interest in juvenile justice. An existing advisory group, committee, or public forum may be used to gather input provided such groups include representation from the entities listed above.

"Director" means the director of the division of community programs/juvenile rehabilitation administration or his or her designee.

"Division" means the division of community programs of the juvenile rehabilitation administration.

"Outcome" means specific changes in the lives of youth and families which lead to a decrease in recidivism.

"Participating county" means a county or counties applying under this chapter.

"Program administrator" or **"administrator"** means the person designated to administer the consolidated juvenile services program in the juvenile court.

"Project" means a specific intervention or program performed as a part of consolidated juvenile services.

"Project supervisor" or **"supervisor"** means a person designated to supervise a project or projects in the consolidated juvenile services program.

"Regional administrator" means the regional administrator of one of the division's six administrative regions, or his or her designee.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0005, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0010 Establishment of a consolidated juvenile services program. (1) Request to participate.

A request by a county or group of counties to participate under this chapter must include a signed resolution or letter of intent submitted to the regional administrator by the executive body expressing intent to participate. The request must include a statement that consolidated juvenile services funds will not be used to replace county funds for existing programs. For those counties with juvenile detention facilities, the counties must include a statement indicating standards of operation as outlined under RCW 13.06.050 are in place.

(2) Program planning process and approval.

(a) Each participating county must develop a program application for the delivery of services and must agree to comply with the provisions of this chapter.

(b) The application must incorporate community input and respond to community comments, which must include but not be limited to:

(i) Efforts to identify and utilize existing community services;

(ii) Appropriate linkage to and support from other elements of the existing juvenile justice, education, and social service systems to reduce or eliminate barriers to effective family centered service delivery;

(iii) Efforts to address racial disproportionality; and

(iv) Efforts to address issues specific to the Americans with Disabilities Act as it relates to client and family service delivery.

(c) Written guidelines and instructions for the application must be provided by the division. The application must be developed in consultation with the regional administrator to ensure the coordination of state, county, and private sector resources within regional boundaries and must be submitted to the regional administrator for review and approval.

(d) The division may provide technical assistance in the development of the application.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0010, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0015 General provisions. (1) Access to services and use of existing community resources. Program administrators must ensure all juveniles participating in the program have access to appropriate services, activities, and opportunities.

(2) All juveniles served by projects covered under this chapter must be afforded judicial due process in all contacts, especially those which may result in a more restrictive intervention.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0015, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0020 Organization. The organizational structure of the program is the prerogative of the juvenile court participating under this chapter and must not be dictated by these standards.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0020, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0025 Administration. (1) Administrators and supervisors are responsible for the implementation of the program and the accomplishment of stated activities and outcomes.

(2) Administrators or supervisors must meet at least annually with the regional administrator to review progress toward the achievement of outcomes.

(3) Case records and management information.

(a) Juvenile offender records must minimally contain a case plan, based upon assessed factors related to risk to reoffend, methods of intervention and a termination/closing report summarizing case activity and outcomes.

(b) The provisions of chapter 13.50 RCW pertaining to the maintenance and confidentiality of social and legal information apply to all programs and projects covered under this chapter.

(c) Administrators and/or supervisors must provide necessary statistical data to maintain the division's management information system and must maintain sufficient data to evaluate program effectiveness and outcomes.

(4) Change in project.

(a) Modification of a project requires the advance written approval of the regional administrator.

(b) The administrator must send written notification to the regional administrator prior to the movement of funds between programs. The regional administrator must confirm in writing all notifications received.

(c) Contract amendments must be processed through the juvenile rehabilitation administration regional office and are necessary when:

(i) Total contract budget amounts are increased or decreased;

(ii) A project is added or deleted;

(iii) The total number of full-time employees in the consolidated programs increases from the original contract number.

(5) Each participating county must ensure program staff receive training necessary to implement programs covered under this chapter.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0025, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0030 Monitoring of performance and evaluation of program impact. (1) It is the responsibility of the administrator to submit monthly reports, annual narrative

reports, corrective action plans and reports, and other reports as specified in the division's application, budget, and monitoring instructions to the regional administrator.

(2) The regional administrator must submit to the director a biennial report of each program.

(3) The regional administrator, may at any time, request a formal program/project or fiscal audit and may also request other available technical services to assist in monitoring and evaluating the program/projects.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0030, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0035 Distribution of funds and fiscal management. Funding constraints.

(1) Funds for programs covered by this chapter must be utilized for the achievement of the outcomes stated for each project.

(2) Failure on the part of any project to perform in accordance with the provisions of this chapter may result in the termination or reduction of funds.

(3) The administrator is responsible for the management of all fiscal matters related to the program. The program must comply with state and local policies and procedures, the terms and conditions of the contract, and the application, budget, and monitoring instructions as outlined by the juvenile rehabilitation administration.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0035, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0040 Exceptions to rules. The juvenile court may request in writing to the director a waiver of the specific requirements of this chapter when the imposition of such requirements can be shown to be detrimental or impractical to overall program operations. The director must consider each waiver request individually and promptly advise the applicant in writing of the director's decision regarding the waiver and explain the basis for such decision.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0040, filed 7/24/00, effective 8/24/00.]

Chapter 388-720 WAC

COLLECTION OF COSTS OF SUPPORT, TREATMENT, AND CONFINEMENT OF JUVENILES UNDER RCW 13.40.220

(Formerly chapter 275-47 WAC)

WAC

WAC 388-720-0010 Definitions. (1) "Juvenile" means juvenile offender sentenced to confinement in the department, other than an offender for whom a parent is approved to receive adoption support under chapter 74.13 RCW.

(2) "Department" means the department of social and health services, state of Washington.

(3) "Gross income" means the total income from all sources, received by the parent, the juvenile, or other children of the parent remaining in the household, other than a stepchild, as determined by the department.

(4) "Parent" means the parent of the juvenile or other person legally-obligated to care for and support the juvenile, not including a stepparent.

(5) "Parents and dependents" means the juvenile's parent or parents, a stepparent living in the home who has no income, any child on whom the parent may claim a federal income tax deduction, not including the juvenile confined to the department, and any stepchild for whom the parent is the sole means of support.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0010, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-010, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0020 Cost reimbursement schedule. A parent shall pay a percentage of gross income to the department for the cost of support, treatment, and confinement of the juvenile in accordance with the reimbursement schedule below:

Monthly Gross Income	Percentage of Gross Income Ordered for Reimbursement of Costs Number of Parents and Dependents Remaining in Household							
	1	2	3	4	5	6	7	8+
AFDC or $0 - 600	0	0	0	0	0	0	0	0
$601 - 1000	8%	6%	4%	2%	0	0	0	0
$1001 - 2000	12%	10%	8%	6%	4%	2%	0	0
$2001 - 3000	16%	14%	12%	10%	8%	6%	4%	2%
$3001 - 4000+	18%	16%	14%	12%	10%	8%	6%	4%

(1) Within fifteen days of receipt, a parent shall mail to the department a certified financial statement on forms provided by the department. Based on the statement and on other information available to it, the department shall determine the parent's gross income, the number of parents and dependents, and the reimbursement obligation, and shall serve on the parent a notice and finding of financial responsibility.

(2) If a parent fails to timely provide a financial statement, the reimbursement obligation shall be twenty-three hundred dollars per month.

(3) If the juvenile's parents reside in separate households, each parent shall be liable for reimbursement.

(4) The gross income of a parent shall be reduced by the amount the parent pays in spousal maintenance to the juvenile's parent, which is gross income to the receiving parent. The gross income of a parent shall be reduced by the amount of current child support paid for any child, including the juvenile offender. This credit shall be available when the support is paid to any section of the department or to any other person legally entitled to receive those support payments, pursuant to court order or administrative order for a child the parent

did not claim as a dependent under the reimbursement schedule.

(5) Reimbursement may not exceed the cost of care as determined by the department.

(6) The reimbursement obligation commences the day the juvenile enters the custody of the department, regardless of when the notice and finding of financial responsibility is received by the parent. A monthly reimbursement obligation shall be reduced on a pro-rata basis for any days in which the juvenile was not in the custody of the department.

(7) The parent of the juvenile shall be exempt from the payment of the cost of the juvenile's care in the state facility if the parent receives adoption support or is eligible to receive adoption support for the juvenile offender; or if the parent, or other legally obligated person, or such person's child, spouse, or spouse's child, was the victim of the offense for which the juvenile was committed to the department.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0020, filed 10/20/00, effective 11/20/00; 96-24-075, § 275-47-020, filed 12/2/96, effective 1/2/97; 94-15-009 (Order 3752), § 275-47-020, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0030 Hearing. A parent may request a hearing under RCW 13.40.220(5) to contest a notice and finding of financial responsibility issued by the department. The department shall ensure the hearing is governed by chapter 34.05 RCW and chapter 388-02 WAC. The sole issues at the hearing include whether the:

(1) Person receiving the notice and finding of financial responsibility is a parent of the juvenile; and

(2) Department correctly:

(a) Determined the parent's gross income and the number of parents and dependents; and

(b) Calculated the reimbursement obligation in accordance with the reimbursement schedule as described under WAC 388-720-0020.

[Statutory Authority: RCW 13.40.220. 00-22-019, amended and recodified as § 388-720-0030, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-030, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0040 Modifications. (1) A parent may modify the parent's financial statement upon a change in gross income or in the number of persons residing in the household only if the change decreases the reimbursement obligation by one hundred dollars per month or more. A decrease may be granted only from the date on which the request for modification is made, and may not be applied retroactively.

(2) A parent shall file a financial statement modification if a change in gross income or the number of persons residing in the household increases the reimbursement obligation by one hundred dollars per month or more. An increase may be applied retroactively.

(3) The department will issue a new notice and finding of financial responsibility upon receipt of a modified financial statement as defined in subsections (1) or (2) of this section. The department may also issue a new notice based upon its own review if the conditions of subsection (1) or (2) of this section are met.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0040, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-040, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0050 Powers of the administrative law judge. The administrative law judge in the initial decision rendered after the hearing conducted in accordance with WAC 388-720-0030 shall include the name and age of the juvenile in that decision. The administrative law judge shall also indicate the parent's or other legally obligated person's monthly liability amount for the period of the juvenile's confinement beginning with the date the child enters the custody of the department. The administrative law judge shall not establish in the decision any amount constituting a repayment figure of any accrued obligation of the parent but shall indicate in the decision that any accrued obligation shall be paid by the parent to the department's office of financial recovery (OFR) and that OFR will be responsible for determining the method of repayment of the parent's accrued obligation.

The administrative law judge shall also include a statement in the decision that the parent's financial obligation is collectible by OFR and that should the parent fail to comply with any payment plan entered into by OFR and the parent, or the parent fails to pay the amount set out in the decision, OFR shall be authorized to take legal collection action to recover the amounts due from the parent. Legal collection action can include, but is not limited to:

(1) The filing of liens against the real and personal property of the parent; or

(2) The issuance of a garnishment order against the wages, bank accounts, or other property of the responsible persons.

[Statutory Authority: RCW 13.40.220. 00-22-019, amended and recodified as § 388-720-0050, filed 10/20/00, effective 11/20/00; 96-24-075, § 275-47-050, filed 12/2/96, effective 1/2/97.]

Chapter 388-730 WAC

PLACEMENT OF JUVENILE OFFENDERS COMMITTED TO THE JUVENILE REHABILITATION ADMINISTRATION (JRA)

(Formerly chapter 275-46 WAC)

WAC

WAC 388-730-0010 Definitions. As used in this chapter:

(1) "Community facility" means a group care facility operated for the care of juveniles committed to the department under RCW 13.40.185. A county detention facility that houses juveniles committed to the department under RCW

13.40.185 pursuant to an interagency agreement with the department is not a community facility.

(2) "Community placement eligibility requirements" means requirements developed by JRA that must be met by a youth to demonstrate progress in treatment and low public safety risk, which justify an institutional minimum or minimum security classification for the youth.

(3) "Initial security classification assessment" means a written instrument, developed by JRA and administered by diagnostic staff, to determine to what extent a juvenile is a threat to public safety for the purpose of determining the juvenile's security classification when the juvenile initially is committed to JRA.

(4) "JRA" means juvenile rehabilitation administration, department of social and health services.

(5) "Juvenile" means a person under the age of twenty-one who has been sentenced to a term of confinement under the supervision of the department under RCW 13.40.185.

(6) "Program administrator" means institution superintendent, regional administrator, or their designees.

(7) "Separate living unit" means sleeping quarters and areas used for daily living activities not specific to treatment and education programs located in a building, wing, or on a different floor which separates resident groups.

(8) "Service provider" means the entity that operates a community facility.

(9) "Specialized treatment program" means a program that addresses additional rehabilitation needs such as sex offender treatment, drug/alcohol treatment, mental health interventions, gang intervention, gender/age specific intervention and other programs meeting specific rehabilitation needs of juveniles.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0010, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-010, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-010, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0015 Assessment. (1) Risk assessment and treatment needs must be the basis of placement decisions involving juveniles.

(2) JRA must ensure juveniles are assessed to determine appropriate placement and treatment programming. Ongoing risk and needs assessment must occur during a juvenile's commitment to JRA.

(3) Risk assessment must include:

(a) Risk to public safety;

(b) Risk for sexually aggressive behavior; and

(c) Risk for vulnerability to sexual aggression.

(4) JRA must use a security classification system to assist in placement decisions.

(5) Student records and information as described in RCW 72.05.425 are required for juvenile offender risk assessment, security classification assignment, and JRA community placement decisions. Designated school officials must ensure student records are provided to the identified juvenile court or JRA representative as required in RCW 28A.600.475 and 13.40.480.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0015, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-015, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0020 Security classifications. (1) There are four JRA security classifications:

(a) Maximum;

(b) Medium;

(c) Institutional minimum; and

(d) Minimum.

(2) A juvenile's initial security classification is determined using the initial security classification assessment. A juvenile's security classification may be changed at any time, and be reviewed at regular intervals as determined by JRA policy.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0020, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-020, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-020, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0030 Maximum security. (1) A maximum security classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment; or

(b) Following the initial security classification, it is determined the juvenile:

(i) Does not meet the community placement eligibility requirements for minimum security; and

(ii) Requires maximum security restrictions to protect public safety, encourage the juvenile to participate in treatment and follow facility rules, or enhance the safe and orderly operation of the facility.

(2) A juvenile classified as maximum security must:

(a) Reside in an institution with the capability of:

(i) Security windows;

(ii) Locked exterior doors;

(iii) Lockable single-person rooms; and

(iv) A security fence.

(b) Be permitted movement between secured buildings only if accompanied by a close staff escort;

(c) Be confined to facility grounds, except for court appearances or emergencies, in which case a staff escort, and transportation in restraints and in a security vehicle, are required; and

(d) Be allowed authorized leave only for emergency and medical purposes pursuant to RCW 13.40.205.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0030, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-030, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-030, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0040 Medium security. (1) A medium security classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment; or

(b) Following the initial security classification, it is determined the juvenile:

(i) Does not meet the community placement eligibility requirements for minimum security; and

(ii) Requires medium security restrictions to protect public safety, encourage the juvenile to participate in treatment and follow facility rules, or enhance the safe and orderly operation of the facility.

(2) A juvenile classified as medium security must:

(a) Reside in an institution with the capability of at least:

(i) Lockable exterior doors or fire exit doors fitted with alarms; and

(ii) A security fence or windows without egress.

(b) Receive during movement a staff escort, continuous visual surveillance, or telephone/radio staff verification of departures and arrivals, unless the program administrator determines such measures are unnecessary;

(c) Be confined to facility grounds, except for:

(i) Participation in work crews or other programs outside the facility that require a close staff escort; and

(ii) Court appearances or emergencies, in which case a staff escort, and transportation in a security vehicle and/or in restraints, are required.

(d) Be allowed authorized leave only for emergency or medical purposes pursuant to RCW 13.40.205.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0040, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-040, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-040, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0050 Institutional minimum. (1) An institutional minimum classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment;

(b) Indicated by the community placement eligibility requirements unless a recent incident indicates the juvenile no longer meets these requirements; or

(c) The assistant secretary for JRA or designee approves an override of the medium security classification.

(2) Even if eligible under subsection (1) of this section, a juvenile must not receive an institutional minimum security classification if:

(a) The assistant secretary for JRA, or designee, signs an administrative override disapproving institutional minimum classification and assigning the juvenile a higher security classification; or

(b) The juvenile is a sex offender who meets the requirements for civil commitment referral under chapter 71.09 RCW or is classified as a risk level III under RCW 13.40.217.

(3) A juvenile classified as institutional minimum security:

(a) Must reside in an institution with the capability of at least:

(i) Lockable exterior doors or fire exit doors fitted with alarms; and

(ii) A security fence or windows without egress.

(b) May be permitted:

(i) Unescorted movement on facility grounds;

(ii) Participation in work crews or other programs outside the facility with a close staff escort;

(iii) Unescorted participation in community work, educational and community service programs, and family treatment or other activities to strengthen family ties, for up to twelve hours per day; and

(iv) Authorized leave pursuant to RCW 13.40.205.

(4) A juvenile on institutional minimum security must be transferred to minimum security upon the availability of an appropriate community placement if:

(a) Ten percent of the juvenile's sentence, and in no case less than thirty days, has been served in a secure facility; and

(b) All placement assessment requirements have been met.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0050, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-050, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-050, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0060 Minimum security. (1) The provisions of WAC 388-730-0050 also apply to a juvenile classified as minimum security, except the juvenile must reside in a community facility or a community commitment program facility (CCP) rather than in an institution.

(2) Juveniles must not be placed in a community facility until:

(a) Ten percent of the juvenile's sentence, and in no case less than thirty days, has been served in a secure facility; and

(b) All placement assessment requirements have been met.

(3) In addition to the provisions of WAC 388-730-0050 (3)(b)(iii), minimum security juveniles may be permitted unescorted participation in treatment programs in the community that do not involve the family for up to twelve hours per day.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0060, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-060, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-060, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0065 Special placement restrictions. Certain placement restrictions apply to community facilities that are commonly used by and under the jurisdiction of both JRA and the children's administration.

(1) When juveniles under commitment to JRA are assessed as a high to moderate risk for sexually aggressive behavior, they may not be placed in a community facility with youths under the jurisdiction of children's administration unless:

(a) They are placed in a separate living unit solely for juveniles currently under the jurisdiction of JRA; or

(b) They are placed in a program that contracts specifically for the provision of services to sexually aggressive youth.

(2) Juveniles under commitment to JRA for a class A felony may not be placed in these community facilities unless:

(a) They are housed in a separate living unit solely for juveniles currently under the jurisdiction of JRA;

(b) They are placed in a community facility that is a specialized treatment program and the juvenile is not assessed as sexually aggressive under RCW 13.40.470; or

(c) They are placed in a community facility that is a specialized treatment program housing one or more sexually aggressive youth and the juvenile is not assessed as sexually vulnerable under RCW 13.40.470.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0065, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-065, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0070 Residential disciplinary standards. (1) Serious violations by a juvenile include:

(a) Escape or attempted escape;

(b) Violence toward others with intent to harm and/or resulting in significant bodily injury;

(c) Involvement in or conviction of a criminal offense under investigation by law enforcement or awaiting adjudication for behavior that occurred during current placement;

(d) Extortion or blackmail that threatens the safety or security of the facility or community;

(e) Setting or causing an unauthorized fire with intent to harm self, others, or property, or with reckless disregard for the safety of others;

(f) Possession or manufacture of weapons or explosives, or tools intended to assist in escape;

(g) Interfering with staff in performing duties relating to the security and/or safety of the facility or community;

(h) Intentional property damage in excess of one thousand five hundred dollars;

(i) Possession, use, or distribution of drugs or alcohol, or use of inhalants;

(j) Rioting or inciting others to riot;

(k) Refusal of urinalysis or search; or

(l) Other behaviors which threaten the safety or security of the facility, its staff, or residents or the community.

(2) Other violations by a juvenile placed in a community facility include:

(a) Unaccounted for time when a juvenile is away from the community facility;

(b) Violation of conditions of authorized leave;

(c) Intimidation or coercion against any person;

(d) Misuse of medication such as hoarding medication or taking another person's medication;

(e) Self-mutilation, self tattooing, body piercing, or assisting others to do the same;

(f) Intentional destruction of property valued at less than fifteen hundred dollars;

(g) Fighting;

(h) Unauthorized withdrawal of funds with intent to commit other violations;

(i) Suspensions or expulsions from school or work;

(j) Violations of school, employment or volunteer work agreements related to custody and security concerns;

(k) Escape talk;

(l) Sexual contact or any other behavior, not defined as a serious violation, resulting in a referral to the department of licensing, child protective services, or law enforcement; or

(m) Lewd or disruptive behavior in the community.

(3) Juveniles must be held accountable when there is reasonable cause to believe they have committed a violation.

(a) Whenever a juvenile placed in a community facility commits a serious violation, the juvenile must be returned to an institution. The JRA program administrator who receives a service provider report of a serious violation must make arrangements to transfer the juvenile to an institution as soon as possible. Juveniles may be placed in a secure JRA or contracted facility pending transportation to an institution.

(b) Sanctions for serious violations committed by juveniles in an institution, and additional sanctions for serious violations committed by juveniles returned to an institution, must include one or more of the following:

(i) Loss of privileges for up to thirty days;

(ii) Loss of program level; or

(iii) Room confinement up to seventy-two hours.

(c) Sanctions for serious violations may also include, but are not limited to, one or more of the following:

(i) Change in release date;

(ii) Referral for prosecution;

(iii) Transfer to an intensive management unit;

(iv) Increase in security classification;

(v) Reprimand and loss of points;

(vi) Restitution; or

(vii) Community service.

(d) Sanctions for violations listed in WAC 388-730-0070(2) may include transfer to a higher security facility and must include one or more of the following:

(i) Loss or privileges;

(ii) Loss of program level;

(iii) Room confinement up to seventy-two hours;

(iv) Change in release date;

(v) Reprimand and/or loss of points;

(vi) Additional restitution; or

(vii) Community service.

(4) When a sanction is imposed, the juvenile must also receive a counseling intervention to address the violation.

(5) If the proposed sanctions for any violation includes extending the juvenile's established release date, the juvenile must be entitled to:

(a) Notice of an administrative review to consider extension of the release date and a written statement of the incident;

(b) An opportunity to be heard before a neutral review chairperson;

(c) Present oral or written statements, and call witnesses unless testimony of a witness would be irrelevant, repetitive, unnecessary, or would disrupt the orderly administration of the facility;

(d) Imposition of the sanction only if the administrative review chairperson finds by a preponderance of the evidence that the serious violation did occur; and

(e) A written decision, stating the reasons for the decision, by the administrative review chairperson.

(6) Each superintendent and service provider must clearly post the list of serious violations and possible sanctions in all living units.

(7) Each program administrator must adopt procedures for implementing the requirements of this section.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0070, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-070, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-070, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0080 Documenting and reporting violations committed by juveniles in residential facilities. (1) All serious violations and violations listed in WAC 388-730-0070(2) must be documented in an incident report. The incident report must include:

(a) Circumstances leading up to the violation(s);

(b) A description of the violation;

(c) Response by staff;

(d) Response by the juvenile(s) involved in the incident; and

(e) Sanctions imposed or recommended for the violation(s).

(2) Service providers must:

(a) Forward all incident reports to the JRA program administrator no later than twenty-four hours after the behavior is discovered; and

(b) Verbally report serious violations to the JRA program administrator immediately.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0080, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-080, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0090 Service provider penalty schedule. (1) Whenever a service provider contracts with the JRA to operate a community facility, the contracted service provider must report any known violation as required in WAC 388-730-0080.

(2) If the contracted service provider fails to report violations within the prescribed time frames, the JRA must impose one or more of the following remedies:

(a) Imposition of a corrective action plan to be completed as determined by the program administrator.

(b) Imposition of the following monetary penalties:

(i) The first time fines are imposed on a service provider, the penalty must be at the rate of fifty dollars per day for each juvenile involved in a violation that was not reported as required. The penalty must be assessed for each day the report was late, and may continue until a corrective action plan is approved by the program administrator.

(ii) Subsequent fines imposed on the service provider during the same calendar year must be at the rate of seventy-five dollars per day for each juvenile involved in a violation that was not reported as required. The penalty must be assessed for each day the report was late, and may continue until a corrective action plan is approved by the program administrator.

(c) Order to stop placement until a corrective action plan is submitted, approved by the program administrator, and implemented.

(d) Termination of the contract for convenience if it is determined such termination is in the best interests of the department.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0090, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-090, filed 8/31/98, effective 9/1/98.]

Chapter 388-740 WAC
JUVENILE PAROLE REVOCATION
(Formerly chapter 275-30 WAC)

WAC

WAC 388-740-0010 Definitions. "Department" means the department of social and health services.

"Detention" means physical custody in Washington state by the department of social and health services in a juvenile rehabilitation administration operated or contracted facility or a Washington state detention facility as defined in RCW 13.40.020(9).

"Juvenile parole officer" means a state employee, or person under contract to the state, whose responsibilities include supervising juvenile parolees.

"Juvenile parolee" means a person under age twenty-one released from a juvenile rehabilitation administration residential facility and placed under the supervision of a juvenile parole officer.

"Modification of parole conditions" means a change in the "order of parole conditions" provided by the juvenile parole officer with full knowledge of the change by the juvenile parolee.

"Parole" means a period of supervision following release from a juvenile rehabilitation administration residential facility, during which time certain parole conditions are to be followed.

"Parole conditions" mean interventions or expectations that include, but are not limited to, those listed in RCW 13.40.210, intended to facilitate the juvenile parolee's reintegration into the community and/or to reduce the likelihood of reoffending.

"Secretary" means secretary of the department of social and health services or his/her designee.

"Violation" means behavior by a juvenile parolee contrary to written parole conditions which may result in sanctions that include, but are not limited to, modification of parole conditions and/or confinement.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, amended and recodified as § 388-740-0010, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-010, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-010, filed 10/5/88.]

WAC 388-740-0030 Parole arrest warrant. (1) A juvenile parole officer:

(a) Must issue a parole arrest warrant when the juvenile parole officer has reason to believe a juvenile parolee pos-

sessed a firearm or used a deadly weapon during the parole period; or

(b) May issue a parole arrest warrant when the juvenile parole officer has reason to believe a juvenile parolee has violated a condition of parole, other than possession of a firearm or use of a deadly weapon.

(2) The parole arrest warrant, on department forms, must include a statement of the nature of the violation(s) and the date it occurred.

(3) A juvenile parolee held in detention for an alleged violation of parole conditions is entitled to an informal hearing to determine whether there is probable cause to believe a parole violation occurred and whether continued detention pending a parole revocation hearing is necessary. The hearing must be:

(a) Held within twenty-four hours (excluding Saturdays, Sundays, and holidays) of being placed in detention for an alleged violation of parole conditions; and

(b) Conducted by a parole supervisor or designee not directly involved in the case. The parole supervisor or designee must:

(i) Interview both the juvenile parolee and a juvenile parole staff with knowledge of the alleged violation(s). If such a parole staff is unavailable, documentation of the allegation(s) may be reviewed in place of the staff interview; and

(ii) Issue a decision, immediately following the hearing, with reasons for either releasing the juvenile parolee or authorizing continued detention. The decision must be documented on department forms. In no event shall a juvenile parolee be held in detention for an alleged violation of parole conditions longer than seventy-two hours (excluding Saturdays, Sundays, and holidays) without a parole revocation petition being filed pursuant to WAC 275-30-040.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0030, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-030, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-030, filed 10/5/88.]

WAC 388-740-0040 Parole revocation petition. (1) The juvenile parole officer:

(a) Must initiate a parole revocation petition if the juvenile parole officer has reason to believe the juvenile parolee possessed a firearm or used a deadly weapon during the parole period; or

(b) May initiate a parole revocation petition if the juvenile parole officer has reason to believe the juvenile parolee has violated a condition of parole, other than possession of a firearm or use of a deadly weapon.

(2) The petition, on department forms, must include:

(a) A statement of the nature of the violation and the date it occurred;

(b) The relief requested by the juvenile parole officer as a result of the violation;

(c) Notice of the juvenile parolee's right to be represented by an attorney, either one of his/her own choosing or one appointed at public expense;

(d) A parole revocation hearing waiver agreement;

(e) The dated signature of the regional administrator or designee; and

(f) If the parole revocation hearing is not waived, notice of the time, date, and location of the parole revocation hearing and notice that failure to appear may result in default.

(3) An initial copy of the petition that includes the information described in subsection (2)(a) through (e) must:

(a) Be provided to the juvenile parolee or the juvenile parolee's attorney; and

(b) Be provided to the juvenile parolee's parent/guardian, if reasonably possible. The juvenile parole officer must document the date and time he/she provided the initial copy of the petition to the juvenile parolee or the juvenile parolee's attorney.

(4) A juvenile parolee, only through an attorney, may waive the right to a parole revocation hearing and agree to the parole revocation and agreed upon relief. The decision to waive must be documented with dated signatures on the original petition.

(5) If the juvenile parolee through his/her attorney does not waive the right to a hearing, the parole revocation petition must be filed with the local office of the state office of administrative hearings within seventy-two hours (excluding Saturdays, Sundays, and holidays) of:

(a) The juvenile parolee being placed in detention for an alleged violation of parole conditions; or

(b) The juvenile parolee or his/her attorney being provided with a copy of the petition under subsection (3) of this section if the juvenile parolee is not detained.

(6) The filed petition must include notice that failure to appear may result in default, and the time, date, and location of the parole revocation hearing, as determined by the state office of administrative hearings. A copy of the filed petition must:

(a) Be served either personally or by certified mail, return receipt requested, on the juvenile parolee or the juvenile parolee's attorney; and

(b) Be provided to the juvenile parolee's parent/guardian, if reasonably possible.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0040, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-040, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-040, filed 10/5/88.]

WAC 388-740-0060 Parole revocation hearing. (1) After the petition is filed a parole revocation hearing must be held to determine whether the alleged parole violation occurred unless the juvenile parolee waives his/her right to a parole revocation hearing. If the juvenile parolee is held in detention as described under WAC 275-30-030, the administrative law judge must hold the hearing within seventy-two hours (excluding Saturdays, Sundays, and holidays) of the petition being served. Otherwise the administrative law judge must hold a hearing no sooner than seven days after the petition is served, but no later than fourteen days after the petition is served.

(2) At the parole revocation hearing, the juvenile may waive the right to be represented by an attorney. A juvenile waiving the right to an attorney may either contest or agree to the parole revocation.

(3) The administrative law judge must:

(a) Conduct a parole revocation hearing in accordance with chapter 10-08 WAC except as otherwise indicated in these rules;

(b) Grant the parole revocation petition if the administrative law judge finds, by a preponderance of the evidence, the violation occurred and the violation warrants revocation;

(c) Order the relief requested in the petition, if the parole revocation petition is granted;

(d) Issue an oral decision immediately following the parole revocation hearing;

(e) Issue a written decision within forty-eight hours of the hearing; and

(f) Provide a copy of the decision to the juvenile parole officer, the juvenile parolee and his/her attorney, the juvenile parolee's parent/guardian, and the department. The administrative law judge's decision shall constitute a final administrative decision.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0060, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-060, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 90-22-072 (Order 3091), § 275-30-060, filed 11/6/90, effective 12/7/90; 88-20-083 (Order 2709), § 275-30-060, filed 10/5/88.]

WAC 388-740-0070 Confinement. (1) A juvenile's confinement for violating one or more conditions of parole, as alleged in a parole revocation petition, may not exceed thirty days. Confinement may be continuous, or for a portion of each day, or for certain days each week with the balance of time under supervision. The department must give the juvenile credit against any period of confinement for days served in detention pending a parole revocation hearing. The juvenile must serve his or her confinement in a county detention facility as defined in RCW 13.40.020, a juvenile rehabilitation administration facility, or, if the juvenile parolee is eighteen years old or older, the juvenile may serve his or her confinement in a county jail.

(2) If a juvenile's parole is revoked two or more times during one parole period, the secretary or designee must approve any period of confinement exceeding a combined total of thirty days.

(3) Instead of confinement under subsection (1) of this section, the secretary or designee may return the offender to confinement in an institution for the remainder of the sentence range if:

(a) The offense for which the offender was sentenced is rape in the first or second degree, rape of a child in the first or second degree, child molestation in the first degree, indecent liberties with forcible compulsion, or a sex offense that is also a serious violent offense as defined under RCW 9.94A.030; or

(b) As otherwise authorized in RCW 13.40.210.

(4) Unless conditions of parole are otherwise amended, the order of parole conditions in effect at the time the parole was revoked shall be deemed reinstated immediately following any period of confinement.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0070, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-070, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 90-22-072 (Order 3091), § 275-30-070, filed 11/6/90, effective 12/7/90; 88-20-083 (Order 2709), § 275-30-070, filed 10/5/88.]

Chapter 388-745 WAC

TRANSFER OF JUVENILE OFFENDER TO THE DEPARTMENT OF CORRECTIONS

(Formerly chapter 275-33 WAC)

WAC

WAC 388-745-020 Notification to juvenile. A juvenile being considered for transfer to DOC shall be notified in writing at least five days in advance of the review board hearing convened to consider the matter. Notification to the juvenile offender will include the reasons the transfer is being considered and a copy of the rules pertaining to the review board hearing. Prior to any review board hearing, the juvenile being considered for transfer to DOC, or the juvenile's attorney, shall have the right of access to, and adequate opportunity to examine any files or records of the department pertaining to the proposed transfer of the juvenile to the department of corrections.

[00-16-078, recodifed as § 388-745-020, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-020, filed 4/30/84.]

WAC 388-745-030 Composition of board. The review board will be composed of the director of DJR or designee and two other juvenile rehabilitation administrators appointed by the chairman.

[00-16-078, recodifed as § 388-745-030, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-030, filed 4/30/84.]

WAC 388-745-040 Attendance at hearing. Attendance at a review board shall be limited to parties directly concerned. The chairperson may exclude unauthorized persons unless the parties agree to their presence. Parties shall have the right to present evidence, cross-examine witnesses and make recommendations to the board. All relevant and material evidence is admissible which, in the opinion of the chairperson, is the best evidence reasonably obtainable, having due regard for its necessity, availability and trustworthiness.

[00-16-078, recodifed as § 388-745-040, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-040, filed 4/30/84.]

WAC 388-745-050 Consideration of evidence. At the conclusion of the hearing, the review board will consider all evidence presented and make a decision whether continued placement of the juvenile offender in an institution for juvenile offenders presents a continuing and serious threat to the safety of others in the institution.

[00-16-078, recodified as § 388-745-050, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-050, filed 4/30/84.]

WAC 388-745-060 Record of decision. The chair of the review board will prepare a written record of the decision

and reasons therefore. The review board shall be recorded manually, or by mechanical, electronic, or other device capable of transcription.

[00-16-078, recodified as § 388-745-060, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-060, filed 4/30/84.]

Chapter 388-750 WAC
IMPACT ACCOUNT--CRIMINAL JUSTICE COST REIMBURSEMENT

WAC

WAC 388-750-010 Definitions. The following words and phrases shall have the following meaning when used in these regulations regarding the interpretation of regulations for the reimbursement from impacts caused by criminal behavior of state institutional residents:

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

"Incremental" means efforts or costs incurred by cities, towns, and/or counties that are not otherwise incurred and are only as a result of the criminal behavior of state institutional residents.

"Resident" means any person committed to a state institution by the courts for confinement as an offender pursuant to chapters 10.64, 10.77, and 13.40 RCW.

"Institution" means any state institution operated by the department for the confinement of offenders committed under chapters 10.64, 10.77, and 13.40 RCW.

"Law enforcement cost" means costs incurred to apprehend escapees or to investigate crimes committed by institutional residents within or outside state institutions listed in this chapter.

"Resident" means any person committed to a state institution by the courts for confinement as an offender under chapters 10.64, 10.77, and 13.40 RCW.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-010, filed 11/14/00, effective 12/15/00.]

WAC 388-750-020 Limitation of funds. The secretary shall make reimbursement to the extent funds are available. Reimbursement shall be strictly limited to political subdivisions in which state institutions, as defined in WAC 388-750-030, are located. Only incremental costs directly, specifically, and exclusively associated with criminal activities of offenders who are residents of state institutions shall be considered for reimbursement. Reimbursement shall be restricted to fully documented law enforcement, prosecutorial, judicial, and jail facilities costs. No such costs shall be paid under these rules if they are reimbursable under other chapters of the Washington Administrative Code. During each biennium, claims for incidents which occurred during the biennium will be paid in the order in which they are received until the biennial appropriation is fully expended.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-020, filed 11/14/00, effective 12/15/00.]

WAC 388-750-030 Institutions and eligible impacted political subdivisions. Reimbursement shall be limited to the following city, town, and county governments impacted by the offenses from residents committed to institutions listed in this section.

Institution	Cities/County
(1) Echo Glen Children's Center	Snoqualmie/King
(2) Green Hill Training School	Chehalis/Lewis
(3) Maple Lane School	Rochester/Thurston
(4) Mission Creek Youth Camp	Belfair/Mason
(5) Naselle Youth Camp	Naselle/Pacific
(6) Woodinville Treatment Center	Woodinville/King
(7) Canyon View Community Facility	East Wenatchee/Douglas
(8) Sunrise Community Facility	Ephrata/Grant
(9) Twin Rivers Community Facility	Richland/Benton
(10) Oakridge Community Facility	Tacoma/Pierce
(11) Park Creek Treatment Center	Kittitas/Kittitas
(12) Ridgeview Community Facility	Yakima/Yakima
(13) Western State Hospital	Steilacoom/Pierce
(14) Eastern State Hospital	Medical Lake/Spokane/Spokane
(15) Child Study and Treatment Center	Steilacoom/Pierce

(16) For any institution not listed in this section, reimbursement shall be limited to the political subdivisions where the institution is located. The institutions include juvenile community facilities, community treatment and community care facilities, as defined in WAC 388-750-010.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-030, filed 11/14/00, effective 12/15/00.]

WAC 388-750-040 Maximum allowable reimbursement for law enforcement costs. The department shall limit reimbursement to the specific political subdivisions listed in WAC 388-750-030. The maximum reimbursement rates shall be twenty-three dollars and ninety-six cents per hour. These reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-040, filed 11/14/00, effective 12/15/00.]

WAC 388-750-050 Maximum allowable reimbursement for prosecutorial costs. The department shall reimburse claims, at the rate set forth in WAC 388-750-040, for pretrial investigations of crimes committed inside or outside institutions, to the political subdivision courts in WAC 388-750-040. If, after investigation, criminal charges are filed, the department may reimburse documented prosecutorial and defense attorney fees. Reimbursement shall not exceed the following rates for each attorney, reimbursement includes costs for paralegals: Fifty-seven dollars and thirty-two cents

per hour. These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-050, filed 11/14/00, effective 12/15/00.]

WAC 388-750-060 Maximum allowable reimbursement for judicial costs. (1) The department shall limit judicial costs strictly to cases involving inmates of institutions listed in WAC 388-750-030 and the listed subdivision in which they reside. Reimbursement shall be limited to judges, court reporters, transcript typing, and witness and jury fees.

(2) The department shall reimburse judges hearing cases including services provided by court clerks and bailiffs at fifty-seven dollars and thirty-two cents per hour. Reimburse court reporters at the rate of twenty-four dollars and seventy-one cents per hour. Reimburse for the typing of transcripts at four dollars and seventy-nine cents per page. If required, reimburse expert witnesses at eighty dollars and forty-three cents per hour.

(3) Reimbursement for witness fees (other than experts) and jury fees shall be at the rate established by the local governmental legislative authority but not in excess of thirty-six dollars and eleven cents per day.

(4) These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-060, filed 11/14/00, effective 12/15/00.]

WAC 388-750-070 Maximum allowable reimbursement for jail facilities. The department shall limit jail facility cost reimbursement strictly to incremental costs as defined in WAC 388-750-010. Requests for reimbursement shall be fully documented and shall include the resident's name and all appropriate admission and release dates. Limit reimbursement to thirty-four dollars and eighty cents per resident day. The department shall not reimburse for costs incurred for holding persons regarding parole revocations or for holding persons involved in civil litigation. The department shall reimburse costs of providing security when residents require hospitalization at the rate of fourteen dollars and nineteen cents per hour. These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-070, filed 11/14/00, effective 12/15/00.]

WAC 388-750-080 Billing procedure. Requests for reimbursement should be made on the standard Washington State Invoice Voucher, Form A19, with supporting documentation attached. All claims may be subject to periodic audits at the discretion of the secretary, per WAC 388-750-110.

(1) All requests for reimbursement under this section shall note the name of the offender for whom costs were incurred, and the institution to which the offender was assigned.

(2) Requests for reimbursement may only be submitted by the jurisdiction's responsible fiscal officer, e.g., city manager, city supervisor, county auditor, county administrator, etc.

(3) All requests for reimbursement must be submitted to: DSHS and the pertinent Accounts Payable Section of either Juvenile Rehabilitation Administration, Mail Stop 45720, Olympia, Washington 98504; or Mental Health Division, Mail Stop 45320, Olympia, Washington 98504.

(4) If the appropriation for a biennium is fully expended prior to the end of the biennium, political subdivisions should continue to submit claims for the purpose of providing justification for requests for adequate funding levels in future biennia.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-080, filed 11/14/00, effective 12/15/00.]

WAC 388-750-090 Exceptions. The secretary, of the department, may allow exceptions to these rules.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-090, filed 11/14/00, effective 12/15/00.]

WAC 388-750-100 Effective date. Claims submitted according to this chapter may only be for costs incurred for appropriate actions, as defined in this chapter, taken by criminal justice agencies on or after August 30, 1979.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-100, filed 11/14/00, effective 12/15/00.]

WAC 388-750-110 Audits. The department has the right to audit any or all claims.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-110, filed 11/14/00, effective 12/15/00.]

Chapter 388-800 WAC
CHEMICAL DEPENDENCY ASSISTANCE PROGRAMS

WAC

WAC 388-800-0005 What is the purpose of this chapter? This chapter explains chemical dependency treatment services available through public assistance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0005, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0020 What detoxification services will the department pay for? (1) The department only pays for services that are:

(a) Provided to eligible persons (see WAC 388-800-0030);

(b) Directly related to detoxification; and

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

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

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

(b) Five days for acute drug addiction.

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

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0020, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0025 What information does the department use to decide if I am eligible for the detoxification program? (1) The department uses the information you provide on the department's application form to determine if you are eligible for the detoxification program.

(2) The department may require an interview, documents or other verification if the department has questions about or needs to confirm the information you provided on your application.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0025, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0030 Who is eligible for detoxification services? (1) You are eligible for detoxification services if you:

(a) Receive benefits from temporary aid for needy families (TANF), general assistance unemployable (GAU), a medical assistance program, or Supplemental Security Income (SSI); or

(b) Do not have a combined nonexempt income and/or resources that exceed the payment standards for TANF.

(2) To determine your financial eligibility for the detoxification program the department deducts or exempts the following:

(a) A home;

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

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

(d) A used and useful automobile;

(e) Mandatory expenses of employment;

(f) Total income and resources of a noninstitutionalized SSI beneficiary;

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

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

(3) The following resources are not exempt:

(a) Cash;

(b) Marketable securities; and

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

(4) If you receive detoxification services you shall not incur a deductible as a factor of eligibility for the covered period of detoxification.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0030, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0035 How long am I eligible to receive detoxification services? You are eligible for detoxification services from the date detoxification begins through the end of the month in which you complete the detoxification.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0035, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0040 What is ADATSA? (1) ADATSA stands for the Alcohol and Drug Addiction Treatment and Support Act which is a legislative enactment providing state-financed treatment and support to chemically dependent indigent persons.

(2) ADATSA provides eligible people with:

(a) Treatment if you are chemically dependent and would benefit from it; or

(b) A program of shelter services if you are chemically dependent and your chemical dependency has resulted in incapacitating physiological or cognitive impairments.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0040, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0045 What services are offered by ADATSA? If you qualify for the ADATSA program you may be eligible for:

(1) Alcohol/drug treatment services and support described under WAC 388-800-0080.

(2) Shelter services as described under WAC 388-800-0120.

(3) Medical care services as described under WAC 388-86-120 and 388-529-0200.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0045, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0048 Who is eligible for ADATSA? To be eligible for ADATSA services you must:

(1) Be eighteen years of age or older;

(2) Be a resident of Washington as defined in WAC 388-468-0005;

(3) Meet citizenship requirements as described in WAC 388-424-0005.

(4) Provide your Social Security Number; and

(5) Meet the same income and resource criteria for the GA-U program; OR be receiving federal assistance under SSI or TANF.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0048, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0050 When am I eligible for ADATSA treatment services? (1) You are eligible for ADATSA treatment services when you meet the:

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

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

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

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0050, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0055 What clinical incapacity must I meet to be eligible for ADATSA treatment services? You are clinically eligible for ADATSA treatment services when you:

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

(2) Are clearly diagnosed as currently dependent on psychoactive substances other than nicotine or caffeine;

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

(4) Have not been gainfully employed in a job in the competitive labor market at any time during the last thirty days. For the purposes of this chapter, "gainfully employed" means performing in a regular and predictable manner an activity for pay or profit. Gainful employment does not include noncompetitive jobs such as work in a department-approved sheltered workshop or sporadic or part-time work, if the person, due to functional limitation, is unable to compete with unimpaired workers in the same job; and

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

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

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

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

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

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

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

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0055, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0057 Will I still be eligible for ADATSA outpatient services if I abstain from using alcohol or drugs, become employed, or have a relapse? When you are successfully participating in ADATSA outpatient treatment services you are still considered incapacitated and eligible for ADATSA treatment through completion of the planned treatment, even if you:

(1) Become employed;

(2) Abstain from alcohol or drug use; or

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

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0057, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0060 What is the role of the ADATSA/adult assessment center in determining eligibility? (1) A department-designated chemical dependency assessment center determines your incapacity based on alcoholism and/or drug addiction.

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

(3) The assessment center provides a written current assessment needed to determine your eligibility.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0060, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0065 What are the responsibilities of ADATSA/adult assessment centers? (1) ADATSA/Adult assessment centers:

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

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

(i) Are chemically dependent;

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

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

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

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0065, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0070 What happens after I am found eligible for ADATSA services? Once your financial and clinical eligibility is established, the assessment center:

(1) Develops your ADATSA treatment plan;

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

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

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

(5) Provides ongoing case monitoring of your treatment services; and

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

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0070, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0075 What criteria does the assessment center use to plan my treatment? When evaluating a treatment plan which will benefit you the most, the assessment center considers clinical or medical factors utilizing the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC).

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0075, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0080 What are the time limits for receiving types of chemical dependency treatment through ADATSA? (1) You are limited to a maximum of six months (one-hundred eighty total calendar days) of chemical dependency treatment in a twenty-four-month period.

(2) The twenty-four-month period begins on the date of your initial entry into treatment.

(3) You are limited to the following time periods for treatment:

(a) Intensive inpatient treatment, no longer than thirty days per admission;

(b) Recovery house treatment, no longer than sixty days per admission;

(c) Long-term care residential treatment, no longer than one hundred eighty days;

(d) ADATSA outpatient treatment no longer than one hundred eighty days.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0080, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0085 Do I have to contribute to the cost of residential treatment? Once you have been determined financially eligible to receive ADATSA residential treatment services the department does not require you to contribute toward the cost of care.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0085, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0090 What happens when I withdraw or am discharged from treatment? (1) You will be terminated from ADATSA treatment services if you leave treatment.

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

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

(4) Once you voluntarily leave treatment you must reapply and be referred again to the assessment to receive further ADATSA treatment services.

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

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0090, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0100 What are the groups that receive priority for ADATSA services? (1) When assigning treatment admissions, the ADATSA/Adult assessment center:

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

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

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

(ii) An injecting drug user (IDU).

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

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0100, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0110 What cash benefits am I eligible for through ADATSA if I am in residential treatment? When you are in ADATSA residential treatment and are below the department payment standard for clothing and personal incidentals (CPI) you are eligible to receive CPI.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0110, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0115 What cash benefits can I receive through ADATSA if I am in outpatient treatment? When you are in ADATSA outpatient treatment, you may be eligible for a treatment living allowance for housing and other living expenses.

(1) Your living allowance maximum amount will be based on the current ADATSA payment standard as provided under WAC 388-478-0030.

(2) Your outpatient provider will act as your protective payee and administer your living allowance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0115, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0120 As an eligible ADATSA client, when would I get state-funded medical assistance? You are eligible for state-funded medical assistance when you are in one of the following situations:

(1) You meet the requirements in WAC 388-800-0048 and are waiting to receive ADATSA treatment services;

(2) When you are participating in ADATSA residential or outpatient treatment;

(3) You choose opiate dependency (methadone maintenance) chemical dependency treatment services instead of other ADATSA treatment, but only if these treatment services are from a state-approved, publicly funded opiate dependency/methadone maintenance program; or

(4) You meet the requirements of WAC 388-800-0135, for shelter services but choose not to receive shelter assistance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0120, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0130 What are ADATSA shelter services? (1) Your shelter assistance in independent housing consists of a monthly shelter assistance payment through an intensive protective payee defined under WAC 388-800-0160; and

(2) You continue to receive benefits for ADATSA shelter if you request a fair hearing within the advance notice period before termination is to occur.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0130, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0135 When am I eligible for ADATSA shelter services? You are eligible for ADATSA shelter services when you meet the:

(1) Financial eligibility criteria in WAC 388-800-0040; and

(2) Incapacity eligibility criteria in WAC 388-800-0140.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0135, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0140 What incapacity criteria must I meet to be eligible for ADATSA shelter services? You are eligible for ADATSA shelter services when you:

(1) Are actively addicted, meaning having used alcohol or drugs within the sixty-day period immediately preceding the latest assessment center evaluation, as determined by the ADATSA/Adult assessment center; and

(2) Have resulting physiological or organic damage, or have resulting cognitive impairment not expected to dissipate within sixty days of sobriety or detoxification, which either:

(a) Limits your functioning because of physiological or organic damage that result in a significant restriction on ability to perform work activities, or

(b) At least a moderate impairment of your ability to understand, remember, and follow complex instructions; and

(c) An overall moderate impairment in your ability to:

(i) Learn new tasks;

(ii) Exercise judgment;

(iii) Make decisions, and

(iv) Perform routine tasks without undue supervision.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0140, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0145 How does the department review my eligibility for ADATSA shelter services? The department:

(1) Redetermines your incapacity and financial and medical eligibility for ADATSA shelter every six months or more often; and

(2) Provides you adequate and advance notice of adverse action.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0145, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0150 Who is my protective payee? Your protective payee is either:

(1) Your outpatient treatment provider while in ADATSA treatment; or

(2) An agency under contract with the department to provide you with intensive protective payee services if you are an ADATSA shelter client.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0150, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0155 What are the responsibilities of my protective payee? Your protective payee:

(1) Has the authority and responsibility to make decisions about the expenditure of your outpatient treatment stipends;

(2) Encourages you to participate in the decision-making process. The amount of decision-making the protective payee allows you depends upon the level of responsibility you demonstrate; and

(3) Disburses funds to meet your basic needs of shelter, utilities, food, clothing, and personal incidentals.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0155, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0160 What are the responsibilities of an intensive protective payee? If you are receiving shelter services, your intensive protective payee provides you with case management services including, but not be limited to:

(1) Disbursing payment for shelter and utilities, such as a check directly to the landlord, mortgage company, utility company, etc.;

(2) Directing payment to vendors directly for goods or services provided to you including personal and incidental expenses.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0160, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0165 What happens if my relationship with my protective payee ends? If the relationship with your protective payee is terminated for any reason, the protective payee shall return any remaining funds to the department or its designee.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0165, filed 7/28/00, effective 9/1/00.]

Chapter 388-805 WAC

CERTIFICATION REQUIREMENTS FOR CHEMICAL DEPENDENCY SERVICE PROVIDERS

(Formerly chapter 440-22 WAC)

WAC

SECTION I—PURPOSE AND DEFINITIONS

WAC 388-805-001 What is the purpose of this chapter? These rules describe the standards and processes necessary to be a certified chemical dependency treatment program. The rules have been adopted under the authority and purposes of the following chapters of law.

(1) Chapter 10.05 RCW, Deferred prosecution—Courts of limited jurisdiction;

(2) Chapter 46.61 RCW, Rules of the road;

(3) Chapter 49.60 RCW, Discrimination—Human rights commission;

(4) Chapter 70.96A RCW, Treatment for alcoholism, intoxication and drug addiction; and

(5) Chapter 74.50 RCW, Alcoholism and Drug Addiction Treatment and Support Act (ADATSA).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-001, filed 11/21/00, effective 1/1/01.]

WAC 388-805-005 What definitions are important throughout this chapter? **"Added service"** means the adding of certification for chemical dependency levels of care to an existing certified agency at an approved location.

"Addiction counseling competencies" means the knowledge, skills, and attitudes of chemical dependency counselor professional practice as described in Technical Assistance Publication No. 21, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services 1998.

"Administrator" means the person designated responsible for the operation of the certified treatment service.

"Adult" means a person eighteen years of age or older.

"Alcoholic" means a person who has the disease of alcoholism.

"Alcoholism" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Approved supervisor" means a person who meets the education and experience requirements described in WAC 246-811-030 and 246-811-045 through 246-811-049 and who is available to the person being supervised.

"Authenticated" means written, permanent verification of an entry in a patient treatment record by an individual, by means of an original signature including first initial, last name, and professional designation or job title, or initials of the name if the file includes an authentication record, and the date of the entry. If patient records are maintained electronically, unique electronic passwords, biophysical or passcard equipment are acceptable methods of authentication.

"Authentication record" means a document that is part of a patient's treatment record, with legible identification of all persons initialing entries in the treatment record, and includes:

(1) Full printed name;

(2) Signature including the first initial and last name; and

(3) Initials and abbreviations indicating professional designation or job title.

"Bloodborne pathogens" means pathogenic microorganisms that are present in human blood and can cause disease in humans. The pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

"Branch site" means a physically separate certified site where qualified staff provides a certified treatment service, governed by a parent organization. The branch site is an extension of a certified provider's services to one or more sites.

"Certified treatment service" means a discrete program of chemical dependency treatment offered by a service provider who has a certificate of approval from the department of social and health services, as evidence the provider meets the standards of chapter 388-805 WAC.

"Change in ownership" means one of the following conditions:

(1) When the ownership of a certified chemical dependency treatment provider changes from one distinct legal entity (owner) to a distinct other;

(2) When the type of business changes from one type to another; or

(3) When the current ownership takes on a new owner of five percent or more of the organizational assets.

"Chemical dependency" means a person's alcoholism or drug addiction or both.

"Chemical dependency counseling" means face-to-face individual or group contact using therapeutic techniques that are:

(1) Led by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP;

(2) Directed toward patients and others who are harmfully affected by the use of mood-altering chemicals or are chemically dependent; and

(3) Directed toward a goal of abstinence for chemically dependent persons.

"Chemical dependency professional" means a person certified as a chemical dependency professional by the Washington state department of health under chapter 18.205 RCW.

"Child" means a person less than eighteen years of age, also known as adolescent, juvenile, or minor.

"County coordinator" means the person designated by the chief executive officer of a county to carry out administrative and oversight responsibilities of the county chemical dependency program.

"Criminal background check" means a search by the Washington state patrol for any record of convictions or civil adjudication related to crimes against children or other persons, including developmentally disabled and vulnerable adults, per RCW 43.43.830 through 43.43.842 relating to the Washington state patrol.

"Danger to self or others," for purposes of WAC 388-805-520, means a youth who resides in a chemical dependency treatment agency and creates a risk of serious harm to the health, safety, or welfare to self or others. Behaviors considered a danger to self or others include:

(1) Suicide threat or attempt;

(2) Assault or threat of assault; or

(3) Attempt to run from treatment, potentially resulting in a dangerous or life-threatening situation.

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

"Detoxification" or **"detox"** means care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Disability, a person with" means a person whom:

(1) Has a physical or mental impairment that substantially limits one or more major life activities of the person;

(2) Has a record of such an impairment; or

(3) Is regarded as having such an impairment.

"Discrete treatment service" means a chemical dependency treatment service that:

(1) Provides distinct chemical dependency supervision and treatment separate from any other services provided within the facility;

(2) Provides a separate treatment area for ensuring confidentiality of chemical dependency treatment services; and

(3) Has separate accounting records and documents identifying the provider's funding sources and expenditures of all funds received for the provision of chemical dependency treatment services.

"Domestic violence" means:

(1) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;

(2) Sexual assault of one family or household member by another;

(3) Stalking as defined in RCW 9A.46.110 of one family or household member by another family or household member; or

(4) As defined in RCW 10.99.020, RCW 26.50.010, or other Washington state statutes.

"Drug addiction" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. Drug addiction is characterized by impaired control over use of drugs, preoccupation with drugs, use of a drug despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Essential requirement" means a critical element of chemical dependency treatment services that must be present in order to provide effective treatment.

"First steps" means a program available across the state for low-income pregnant women and their infants. First steps provides maternity care for pregnant and postpartum women and health care for infants and young children.

"Governing body" means the legal entity responsible for the operation of the chemical dependency treatment service.

"HIV/AIDS brief risk intervention (BRI)" means an individual face-to-face interview with a client or patient, to help that person assess personal risk for HIV/AIDS infection and discuss methods to reduce infection transmission.

"HIV/AIDS education" means education, in addition to the brief risk intervention, designed to provide a person with information regarding HIV/AIDS risk factors, HIV antibody testing, HIV infection prevention techniques, the impact of alcohol and other drug use on risks and the disease process, and trends in the spread of the disease.

"Medical practitioner" means a physician, advanced registered nurse practitioner (ARNP), or certified physician's assistant. ARNPs and midwives with prescriptive authority may perform practitioner functions related only to indicated specialty services.

"Misuse" means use of alcohol or other drugs by a person in:

(1) Violation of any law; or

(2) Breach of agency policies relating to the drug-free work place.

"Off-site treatment" means provision of chemical dependency treatment by a certified provider at a location where treatment is not the primary purpose of the site; such as in schools, hospitals, or correctional facilities.

"Opiate substitution treatment agency" means an organization that administers or dispenses an approved drug as specified in 212 CFR Part 291 for treatment or detoxification of opiate substitution. The agency is:

(1) Approved by the Federal Food and Drug Administration;

(2) Registered with the Federal Drug Enforcement Administration;

(3) Registered with the State Board of Pharmacy;

(4) Licensed by the county in which it operates; and

(5) Certified as an opiate substitution treatment agency by the department.

"Outcomes evaluation" means a system for determining the effectiveness and efficiency of results achieved by patients during or following service delivery, and patient satisfaction with those results for the purpose of program improvement.

"Patient" is a person receiving chemical dependency treatment services from a certified program.

"Patient contact" means time spent with a client or patient to do assessments, individual or group counseling, or education.

"Patient placement criteria (PPC)" means admission, continued service, and discharge criteria found in the Patient Placement Criteria for the Treatment of Substance-Related Disorders as published and revised by the American Society of Addiction Medicine (ASAM).

"Probation assessment officer (PAO)" means a person employed at a certified district or municipal court probation assessment service that meets the PAO requirements of WAC 388-805-220.

"Probation assessment service" means a certified assessment service offered by a misdemeanant probation department or unit within a county or municipality.

"Progress notes" are a permanent record of ongoing assessments of a patient's participation in and response to treatment, and progress in recovery.

"Qualified personnel" means trained, qualified staff, consultants, trainees, and volunteers who meet appropriate legal, licensing, certification, and registration requirements.

"Registered counselor" means a person registered, or certified by the state department of health as required by chapter 18.19 RCW.

"Relocation" means change in location from one office space to a new office space, or moving from one office building to another.

"Remodeling" means expansion of existing office space to additional office space at the same address, or remodeling of interior walls and space within existing office space.

"Restraint," for purposes of WAC 388-805-520, means the use of methods, by a trained staff person, to prevent or limit free body movement in case of out-of-control behavior.

"Restraint" includes:

(1) Containment or seclusion in an unlocked quiet room;

(2) Physical restraint, meaning a person physically holds or restricts another person in a safe manner for a short time in an immediate crisis; or

(3) Use of a safe and humane apparatus, which the person cannot release by oneself.

"Service provider" or **"provider"** means a legally operated entity certified by the department to provide chemical dependency services. The components of a service provider are:

(1) Legal entity/owner;

(2) Facility; and

(3) Staff and services.

"Sexual abuse" means sexual assault, incest, or sexual exploitation.

"Sexual harassment" means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

(1) Submission to such conduct is made either explicitly or implicitly a term or condition of employment or treatment; or

(2) Such conduct interferes with work performance or creates an intimidating, hostile, or offensive work or treatment environment.

"Substance abuse" means a recurring pattern of alcohol or other drug use that substantially impairs a person's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.

"Summary suspension" means an immediate suspension of certification, per RCW 34.05.422(4), by the department pending administrative proceedings for suspension, revocation, or other actions deemed necessary by the department.

"Supervision" means:

(1) Regular monitoring of the administrative, clinical, or clerical work performance of a staff member, trainee, student, volunteer, or employee on contract by a person with the authority to give directions and require change; and

(2) **"Direct supervision"** means the supervisor is on the premises and available for immediate consultation.

"Suspend" means termination of the department's certification of a provider's treatment services for a specified period or until specific conditions have been met and the department notifies the provider of reinstatement.

"Treatment services" means the broad range of emergency, detoxification, residential, and outpatient services and care. Treatment services include diagnostic evaluation, chemical dependency education, individual and group counseling, medical, psychiatric, psychological, and social services, vocational rehabilitation and career counseling that may be extended to alcoholics and other drug addicts and their families, persons incapacitated by alcohol or other drugs, and intoxicated persons.

"Urinalysis" means analysis of a patient's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a provider who is exempted from licensure by the department of health:

(1) **"Negative urine"** is a urine sample in which the lab does not detect specific levels of alcohol or other specified drugs; and

(2) **"Positive urine"** is a urine sample in which the lab confirms specific levels of alcohol or other specified drugs.

"Vulnerable adult" means a person who lacks the functional, mental, or physical ability to care for oneself.

"Young adult" means an adult who is eighteen, nineteen, or twenty years old.

"Youth" means a person seventeen years of age or younger.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-005, filed 11/21/00, effective 1/1/01.]

SECTION II—APPLICATION FOR CERTIFICATION

WAC 388-805-010 What chemical dependency services are certified by the department? (1) The department certifies the following types of chemical dependency services:

(a) **Detoxification services**, which assist patients in withdrawing from alcohol and other drugs including:

(i) **Acute detox**, which provides medical care and physician supervision for withdrawal from alcohol or other drugs; and

(ii) **Sub-acute detox**, which is nonmedical detoxification or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment.

(b) **Residential treatment services**, which provide chemical dependency treatment for patients and include room and board in a twenty-four-hour-a-day supervised facility, including:

(i) **Intensive inpatient**, a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families;

(ii) **Recovery house**, a program of care and treatment with social, vocational, and recreational activities to aid in

patient adjustment to abstinence and to aid in job training, employment, or other types of community activities; and

(iii) **Long-term treatment**, a program of treatment with personal care services for chronically impaired alcoholics and addicts with impaired self-maintenance capabilities. These patients need personal guidance to maintain abstinence and good health.

(c) **Outpatient treatment services**, which provide chemical dependency treatment to patients less than twenty-four hours a day, including:

(i) **Intensive outpatient**, a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts and their families;

(ii) **Outpatient**, individual and group treatment services of varying duration and intensity according to a prescribed plan; and

(iii) **Opiate substitution outpatient treatment**, which meets both outpatient and opiate substitution treatment service requirements.

(d) **Assessment services**, which include:

(i) **ADATSA assessments**, alcohol and other drug assessments of clients seeking financial assistance from the department due to the incapacity of chemical dependency. Services include assessment, referral, case monitoring, and assistance with employment; and

(ii) **DUI assessments**, diagnostic services requested by the courts to determine a client's involvement with alcohol and other drugs and to recommend a course of action.

(e) **Information and assistance services**, which include:

(i) **Alcohol and drug information school**, an education program about the use and abuse of alcohol and other drugs, for persons referred by the courts and others, who do not present a significant chemical dependency problem, to help those persons make informed decisions about the use of alcohol and other drugs;

(ii) **Information and crisis services**, response to persons having chemical dependency needs, by phone or in person;

(iii) **Emergency service patrol**, assistance provided to intoxicated persons in the streets and other public places;

(iv) **Treatment alternatives to street crime (TASC)**, is a referral and case management service. TASC providers furnish a link between the criminal justice system and the treatment system. TASC identifies, assesses, and refers appropriate alcohol and other drug dependent offenders to community-based substance abuse treatment and monitors the outcome for the criminal justice system.

(2) The department may certify a provider for more than one of the services listed under subsection (1) of this section when the provider complies with the specific requirements of the selected services.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-010, filed 11/21/00, effective 1/1/01.]

WAC 388-805-015 How do I apply for certification as a chemical dependency service provider? (1) A potential new chemical dependency service provider, otherwise referred to as applicant, seeking certification for one or more services, as described under WAC 388-805-010, must:

(a) Request from the department an application packet of information on how to become a certified chemical dependency service provider; and

(b) Obtain a license as a residential treatment facility from the department of health, if planning to offer residential services.

(2) The applicant must submit a completed application to the department that includes:

(a) If the applicant is a sole provider: the name and address of the applicant, and a statement of sole proprietorship;

(b) If the applicant is a partnership: the name and address of every partner, and a copy of the written partnership agreement;

(c) If the applicant is a limited liability company: the name and addresses of its officers, and any owner of five percent or more of the organizational assets, and a copy of the certificate of formation issued by the state of Washington, secretary of state;

(d) If the applicant is a corporation: the names and addresses of its officers, board of directors and trustees, and any owner of five percent or more or the organizational assets, and a copy of the corporate articles of incorporation and bylaws;

(e) A copy of the Master Business License authorizing the organization to do business in Washington state;

(f) The Social Security Number or Federal Employer Identification Number for the governing organization or person;

(g) The name of the individual administrator under whose management or supervision the services will be provided;

(h) A copy of the report of findings from a criminal background check of any owner of five percent or more of the organizational assets and the administrator;

(i) Additional disclosure statements or background inquiries if the department has reason to believe that offenses, specified under RCW 43.43.830, have occurred since completion of the original application;

(j) The physical location of the facility where services will be provided including, in the case of a location known only by postal route and box numbers, and the street address;

(k) A plan of the premises assuring the chemical dependency treatment service is discrete from other programs, indicating capacities of the location for the proposed uses;

(l) Floor plan showing use of each room and location of:

(i) Windows and doors;

(ii) Restrooms;

(iii) Floor to ceiling walls;

(iv) Areas serving as confidential counseling rooms;

(v) Other therapy and recreation areas and rooms;

(vi) Confidential patient records storage; and

(vii) Sleeping rooms, if a residential facility.

(m) A completed facility accessibility self-evaluation form;

(n) Policy and procedure manuals specific to the agency at the proposed site, and meet the manual requirements described later in this regulation, including the:

(i) Administrative manual;

(ii) Personnel manual; and

(iii) Clinical manual.

(o) Sample patient records for each treatment service applied for; and

(p) Evidence of sufficient qualified staff to deliver services.

(3) The agency owner or legal representative must:

(a) Sign the completed application form and submit the original to the department;

(b) Send a copy of the completed application form to the county coordinator in the county where services will be provided;

(c) Submit the application fee with the application materials; and

(d) Report any changes occurring during the certification process.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-015, filed 11/21/00, effective 1/1/01.]

WAC 388-805-020 How do I apply for certification of a branch agency or added service? (1) A certified chemical dependency service provider applying for a branch site or an additional certified service must request an abbreviated application packet from the department.

(2) The applicant must submit an abbreviated application, including:

(a) The name of the individual administrator providing management or supervision of the services;

(b) A written declaration that a current copy of the agency policy and procedure manual will be maintained at the branch site and that the manual has been revised to accommodate the differences in business and clinical practices at that site;

(c) An organization chart, showing the relationship of the branch to the main organization, job titles, and lines of authority;

(d) Evidence of sufficient qualified staff to deliver services at the branch site; and

(e) Evidence of meeting the requirements of:

(i) WAC 388-805-015 (1)(b);

(ii) WAC 388-805-015 (2)(h) through (2)(l) and (m); and

(iii) WAC 388-805-015(3).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-020, filed 11/21/00, effective 1/1/01.]

WAC 388-805-030 How do I apply for opiate substitution treatment service certification? In addition to WAC 388-805-015 or 388-805-020 requirements, a potential opiate substitution treatment service provider must submit to the department:

(1) Evidence of licensure from the county served, or evidence the county has authorized a specific certified agency to provide opiate substitution treatment, per RCW 70.96A.400 through 70.96A.420.

(2) A copy of the registration certificate from the Washington state board of pharmacy.

(3) A copy of the application to the Federal Drug Enforcement Administration.

(4) A copy of the application to the Federal Food and Drug Administration.

(5) Policies and procedures identified under WAC 388-805-700 through 388-805-750.

(6) Certification for opiate substitution treatment is contingent on the concurrent approval by the applicable county, state, and federal regulatory authorities.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-030, filed 11/21/00, effective 1/1/01.]

WAC 388-805-060 How does the department conduct an examination of nonresidential facilities? The department must conduct an on-site examination of each new nonresidential applicant's facility or branch facility. The department must determine if the applicant's facility is:

(1) Substantially as described.

(2) Suitable for the purposes intended.

(3) Not a personal residence.

(4) Approved as meeting all building and safety requirements.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-060, filed 11/21/00, effective 1/1/01.]

WAC 388-805-065 How does the department determine disqualification or denial of an application? The department must consider the ability of each person named in the application to operate in accord with this chapter before the department grants or renews certification of a chemical dependency service.

(1) The department must deny an applicant's certification when any of the following conditions occurred and was not satisfactorily resolved, or when any owner or administrator:

(a) Had a license or certification for a chemical dependency treatment service or health care agency denied, revoked, or suspended;

(b) Was convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse;

(c) Obtained or attempted to obtain a health provider license, certification, or registration by fraudulent means or misrepresentation;

(d) Committed, permitted, aided, or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180;

(e) Demonstrated cruelty, abuse, negligence, misconduct, or indifference to the welfare of a patient or displayed acts of discrimination;

(f) Misappropriated patient property or resources;

(g) Failed to meet financial obligations or contracted service commitments that affect patient care;

(h) Has a history of noncompliance with state or federal regulations in an agency with which the applicant has been affiliated;

(i) Knowingly, or with reason to know, made a false statement of fact or failed to submit necessary information in:

(i) The application or materials attached; and

(ii) Any matter under department investigation.

(j) Refused to allow the department access to records, files, books, or portions of the premises relating to operation of the chemical dependency service;

(k) Willfully interfered with the preservation of material information or attempted to impede the work of an authorized department representative;

(l) Is in violation of any provision of chapter 70.96A RCW; or

(m) Does not meet criminal background check requirements.

(2) The department may deny certification when an applicant:

(a) Fails to provide satisfactory application materials; or

(b) Advertises itself as certified when certification has not been granted, or has been revoked or canceled.

(3) The applicant may appeal department decisions in accord with chapter 34.05 RCW, the Washington Administrative Procedure Act and chapter 388-02 WAC.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-065, filed 11/21/00, effective 1/1/01.]

WAC 388-805-070 What happens after I make application for certification? (1) The department may grant an applicant initial certification after a review of application materials and an on-site visit confirms the applicant has the capacity to operate in compliance with this chapter.

(2) A provider's failure to meet and maintain conditions of the initial certification may result in suspension of certification.

(3) An initial certificate of approval may be issued for up to one year.

(4) The provider must post the certificate in a conspicuous place on the premises.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-070, filed 11/21/00, effective 1/1/01.]

WAC 388-805-075 How do I apply for an exemption? (1) The department may grant an exemption from compliance with specific requirements in this WAC chapter when a provider submits an exemption request in writing. The provider must assure the exemption request does not:

(a) Jeopardize the safety, health, or treatment of patients; and

(b) Impede fair competition of another service provider.

(2) Providers must submit a signed letter requesting the exemption to the Supervisor, Certification Section, Division of Alcohol and Substance Abuse, P.O. Box 45331, Olympia, WA 98504-5331.

(3) The department must approve or deny all exemption requests in writing.

(4) The department and the provider must maintain a copy of the decision.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-075, filed 11/21/00, effective 1/1/01.]

SECTION III—CERTIFICATION FEES

WAC 388-805-080 What are the fee requirements for certification? (1) The department must set fees to be charged for certification.

(2) Providers must pay certification fees:

(a) At the time of application. One-half of the application fee may be refunded if an application is withdrawn before certification or denial; and

(b) Within thirty days of receiving an invoice.

(3) Payment must be made by check, draft, or money order made payable to the department of social and health services.

(4) Fees will not be refunded when certification is denied, revoked, or suspended.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-080, filed 11/21/00, effective 1/1/01.]

WAC 388-805-085 What are the fees for agency certification? (1) Application fees:

(a) New agency	$500
(b) Branch agency	$500
(c) Application for adding one or more services	$200
(d) Change in ownership	$500

(2) Initial and annual certification fees:

(a) For detoxification and residential services:	$26 per licensed bed
(b) For nonresidential services:	
(i) Large size agencies: 3,000 or more clients served per year	$1,125 per year
(ii) Medium size agencies: 1,000-2,999 clients served per year	$750 per year
(iii) Small size agencies: 0-999 clients served per year	$375 per year
(c) For agencies certified through deeming per WAC 388-805-0115	$200 per year

(3) Each year providers must complete a declaration form provided by the department indicating the number of patients served annually, the provider's national accreditation status, and other information necessary for establishing fees and updating certification information.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-085, filed 11/21/00, effective 1/1/01.]

WAC 388-805-090 May certification fees be waived? (1) Certification fees may be waived when the fees would not be in the interest of public health and safety, or when the fees would be to the financial disadvantage of the state.

(2) Providers may submit a letter requesting a waiver of fees to the Supervisor, Certification Section, Division of Alcohol and Substance Abuse, P.O. Box 45331, Olympia, Washington, 98504-5331.

(3) Fee waivers may be granted to qualified providers who receive funding from tribal, federal, state or county government resources as follows:

(a) For residential providers: The twenty-six dollar per bed annual fee will be assessed only for those beds not funded by a governmental source;

(b) For nonresidential providers: The amount of the fee waiver must be determined by the percent of the provider's

revenues that come from governmental sources, according to the following schedule:

Percent Government Revenues	90-100%	75-89%	50-74%	0-49%
Small agency	No fee	$90	$185	$375
Medium agency	No fee	$185	$375	$750
Large agency	No fee	$285	$565	$1,125

(4) Requests for fee waiver must be mailed to the department and include the following:

(a) The reason for the request;

(b) For residential providers:

(i) Documentation of the number of beds currently licensed by the department of health;

(ii) Documentation showing the number of beds funded by a government entity including, tribal, federal, state or county government sources.

(c) For nonresidential providers:

(i) Documentation of the number of clients served during the previous twelve-month period;

(ii) Documentation showing the amount of government revenues received during the previous twelve-month period;

(iii) Documentation showing the amount of private revenues received during the previous twelve-month period.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-090, filed 11/21/00, effective 1/1/01.]

WAC 388-805-095 How long are certificates effective? Certificates are effective for one year from the date of issuance unless:

(1) The department has taken action for noncompliance under WAC 388-805-065, 388-805-125, or 388-805-130; or

(2) The provider does not pay required fees.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-095, filed 11/21/00, effective 1/1/01.]

SECTION IV—MAINTAINING CERTIFICATION

WAC 388-805-100 What do I need to do to maintain agency certification? (1) A service provider's continued certification and renewal is contingent upon:

(a) Completion of an annual declaration of certification; and

(b) Payment of certification fees, if applicable.

(2) Providing the essential requirements for chemical dependency treatment, including the following elements:

(a) Treatment process:

(i) Assessments, as described in WAC 388-805-310;

(ii) Treatment planning, as described in WAC 388-805-315 (2)(a) and 388-805-325(11);

(iii) Documenting patient progress, as described in WAC 388-805-315 (1)(c) and 388-805-325(13);

(iv) Treatment plan reviews and updates, as described in WAC 388-805-315 (2)(b), 388-805-325 (11)(g) and 388-805-325 (13)(c);

(v) Patient compliance reports, as described in WAC 388-805-315 (4)(b), 388-805-325(17), and 388-805-330;

(vi) Continuing care, and discharge planning, as described in WAC 388-805-315 (2)(e)(f) and (7), and 388-805-325 (18) and (19).

(b) Staffing: Provide sufficient qualified personnel for the care of patients as described in WAC 388-805-140(4) and 388-805-145(4);

(c) Facility:

(i) Provide sufficient facilities, equipment, and supplies for the care and safety of patients as described in WAC 388-805-140 (4) and (5);

(ii) If a residential provider, be licensed by the department of health as described by WAC 388-805-015 (1)(b).

(3) Findings during periodic on-site surveys and complaint investigations to determine the provider's compliance with this chapter. During on-site surveys and complaint investigations, provider representatives must cooperate with department representatives to:

(a) Examine any part of the facility at reasonable times and as needed;

(b) Review and evaluate records, including patient clinical records, personnel files, policies, procedures, fiscal records, data, and other documents as the department requires to determine compliance; and

(c) Conduct individual interviews with patients and staff members.

(4) The provider must post the notice of a scheduled department on-site survey in a conspicuous place accessible to patients and staff.

(5) The provider must correct compliance deficiencies found at such surveys immediately or as agreed by a plan of correction approved by the department.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-100, filed 11/21/00, effective 1/1/01.]

WAC 388-805-105 What do I need to do for a change in ownership? (1) When a certified chemical dependency service provider plans a change in ownership, the current service provider must submit a change in ownership application form sixty or more days before the proposed date of ownership change.

(2) The current provider must include the following information with the application:

(a) Name and address of each new prospective owner of five percent or more of the organizational assets as required by WAC 388-805-015 (2)(a) through (d);

(b) Current and proposed name (if applicable) of the affected;

(c) Date of the proposed transaction;

(d) A copy of the transfer agreement between the outgoing and incoming owner(s);

(e) If a corporation, the names and addresses of the proposed responsible officers or partners;

(f) A statement regarding the disposition and management of patient records, as described under 42 CFR, Part 2 and WAC 388-805-320; and

(g) A copy of the report of findings from a criminal background check of any new owner of five percent or more of the organizational assets and new administrator when applicable.

(3) The department must determine which, if any, WAC 388-805-015 or 388-805-020 requirements apply to the potential new service provider, depending on the extent of ownership and operational changes.

(4) The department may grant certification to the new owner when the new owner:

(a) Successfully completes the application process; and

(b) Ensures continuation of compliance with rules of this chapter and implementation of plans of correction for deficiencies relating to this chapter, when applicable.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-105, filed 11/21/00, effective 1/1/01.]

WAC 388-805-110 What do I do to relocate or remodel a facility? When a certified chemical dependency service provider plans to relocate or change the physical structure of a facility in a manner that affects patient care, the provider must:

(1) Submit a completed agency relocation approval request form, or a request for approval in writing if remodeling, sixty or more days before the proposed date of relocation or change.

(2) Submit a sample floor plan that includes information identified under WAC 388-805-015 (2)(f) through (k).

(3) Submit a completed facility accessibility self-evaluation form.

(4) Provide for department examination of nonresidential premises before approval, as described under WAC 388-805-060.

(5) Contact the department of health for approval before relocation or remodel if a residential treatment facility.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-110, filed 11/21/00, effective 1/1/01.]

WAC 388-805-115 How does the department deem national accreditation? (1) The department must deem accreditation by a national chemical dependency accreditation body, recognized by the department, if the treatment provider was initially certified by the department and when:

(a) A major portion of the national accreditation body requirements meet or exceed chapter 388-805 WAC requirements;

(b) The national accreditation time intervals meet or exceed state expectations;

(c) The provider notifies the department of scheduled onsite surveys;

(d) The provider promptly sends a copy of survey findings, corrective action plans, and follow-up responses to the department; and

(e) WAC 388-805-001 through 388-805-135 continue to apply at all times.

(2) The department may apply an abbreviated department survey, which includes requirements specific to Washington state at its regular certification intervals.

(3) The department must act upon:

(a) Complaints received; and

(b) Deficiencies cited by the national accreditation body for which there is no evidence of correction.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-115, filed 11/21/00, effective 1/1/01.]

WAC 388-805-120 How does the department assess penalties? (1) When the department determines that a service provider fails to comply with provider entry requirements or ongoing requirements of this chapter, the department may:

(a) Assess fees to cover costs of added certification activities;

(b) Cease referrals of new patients who are recipients of state or federal funds; and

(c) Notify the county alcohol and drug coordinator and local media of ceased referrals, involuntary cancellations, suspensions, revocations, or nonrenewal of certification.

(2) When the department determines a service provider knowingly failed to report to the court a patient's noncompliance with treatment ordered by the court under chapter 46.61 RCW, the department must assess the provider a fine of two hundred fifty dollars for each incident of nonreporting.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-120, filed 11/21/00, effective 1/1/01.]

WAC 388-805-125 How does the department cancel certification? The department may cancel a provider's certification if the provider:

(1) Ceases to provide services for which the provider is certified.

(2) Voluntarily cancels certification.

(3) Fails to submit required certification fees.

(4) Changes ownership without prior notification and approval.

(5) Relocates without prior notification and approval.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-125, filed 11/21/00, effective 1/1/01.]

WAC 388-805-130 How does the department suspend or revoke certification? (1) The department must suspend or revoke a provider's certification when a disqualifying situation described under WAC 388-805-065 applies to a current service provider.

(2) The department must revoke a provider's certification when the provider knowingly failed to report to the court, within a continuous twelve-month period, three incidents of patient noncompliance with treatment ordered by the court under chapter 46.61 RCW.

(3) The department may suspend or revoke a provider's certification when any of the following provider deficiencies or circumstances occur:

(a) A provider fails to provide the essential requirements of chemical dependency treatment as described in WAC 388-805-100(2), and one or more of the following conditions occur:

(i) Violation of a rule threatens or results in harm to a patient;

(ii) A reasonably prudent provider should have been aware of a condition resulting in significant violation of a law or rule;

(iii) A provider failed to investigate or take corrective or preventive action to deal with a suspected or identified patient care problem;

(iv) Noncompliance occurs repeatedly in the same or similar areas;

(v) There is an inability to attain compliance with laws or rules within a reasonable period of time.

(b) The provider fails to submit an acceptable and timely plan of correction for cited deficiencies; or

(c) The provider fails to correct cited deficiencies.

(4) The department may suspend certification upon receipt of a providers written request. Providers requesting voluntary suspension must submit a written request for reinstatement of certification within one year from the effective date of the suspension. The department will review the request for reinstatement, determine if the provider is able to operate in compliance with certification requirements, and notify the provider of the results of the review for reinstatement.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-130, filed 11/21/00, effective 1/1/01.]

WAC 388-805-135 What is the prehearing, hearing and appeals process? (1) In case of involuntary certification cancellation, suspension, or revocation of the certification, or a penalty for noncompliance, the department must:

(a) Notify the service provider and the county coordinator of any action to be taken; and

(b) Inform the provider of pre-hearing and dispute conferences, hearing, and appeal rights under chapter 388-02 WAC.

(2) The department may order a summary suspension of the provider's certification pending completion of the appeal process when the preservation of public health, safety, or welfare requires emergency action.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-135, filed 11/21/00, effective 1/1/01.]

SECTION V—ORGANIZATIONAL STANDARDS

WAC 388-805-140 What are the requirements for a provider's governing body? The provider's governing body, legally responsible for the conduct and quality of services provided, must:

(1) Appoint an administrator responsible for the day-to-day operation of the program.

(2) Maintain a current job description for the administrator including the administrator's authority and duties.

(3) Establish the philosophy and overall objectives for the treatment services.

(4) Notify the department within thirty days, of changes of the agency administrator.

(5) Provide personnel, facilities, equipment, and supplies necessary for the safety and care of patients.

(6) If a nonresidential provider, ensure:

(a) Safety of patients and staff; and

(b) Maintenance and operation of the facility.

(7) Review and approve written administrative, personnel, and clinical policies and procedures required under WAC 388-805-150, 388-805-200, and 388-805-300.

(8) Ensure the administration and operation of the agency is in compliance with:

(a) Chapter 388-805 WAC requirements;

(b) Applicable federal, state, and local laws and rules; and

(c) Federal, state, and local licenses, permits, and approvals.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-140, filed 11/21/00, effective 1/1/01.]

WAC 388-805-145 What are the key responsibilities required of an agency administrator? (1) The administrator is responsible for the day-to-day operation of the certified treatment service, including:

(a) All administrative matters;

(b) Patient care services; and

(c) Meeting all applicable rules and ethical standards.

(2) When the administrator is not on duty or on call, a staff person must be delegated the authority and responsibility to act in the administrator's behalf.

(3) The administrator must ensure administrative, personnel, and clinical policy and procedure manuals:

(a) Are developed and adhered to; and

(b) Are reviewed and revised as necessary, and at least annually.

(4) The administrator must employ sufficient qualified personnel to provide adequate chemical dependency treatment, facility security, patient safety and other special needs of patients.

(5) The administrator must ensure all persons providing counseling services are registered, certified or licensed by the department of health.

(6) The administrator must ensure full-time chemical dependency professionals (CDPs) or CDP trainees do not exceed one hundred twenty hours of patient contact per month.

(7) The administrator must assign the responsibilities for a clinical supervisor to a least one person within the organization.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-145, filed 11/21/00, effective 1/1/01.]

WAC 388-805-150 What must be included in an agency administrative manual? Each service provider must have and adhere to an administrative manual that contains at a minimum:

(1) The organization's:

(a) Articles and certificate of incorporation if the owner is a corporation;

(b) Partnership agreement if the owner is a partnership; or

(c) Statement of sole proprietorship.

(2) The agency's bylaws if the owner is a corporation.

(3) Copies of a current master license and state business licenses or a current declaration statement that they are updated as required.

(4) The provider's philosophy on and objectives of chemical dependency treatment with a goal of total abstinence, consistent with RCW 70.96A.011.

(5) Policies and procedures describing how services will be made sensitive to the needs of each patient, including assurance that:

(a) Certified interpreters or other acceptable alternatives are available for persons with limited English-speaking proficiency and persons having a sensory impairment; and

(b) Assistance will be provided to persons with disabilities in case of an emergency.

(6) A policy addressing special needs and protection for youth and young adults, and for determining whether a youth or young adult can fully participate in treatment, before admission of:

(a) A youth to a treatment service caring for adults; or

(b) A young adult to a treatment service caring for youth.

(7) An organization chart specifying:

(a) The governing body;

(b) Each staff position by job title, including volunteers, students, and persons on contract; and

(c) The number of full- or part-time persons for each position.

(8) A delegation of authority policy.

(9) A copy of current fee schedules.

(10) Policies and procedures implementing state and federal regulations on patient confidentiality, including provision of a summary of 42 CFR Part 2.22 (a)(1) and (2) to each patient.

(11) Policies and procedures for reporting suspected child abuse and neglect.

(12) Policies and procedures for reporting the death of a patient to the department when:

(a) The patient is in residence; or

(b) An outpatient dies on the premises.

(13) Patient grievance policy and procedures.

(14) Policies and procedures on reporting of incidents and actions taken.

(15) Smoking policies consistent with the Washington Clean Indoor Air Act, chapter 70.160 RCW.

(16) For a residential provider, a facility security policy and procedures, including:

(a) Preventing entry of unauthorized visitors; and

(b) Use of passes for leaves of patients.

(17) For a nonresidential provider, an evacuation plan for use in the event of a disaster, addressing:

(a) Communication methods for patients, staff, and visitors including persons with a visual or hearing impairment or limitation;

(b) Evacuation of mobility-impaired persons;

(c) Evacuation of children if child care is offered;

(d) Different types of disasters;

(e) Placement of posters showing routes of exit; and

(f) The need to mention evacuation routes at public meetings.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-150, filed 11/21/00, effective 1/1/01.]

WAC 388-805-155 What are the requirements for provider facilities? (1) The administrator must ensure the treatment service site:

(a) Is accessible to a person with a disability;

(b) Has a reception area separate from living and therapy areas;

(c) Has adequate private space for personal consultation with a patient, staff charting, and therapeutic and social activities, as appropriate;

(d) Has secure storage of active and closed confidential patient records; and

(e) Has one private room available if youth are admitted to a detox or residential facility.

(2) The administrator of a nonresidential facility must ensure:

(a) Evidence of a current fire inspection approval;

(b) Facilities and furnishings are kept clean, in good repair;

(c) Adequate lighting, heating, and ventilation; and

(d) Separate and secure storage of toxic substances, which are used only by staff or supervised persons.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-155, filed 11/21/00, effective 1/1/01.]

SECTION VI—HUMAN RESOURCE MANAGEMENT

WAC 388-805-200 What must be included in an agency personnel manual? The administrator must have and adhere to a personnel manual, which contains policies and procedures describing how the agency:

(1) Meets the personnel requirements of WAC 388-805-210 through 388-805-260.

(2) Conducts criminal background checks on its employees in order to comply with the rules specified in RCW 43.43.830 through 43.43.842.

(3) Provides for a drug free work place which includes:

(a) A philosophy of nontolerance of illegal drug-related activity;

(b) Agency standards of prohibited conduct; and

(c) Actions to be taken in the event a staff member misuses alcohol or other drugs.

(4) If a nonresidential provider, provides for prevention and control of communicable disease, including specific training and procedures on:

(a) Bloodborne pathogens, including HIV/AIDS and Hepatitis B;

(b) Tuberculosis; and

(c) Other communicable diseases.

(5) Provides staff orientation prior to assigning unsupervised duties, including orientation to:

(a) The administrative, personnel and clinical manuals;

(b) Staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities;

(c) Staff and patient grievance procedures; and

(d) The facility evacuation plan.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-200, filed 11/21/00, effective 1/1/01.]

WAC 388-805-205 What are agency personnel file requirements? (1) The administrator must ensure that there is a current personnel file for each employee, trainee, student, and volunteer, and for each contract staff person who provides or supervises patient care.

(2) The administrator must designate a person to be responsible for management of personnel files.

(3) Each person's file must contain:

(a) A copy of the results of a tuberculin skin test or evidence the person has completed a course of treatment approved by a physician or local health officer if the results are positive;

(b) Documentation of training on bloodborne pathogens, including HIV/AIDS and hepatitis B for all employees, volunteers, students, and treatment consultants on contract;

(i) At the time of staff's initial assignment to tasks where occupational exposure may take place;

(ii) Annually thereafter for bloodborne pathogens;

(c) A signed and dated commitment to maintain patient confidentiality in accordance with state and federal confidentiality requirements; and

(d) A record of an orientation to the agency as described in WAC 388-805-200(5).

(4) For residential facilities, documentation of current cardiopulmonary resuscitation (CPR) and first aid training for at least one person on each shift.

(5) Documentation of health department training and approval for any staff administering or reading a TB test.

(6) Employees who are patients or have been patients of the agency must have personnel records:

(a) Separate from clinical records; and

(b) Have no indication of current or previous patient status.

(7) In addition, each patient care staff member's personnel file must contain:

(a) Verification of qualifications for their assigned position including:

(i) For a chemical dependency professional (CDP): A copy of the person's valid CDP certification issued by the department of health (DOH);

(ii) For approved supervisors: Documentation to substantiate the person meets the qualifications of an approved supervisor as defined in WAC 246-811-010.

(iii) For other persons providing counseling, a copy of a valid registration, certification, or license issued by the DOH.

(iv) For probation assessment officers (PAO): Documentation that the person has met the education and experience requirements described in WAC 388-805-220;

(v) For probation assessment officer trainees:

(A) Documentation that the person meets the qualification requirements described in WAC 388-805-225; and

(B) Documentation of the PAO trainee's supervised experience as described in WAC 388-805-230 including an individual education and experience plan and documentation of progress toward completing the plan.

(vi) For information school instructors:

(A) A copy of a certificate of completion of an alcohol and other drug information school instructor's training course approved by the department; and

(B) Documentation of continuing education as specified in WAC 388-805-250.

(b) A copy of a current job description, signed and dated by the employee and supervisor which includes:

(i) Job title;

(ii) Minimum qualifications for the position;

(iii) Summary of duties and responsibilities;

(iv) For contract staff, formal agreements or personnel contracts, which describe the nature and extent of patient care services, may be substituted for job descriptions.

(c) A written performance evaluation for each year of employment:

(i) Conducted by the immediate supervisor of each staff member; and

(ii) Signed and dated by the employee and supervisor.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-205, filed 11/21/00, effective 1/1/01.]

WAC 388-805-210 What are the requirements for approved supervisors of chemical dependency professional trainees? (1) When an administrator decides to provide training opportunities for persons seeking to become chemical dependency professionals (CDP) trainees, the administrator must assign an approved supervisor, as defined in WAC 388-805-005, to each CDP trainee.

(2) Approved supervisors must provide the CDP trainees assigned to them with documentation substantiating their qualifications as an approved supervisor before the initiation of training.

(3) Approved supervisors must decrease the hours of patient contact allowed under WAC 388-805-145(6) by twenty percent for each full-time CDP trainee supervised.

(4) Approved supervisors are responsible for all patients assigned to the CDP trainees under their supervision.

(5) An approved supervisor must provide supervision to a CDP trainee as required by WAC 246-811-048.

(6) CDPs must review and co-authenticate all clinical documentation of CDP trainees.

(7) Approved supervisors must supervise, assess and document the progress the CDP trainees under their supervision are making toward meeting the requirements described in WAC 246-811-030 and 246-811-047. This documentation must be provided to trainees upon request.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-210, filed 11/21/00, effective 1/1/01.]

WAC 388-805-220 What are the requirements to be a probation assessment officer? A probation assessment officer (PAO), must:

(1) Be employed as a probation officer at a misdemeanant probation department or unit within a county or municipality;

(2) Be certified as a chemical dependency professional, or

(3) Have obtained a bachelor's or graduate degree in a social or health sciences field and have completed twelve quarter or eight semester credits from an accredited college or university in courses that include the following topics:

(a) Understanding addiction and the disease of chemical dependency;

(b) Pharmacological actions of alcohol and other drugs;

(c) Substance abuse and addiction treatment methods;

(d) Understanding addiction placement, continuing care, and discharge criteria, including ASAM PPC criteria;

(e) Cultural diversity including people with disabilities and it's implication for treatment;

(f) Chemical dependency clinical evaluation (screening and referral to include co-morbidity);

(g) HIV/AIDS brief risk intervention for the chemically dependent;

(h) Chemical dependency confidentiality;

(i) Chemical dependency rules and regulations.

(4) In addition, a PAO must complete:

(a) Two thousand hours of supervised experience as a PAO trainee in a state-certified DUI assessment service program if a PAO possesses a baccalaureate degree;

(b) One thousand five hundred hours of experience as a PAO trainee in a state-certified DUI assessment service program if a PAO possesses a masters or higher degree.

(5) PAOs, must complete fifteen clock hours of continuing education each year in chemical dependency subject areas which will enhance competency as a PAO beginning on January 1 of the year following the year of initial qualification.

(6) A PAO is grandparented if they were qualified as a PAO by June 30, 2000, under WAC 440-22-240(2).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-220, filed 11/21/00, effective 1/1/01.]

WAC 388-805-225 What are the requirements to be a probation assessment officer trainee? A probation assessment officer (PAO) trainee must:

(1) Be employed as a probation officer at a misdemeanant probation department or unit within a county or municipality; and

(2) Be directly supervised and tutored by a PAO.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-225, filed 11/21/00, effective 1/1/01.]

WAC 388-805-230 What are the requirements for supervising probation assessment officer trainees? (1) Probation assessment officers (PAO) are responsible for all offenders assigned to PAO trainees under their supervision.

(2) PAO trainee supervisors must:

(a) Review and co-authenticate all trainee assessments entered in each offender's assessment record;

(b) Assist the trainee to develop and maintain an individualized education and experience plan (IEEP) designed to assist the trainee in obtaining the education and experience necessary to become a PAO;

(c) Provide the trainee orientation to the various laws and regulations that apply to the delivery of chemical dependency assessment and treatment services;

(d) Instruct the trainee in assessment methods and the transdisciplinary foundations described in the addiction counseling competencies;

(e) Observe the trainee conducting assessments; and

(f) Document quarterly evaluations of the progress of each trainee.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-230, filed 11/21/00, effective 1/1/01.]

WAC 388-805-240 What are the requirements for student practice in treatment agencies? (1) The treatment provider must have a written agreement with each educational institution using the treatment agency as a setting for student practice.

(2) The written agreement must describe the nature and scope of student activity at the treatment setting and the plan for supervision of student activities.

(3) Each student and academic supervisor must sign a confidentiality statement, which the provider must retain.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-240, filed 11/21/00, effective 1/1/01.]

WAC 388-805-250 What are the requirements to be an information school instructor? (1) An information school instructor must:

(a) Have a certificate of completion of an alcohol and other drug information school instructor's training course approved by the department; and

(b) Not have a history of alcohol or other drug misuse for two years before being qualified by the department.

(2) To remain qualified, the information school instructor must:

(a) Not display misuse of alcohol or other drugs while serving as an information school instructor; and

(b) Maintain information school instructor status by completing fifteen clock hours of continuing education:

(i) During each two-year period beginning January of the year following initial qualification; and

(ii) In subject areas that increase knowledge and skills in training, teaching techniques, curriculum planning and development, presentation of educational material, laws and rules, and developments in the chemical dependency field.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-250, filed 11/21/00, effective 1/1/01.]

WAC 388-805-260 What are the requirements for using volunteers in a treatment agency? (1) Each volunteer assisting a provider must be oriented as required under WAC 388-805-200(5).

(2) A volunteer must meet the qualifications of the position to which the person is assigned.

(3) A volunteer may provide counseling services when the person meets the requirements for a chemical dependency professional trainee or is a chemical dependency professional.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-260, filed 11/21/00, effective 1/1/01.]

SECTION VII—PROFESSIONAL PRACTICES

WAC 388-805-300 What must be included in the agency clinical manual? Each chemical dependency service provider must have and adhere to a clinical manual containing patient care policies and procedures, including:

(1) How the provider meets WAC 388-805-305 through 388-805-350 requirements.

(2) How the provider will meet applicable certified service requirements of WAC 388-805-400 through 388-805-840, including a description of each service offered, detailing:

(a) The number of hours of treatment and education for each certified service; and

(b) Allowance of up to twenty percent of education time to consist of film or video presentations.

(3) Identification of resources and referral options so staff can make referrals required by law and as indicated by patient needs.

(4) Assurance that there is an identified clinical supervisor who:

(a) Is a chemical dependency professional (CDP);

(b) Reviews a sample of patient records of each CDP quarterly; and

(c) Ensures implementation of assessment, treatment, continuing care, transfer and discharge plans in accord with WAC 388-805-315.

(5) Patient admission and discharge criteria using PPC:

(a) The administrator must not admit or retain a person unless the person's treatment needs can be met;

(b) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must assess and refer each patient to the appropriate treatment service; and

(c) A person needing detoxification must immediately be referred to a detoxification provider, unless the person needs acute care in a hospital.

(6) Tuberculosis screening for prevention and control of TB in all detox, residential, and outpatient programs, including:

(a) Obtaining a history of preventive or curative therapy;

(b) Screening and related procedures for coordinating with the local health department; and

(c) Implementing TB control as provided by the department of health TB control program.

(7) HIV/AIDS information, brief risk intervention, and referral.

(8) Limitation of group counseling sessions to twelve or fewer patients.

(9) Counseling sessions with nine to twelve youths to include a second adult staff member.

(10) Provision of education to each patient on:

(a) Alcohol, other drugs, and chemical dependency;

(b) Relapse prevention; and

(c) HIV/AIDS, hepatitis, and TB.

(11) Provision of education or information to each patient on:

(a) The impact of chemical use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of chemical use during pregnancy;

(b) Emotional, physical, and sexual abuse; and

(c) Nicotine addiction.

(12) An outline of each lecture and education session included in the service, sufficient in detail for another trained staff person to deliver the session in the absence of the regular instructor.

(13) Assigning of work to a patient by a CDP when the assignment:

(a) Is part of the treatment program; and

(b) Has therapeutic value.

(14) Use of self-help groups.

(15) Patient rules and responsibilities, including disciplinary sanctions for noncomplying patients.

(16) If youth are admitted, a policy and procedure for assessing the need for referral to child welfare services.

(17) Implementation of the deferred prosecution program.

(18) Policy and procedures for reporting status of persons convicted under chapter 46.61 RCW to the department of licensing.

(19) Nonresidential providers must have policies and procedures on:

(a) Medical emergencies;

(b) Suicidal and mentally ill patients;

(c) Medical oversight, including provision of a physical examination by a medical practitioner, on a person who:

(i) Is at risk of withdrawal from barbiturates or benzodiazepines; or

(ii) Used intravenous drugs in the thirty days before admission;

(d) Laboratory tests;

(e) Services and resources for pregnant women:

(i) A pregnant woman who is not seen by a private physician must be referred to a physician or the local first steps maternity care program for determination of prenatal care needs; and

(ii) Services include discussion of pregnancy specific issues and resources.

(f) If using medication services:

(i) A medical practitioner must evaluate each patient who is taking disulfiram at least once every ninety days;

(ii) Patient medications are stored, disbursed, and recorded in accord with chapter 246-326 WAC; and

(iii) Only a licensed nurse or medical practitioner may administer medication.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-300, filed 11/21/00, effective 1/1/01.]

WAC 388-805-305 What are patients' rights requirements in certified agencies? (1) Each service provider must ensure each patient:

(a) Is admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria;

(b) Is reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;

(c) Is treated in a manner sensitive to individual needs and which promotes dignity and self-respect;

(d) Is protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;

(e) Has all clinical and personal information treated in accord with state and federal confidentiality regulations;

(f) Has the opportunity to review their own treatment records in the presence of the administrator or designee;

(g) Has the opportunity to have clinical contact with a same gender counselor, if requested and determined appropriate by the supervisor, either at the agency or by referral;

(h) Is fully informed regarding fees charged, including fees for copying records to verify treatment and methods of payment available;

(i) Is provided reasonable opportunity to practice the religion of their choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. The patient has the right to refuse participation in any religious practice;

(j) Is allowed necessary communication:

(i) Between a minor and a custodial parent or legal guardian;

(ii) With an attorney; and

(iii) In an emergency.

(k) Is protected from abuse by staff at all times, or from other patients who are on agency premises, including:

(i) Sexual abuse or harassment;

(ii) Sexual or financial exploitation;

(iii) Racism or racial harassment; and

(iv) Physical abuse or punishment.

(l) Is fully informed and receives a copy of counselor disclosure requirements established under RCW 18.170.060;

(m) Receives a copy of patient grievance procedures upon request; and

(n) In the event of an agency closure or treatment service cancellation, each patient must be:

(i) Given thirty days notice;

(ii) Assisted with relocation;

(iii) Given refunds to which the person is entitled; and

(iv) Advised how to access records to which the person is entitled.

(2) A service provider must obtain patient consent for each release of information to any other person or entity. This consent for release of information must include:

(a) Name of the consenting patient;

(b) Name or designation of the provider authorized to make the disclosure;

(c) Name of the person or organization to whom the information is to be released;

(d) Nature of the information to be released, as limited as possible;

(e) Purpose of the disclosure, as specific as possible;

(f) Specification of the date or event on which the consent expires;

(g) Statement that the consent can be revoked at any time, except to the extent that action has been taken in reliance on it;

(h) Signature of the patient or parent, guardian, or authorized representative, when required, and the date; and

(i) A statement prohibiting further disclosure unless expressly permitted by the written consent of the person to whom it pertains.

(3) A service provider must notify patients that outside persons or organizations which provide services to the agency are required by written agreement to protect patient confidentially.

(4) A service provider must notify an ADATSA recipient of the recipient's additional rights as required by WAC 388-800-0090.

(5) The administrator must ensure a copy of patients' rights is given to each patient receiving services, both at admission and in case of disciplinary discharge.

(6) The administrator must post a copy of patients' rights in a conspicuous place in the facility accessible to patients and staff.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-305, filed 11/21/00, effective 1/1/01.]

WAC 388-805-310 What are the requirements for chemical dependency assessments? A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must conduct and document an assessment of each client's involvement with alcohol and other drugs. The CDP's assessment must include:

(1) A face-to-face diagnostic interview with each client to obtain, review, evaluate, and document the following:

(a) A history of the client's involvement with alcohol and other drugs, including:

(i) The type of substances used;

(ii) The route of administration; and

(iii) Amount, frequency, and duration of use.

(b) History of alcohol or other drug treatment or education;

(c) The client's self-assessment of use of alcohol and other drugs;

(d) A relapse history; and

(e) A legal history.

(2) If the client is in need of treatment, a multidimensional assessment of the person's:

(a) Acute intoxication and/or withdrawal risk;

(b) Biomedical conditions and complications;

(c) Emotional/behavioral conditions and complications;

(d) Treatment acceptance/resistance;

(e) Relapse/continued use potential; and

(f) Recovery environment.

(3) If an assessment is conducted on a youth, and the client is in need of treatment, the CDP, or CDP trainee under supervision of a CDP, must also obtain the following information:

(a) Parental and sibling use of drugs;

(b) History of school assessments for learning disabilities or other problems, which may affect ability to understand written materials;

(c) Past and present parent/guardian custodial status, including running away and out-of-home placements;

(d) History of emotional or psychological problems;

(e) History of child or adolescent developmental problems; and

(f) Ability of parents/guardians to participate in treatment.

(4) Documentation of the information collected, including:

(a) A written summary interpreting the data gathered in subsections (1), (2), and (3) of this section including patient strengths and needs for each dimension;

(b) A diagnostic assessment statement including applicable criteria and severity of involvement with alcohol and other drugs;

(c) A statement regarding provision of an HIV/AIDS brief risk intervention, and referrals made; and

(d) Evidence the client:

(i) Was notified of the assessment results; and

(ii) Documentation of treatment options provided, and the client's choice; or

(iii) If the client was not notified of the results and advised of referral options, the reason must be documented.

(5) Documentation of the treatment recommended, using PPC.

(6) Completion and submission of all reports required by the courts, department of licensing, and department of social and health services in a timely manner.

(7) Referral of an adult or minor who requires assessment for involuntary chemical dependency treatment to the county-designated chemical dependency specialist.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-310, filed 11/21/00, effective 1/1/01.]

WAC 388-805-315 What are the requirements for treatment, continuing care, transfer, and discharge plans? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must be responsible for the overall treatment plan for each patient, including:

(a) Patient involvement in treatment planning;

(b) Documentation of progress toward patient attainment of goals; and

(c) Completeness of patient records.

(2) A CDP or a CDP trainee under supervision of a CDP must:

(a) Develop the individualized treatment plan based on PPC;

(b) Conduct individual and group counseling;

(c) Evaluate the patient and conduct ongoing assessments in accord with PPC. In cases where it is not possible to place or provide the patient with the clinically indicated treatment, the reason must be documented as well as whether other treatment will be provided;

(d) Update the treatment plan, and determine continued service needs using PPC;

(e) Develop the continuing care plan using PPC; and

(f) Complete the discharge summary using PPC.

(3) A CDP, or CDP trainee under supervision of a CDP, must also include in the treatment plan for youth problems identified in specific youth assessment, including any referrals to school and community support services.

(4) A CDP, or CDP trainee under supervision of a CDP, must follow up when a patient misses an appointment to:

(a) Try to motivate the patient to stay in treatment; and

(b) Report a noncompliant patient to the committing authority as appropriate.

(5) A CDP, or CDP trainee under supervision of a CDP, must involve each patient's family or other support persons, when the patient gives written consent:

(a) In the treatment program; and

(b) In self-help groups.

(6) When transferring a patient from one certified treatment service to another within the same agency, at the same location, a CDP, or a CDP trainee under supervision of a CDP, must:

(a) Update the patient assessment and treatment plan using PPC; and

(b) Provide a summary report of the patient's treatment and progress, in the patient's record. In detox, this may be done by a nurse or physician.

(7) A CDP, or CDP trainee under supervision of a CDP, must meet with each patient at the time of discharge from any treatment agency, unless in detox or when a patient leaves treatment without notice, to:

(a) Finalize a continuing care plan using PPC to assist in determining appropriate recommendation for care;

(b) Assist the patient in making contact with necessary agencies or services; and

(c) Provide the patient a copy of the plan.

(8) When transferring a patient to another treatment provider, the current provider must forward copies of the following information to the receiving provider when a release of confidential information is signed by the patient:

(a) Patient demographic information;

(b) Diagnostic assessment statement and other assessment information, including:

(i) Documentation of the HIV/AIDS intervention;

(ii) TB test result;

(iii) A record of the patient's detox and treatment history;

(iv) The reason for the transfer, based on using PPC; and

(v) Court mandated or agency recommended follow-up treatment.

(c) Discharge summary; and

(d) The plan for continuing care or treatment.

(9) A CDP, or CDP trainee under supervision of a CDP, must complete a discharge summary, within seven days of each patient's discharge from the agency, which includes:

(a) The date of discharge or transfer;

(b) A summary of the patient's progress toward each treatment goal, except in detox; and

(c) In detox, a summary of the patient's physical condition.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-315, filed 11/21/00, effective 1/1/01.]

WAC 388-805-320 What are the requirements for a patient record system? Each service provider must have a comprehensive patient record system maintained in accord with recognized principles of health record management. The provider must ensure:

(1) A designated individual is responsible for the record system;

(2) A secure storage system which:

(a) Promotes confidentiality of and limits access to both active and inactive records; and

(b) Protects active and inactive files from damage during storage.

(3) Patient record policies and procedures on:

(a) Who has access to records;

(b) Content of active and inactive patient records;

(c) A systematic method of identifying and filing individual patient records so each can be readily retrieved;

(d) Assurance that each patient record is complete and authenticated by the person providing the observation, evaluation, or service;

(e) Retention of patient records for a minimum of five years after the discharge or transfer of the patient; and

(f) Destruction of patient records.

(4) In addition to subsection (1) through (3) of this section, providers maintaining electronic patient records must:

(a) Make records available in paper form upon request:

(i) For review by the department;

(ii) By patients requesting record review as authorized by WAC 388-805-305 (1)(f).

(b) Provide secure, limited access through means that prevent modification or deletion after initial preparation;

(c) Provide for back up of records in the event of equipment, media or human error;

(d) Provide for protection from unauthorized access, including network and Internet access.

(5) In case of an agency closure, the provider closing its treatment agency must arrange for the continued management of all patient records. The closing provider must notify the department in writing of the mailing and street address where records will be stored and specify the person managing the records. The closing provider may:

(a) Continue to manage the records and give assurance they will respond to authorized requests for copies of patient records within a reasonable period of time;

(b) Transfer records of patients who have given written consent to another certified provider;

(c) Enter into a qualified service organization agreement with a certified provider to store and manage records, when the outgoing provider will no longer be a chemical dependency treatment provider; or

(d) In the event none of the arrangements listed in (a) through (c) of this subsection can be made, the closing provider must arrange for transfer of patient records to the department.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-320, filed 11/21/00, effective 1/1/01.]

WAC 388-805-325 What are the requirements for patient record content? The service provider must ensure patient record content includes:

(1) Demographic information;

(2) A chemical dependency assessment and history of involvement with alcohol and other drugs;

(3) Documentation the patient was informed of the diagnostic assessment and options for referral or the reason not informed;

(4) A report of a physical examination by a medical practitioner in accord with a nonresidential provider's policy on medical oversight, when a patient is at risk of withdrawal from barbiturates or benzodiazepines, or used intravenous drugs within thirty days of admission;

(5) Documentation the patient was informed of federal confidentiality requirements and received a copy of the patient notice required under 42 CFR, Part 2;

(6) Treatment service rules, translated when needed, signed and dated by the patient before beginning treatment;

(7) Voluntary consent to treatment signed and dated by the patient, parent or legal guardian, except as authorized by law for protective custody and involuntary treatment;

(8) Evidence of counselor disclosure information, acknowledged by the provider and patient by signature and date;

(9) Evidence of a tuberculosis test and results;

(10) Evidence of the HIV/AIDS brief risk intervention;

(11) Initial and updated individual treatment plans, including results of the initial assessment and periodic reviews, addressing:

(a) Patient biopsychosocial problems;

(b) Short- and long-term treatment goals;

(c) Estimated dates for completion of each treatment goal;

(d) Approaches to resolve the problems;

(e) Identification of persons responsible for implementing the approaches;

(f) Medical orders, if appropriate.

(12) Documentation of referrals made for specialized care or services;

(13) At least weekly individualized documentation of ongoing services in residential services, and as required in intensive outpatient and outpatient services, including:

(a) Date, duration, and content of counseling and other treatment sessions;

(b) Ongoing assessments of each patient's participation in and response to treatment and other activities;

(c) Progress notes as events occur, each shift in detox, and treatment plan reviews as specified under each treatment service of chapter 388-805 WAC; and

(d) Documentation of missed appointments.

(14) Medication records, if applicable;

(15) Laboratory reports, if applicable;

(16) Properly completed authorizations for release of information;

(17) Copies of all correspondence related to the patient, including reports of noncompliance;

(18) A copy of the continuing care plan signed and dated by the CDP and the patient; and

(19) The discharge summary.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-325, filed 11/21/00, effective 1/1/01.]

WAC 388-805-330 What are the requirements for reporting patient noncompliance? The following standards define patient noncompliance behaviors and set minimum time lines for reporting these behaviors to the appropriate court. Chemical dependency service providers failing to report patient noncompliance with court ordered or deferred prosecution treatment requirements may be considered in violation of chapter 46.61 or 10.05 RCW reporting requirements and be subject to penalties specified in WAC 388-805-120, 388-805-125, and 388-805-130.

(1) For emergent noncompliance: The following noncompliance is considered emergent noncompliance and must be reported to the appropriate court within three working days from obtaining the information:

(a) Patient failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by patient self-report, identified third party report confirmed by the agency, or blood alcohol content or other laboratory test;

(b) Patient reports a subsequent alcohol/drug related arrest;

(c) Patient leaves program against program advice or is discharged for rule violation.

(2) For nonemergent noncompliance: The following noncompliance is considered nonemergent noncompliance and must be reported to the appropriate court as required by subsection (3) and (4) of this section:

(a) Patient has unexcused absences or failure to report. Agencies must report all patient unexcused absences, including failure to attend self-help groups. Report failure of patient to provide agency with documentation of attendance at self-help groups if under a deferred prosecution order or required by the treatment plan. In providing this report, include the agency's recommendation for action.

(b) Patient failure to make acceptable progress in any part of the treatment plan. Report details of the patient's non-

compliance behavior along with a recommendation for action.

(3) If a court accepts monthly progress reports, nonemergent noncompliance may be reported in monthly progress reports, which must be mailed to the court within ten working days from the end of each reporting period.

(4) If a court does not wish to receive monthly reports and only requests notification of noncompliance or other significant changes in patient status, the reports should be transmitted as soon as possible, but in no event longer than ten working days from the date of the noncompliance.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-330, filed 11/21/00, effective 1/1/01.]

SECTION VIII—OUTCOMES EVALUATION

WAC 388-805-350 What are the requirements for outcomes evaluation? Each service provider must develop and implement policies and procedures for outcomes evaluation, to monitor and evaluate outcomes for the purpose of program improvement. Outcomes evaluation includes:

(1) A program description of:

(a) Measurable program objectives in the areas of effectiveness, efficiency, and patient satisfaction;

(b) Baseline measurement of program objectives; and measurement of outcomes at least two of the following times:

(i) during treatment, or

(ii) at discharge, or

(iii) after treatment.

(2) Use of the results.

(3) Measurement of a representative sample of patients served by the treatment provider.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-350, filed 11/21/00, effective 1/1/01.]

SECTION IX—PROGRAM SERVICE STANDARDS

WAC 388-805-400 What are the requirements for detoxification providers? Detoxification services include acute and subacute services. To be certified to offer detoxification services, a provider must:

(1) Meet WAC 388-805-001 through 388-805-350 requirements; and

(2) Meet relevant requirements of chapter 246-326 WAC.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-400, filed 11/21/00, effective 1/1/01.]

WAC 388-805-410 What are the requirements for detox staffing and services? (1) The service provider must ensure staffing as follows:

(a) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must assess, counsel, and attempt to motivate each patient for referral;

(b) Other staff as necessary to provide services needed by each patient;

(c) All personnel providing patient care, except licensed staff and CDPs, must complete a minimum of forty hours of documented training before assignment of patient care duties. The personnel training must include:

(i) Chemical dependency;

(ii) HIV/AIDS and hepatitis B education;

(iii) TB prevention and control; and

(iv) Detox screening, admission, and signs of trauma.

(d) All personnel providing patient care must have current training in:

(i) Cardio-pulmonary resuscitation (CPR); and

(ii) First aid.

(2) The service provider must ensure detoxification services include:

(a) Screening of each person before admission by a person knowledgeable about alcoholism and other addictions and skilled in observation and eliciting information;

(b) A chemical dependency assessment, which must be attempted within forty-eight hours of a patient's admission;

(c) Counseling of each patient by a CDP, or CDP trainee under supervision of a CDP, at least once:

(i) Regarding the patient's chemical dependency; and

(ii) Attempting to motivate each person to accept referral into a continuum of care for chemical dependency treatment.

(d) Sleeping arrangements that permit observation of patients;

(e) Separate sleeping rooms for youth and adults; and

(f) Referral of each patient to other appropriate treatment services.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-410, filed 11/21/00, effective 1/1/01.]

WAC 388-805-500 What are the requirements for residential providers? To be certified to offer intensive inpatient, recovery, or long-term residential services, a provider must meet the requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-510 through 388-805-550 as applicable; and

(3) Chapter 246-326 WAC as required for department of health licensing.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-500, filed 11/21/00, effective 1/1/01.]

WAC 388-805-510 What are the requirements for residential providers admitting youth? A residential service provider admitting youth must ensure:

(1) A youth will be admitted only with the written permission of a parent or legal guardian. In cases where the youth meets the requirements of child in need of services (CHINS) the youth may sign themselves into treatment.

(2) The youth must agree to, and both the youth and parent or legal guardian must sign the following when possible:

(a) Statement of patient rights and responsibilities;

(b) Treatment or behavioral contracts; and

(c) Any consent or release form.

(3) Youth chemical dependency treatment must include:

(a) Group meetings to promote personal growth; and

(b) Recreational, leisure, and other therapy and related activities.

(4) A certified teacher or tutor must provide each youth one or more hours per day, five days each week, of super-

vised academic tutoring or instruction when the youth is unable to attend school for an estimated period of four weeks or more. The provider must:

(a) Document the patient's most recent academic placement and achievement level; and

(b) Obtain schoolwork, where applicable, from the patient's home school or provide schoolwork and assignments consistent with the person's academic level and functioning.

(5) Adult staff must lead or supervise seven or more hours of structured recreation each week.

(6) Staff must conduct room checks frequently and regularly when patients are in their rooms.

(7) A person fifteen years of age or younger must not room with a person eighteen years of age or older.

(8) Sufficient numbers of adult staff, whose primary task is supervision of patients, must be trained and available at all times to ensure appropriate supervision, patient safety, and compliance with WAC 388-805-520.

(9) In co-ed treatment services, there must be at least one adult staff person of each gender present or on call at all times.

(10) There must be at least one chemical dependency professional (CDP) for every ten youth patients.

(11) Staff must document attempts to notify the parent or legal guardian within two hours of any change in the status of a youth.

(12) For routine discharge, each youth must be discharged to the care of the youth's legal custodian.

(13) For emergency discharge and when the custodian is not available, the provider must contact the appropriate authority.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-510, filed 11/21/00, effective 1/1/01.]

WAC 388-805-520 What are the requirements for behavior management? (1) Upon application for a youth's admission, a service provider must:

(a) Advise the youth's parent and other referring persons of the programmatic and physical plant capabilities and constraints in regard to providing treatment with or without a youth's consent;

(b) Obtain the parent's or other referring person's agreement to participate in the treatment process as appropriate and possible; and

(c) Obtain the parent's or other referring person's agreement to return and take custody of the youth as necessary and appropriate on discharge or transfer.

(2) The administrator must ensure policies and procedures are written and implemented which detail least to increasingly restrictive practices used by the provider to stabilize and protect youth who are a danger to self or others, including:

(a) Obtaining signed behavioral contracts from the youth, at admission and updated as necessary;

(b) Acknowledging positive behavior and fostering dignity and self respect;

(c) Supporting self-control and the rights of others;

(d) Increased individual counseling;

(e) Increased staff monitoring;

(f) Verbal de-escalation;

(g) Use of unlocked room for containment or seclusion;

(h) Use of restraints; and

(i) Emergency procedures, including notification of the parent, guardian or other referring person, and, when appropriate, law enforcement.

(3) The provider must ensure staff is trained in safe and therapeutic techniques for dealing with a youth's behavioral and emotional crises, including:

(a) Verbal de-escalation;

(b) Crisis intervention;

(c) Anger management;

(d) Suicide assessment and intervention;

(e) Conflict management and problem solving skills;

(f) Management of assaultive behavior;

(g) Proper use of restraint; and

(h) Emergency procedures.

(4) To prevent a youth's unauthorized exit from the residential treatment site, the provider may have:

(a) An unlocked room for containment or seclusion;

(b) A secure perimeter, such as a nonscalable fence with locked gates; and

(c) Locked windows and exterior doors.

(5) Providers using holding mechanisms in subsection (4) of this section must meet current Uniform Building Code requirements, which include fire safety and special egress control devices, such as alarms and automatic releases.

(6) When less restrictive measures are not sufficient to de-escalate a behavioral crisis, clinical staff may contain or seclude a youth in a quiet unlocked room which has a window for observation and:

(a) The clinical supervisor must be notified immediately of the staff person's use of a quiet room for a youth, and must determine its appropriateness;

(b) A chemical dependency professional (CDP) must consult with the youth immediately and at least every ten minutes, for counseling, assistance, and to maintain direct communication; and

(c) The clinical supervisor or designated alternate must evaluate the youth and determine the need for mental health consultation.

(7) Youth who demonstrate continuing refusal to participate in treatment or continuing to exhibit behaviors that present health and safety risks to self, other patients, or staff may be discharged or transferred to more appropriate care after:

(a) Interventions appropriate to the situation from those listed in subsection (2) of this section have been attempted without success;

(b) The person has been informed of the consequences and return options;

(c) The parents, guardian, or other referring person has been notified of the emergency and need to transfer or discharge the person; and

(d) Arrangements are made for the physical transfer of the person into the custody of the youth's parent, guardian, or other appropriate person or program.

(8) Involved staff must document the circumstances surrounding each incident requiring intervention in the youth's record and include:

(a) The precipitating circumstances;
(b) Measures taken to resolve the incident;
(c) Final resolution; and
(d) Record of notification of appropriate others.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-520, filed 11/21/00, effective 1/1/01.]

WAC 388-805-530 What are the requirements for intensive inpatient services? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

(a) Complete the initial treatment plan within five days of admission;

(b) Conduct at least one face-to-face individual chemical dependency counseling session with each patient each week;

(c) Provide a minimum of ten hours of chemical dependency counseling with each patient each week;

(d) Document a treatment plan review, at least weekly, which updates patient status, progress toward goals, and PPC level of service; and

(e) Refer each patient for ongoing treatment or support, as necessary, upon completion of treatment.

(2) The provider must ensure a minimum of twenty hours of treatment services for each patient each week; up to ten hours may be education.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-530, filed 11/21/00, effective 1/1/01.]

WAC 388-805-540 What are the requirements for recovery house services? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must provide a minimum of five hours of treatment, for each patient each week, consisting of:

(a) Education regarding drug-free and sober living; and

(b) Individual or group counseling.

(2) A CDP, or CDP trainee under supervision of a CDP, must update patient records at least monthly; and

(3) Staff must assist patients with general reentry living skills and, for youth, continuation of educational or vocational training.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-540, filed 11/21/00, effective 1/1/01.]

WAC 388-805-550 What are the requirements for long-term treatment services? Each chemical dependency service provider must ensure each patient receives:

(1) Education regarding alcohol, other drugs, and other addictions, at least two hours each week.

(2) Individual or group counseling by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP, a minimum of two hours each week.

(3) Education on social and coping skills.

(4) Social and recreational activities.

(5) Assistance in seeking employment, when appropriate.

(6) Patient record review and update at least monthly.

(7) Assistance with re-entry living skills.

(8) A living arrangement plan.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-550, filed 11/21/00, effective 1/1/01.]

WAC 388-805-600 What are the requirements for outpatient providers? To be certified to provide intensive or other outpatient services, a chemical dependency service provider must meet the requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-610 through 388-805-630, as applicable; and

(3) WAC 388-805-700 through 388-805-750, if offering opiate substitution treatment services.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-600, filed 11/21/00, effective 1/1/01.]

WAC 388-805-610 What are the requirements for intensive outpatient treatment services? (1) Patients admitted to intensive outpatient treatment under a deferred prosecution order pursuant to chapter 10.05 RCW, must complete intensive treatment as described in subsection (2) of this section. Any exceptions to this requirement must be approved, in writing, by the court having jurisdiction in the case.

(2) Each chemical dependency service provider must ensure intensive outpatient services are designed to deliver:

(a) A minimum of seventy-two hours of treatment services within a maximum of twelve weeks,

(b) The first four weeks of treatment must consist of:

(i) At least three sessions each week;

(ii) Each group session must last at least one hour; and

(iii) Each session must be on separate days of the week.

(c) Individual chemical dependency counseling sessions with each patient every twenty hours of treatment, or more if clinically indicated;

(d) Education totaling not more than fifty percent of the treatment services regarding alcohol, other drugs, relapse prevention, HIV/AIDS, hepatitis B and TB prevention, and other air/blood-borne pathogens;

(e) Self-help group attendance in addition to the seventy-two hours;

(f) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must conduct and document a review of each patient's treatment plan every twenty hours of treatment, to assess adequacy and attainment of goals, using PPC;

(g) Upon completion of intensive outpatient treatment, a CDP, or a CDP trainee under the supervision of a CDP, must refer each patient for ongoing treatment or support, as necessary, using PPC.

(3) Patients not under deferred prosecution orders, including youth patients, may be admitted to levels of care as determined appropriate using PPC.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-610, filed 11/21/00, effective 1/1/01.]

WAC 388-805-620 What are the requirements for outpatient services? A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

(1) Complete admission assessments within ten calendar days of admission, or by the second visit, unless participation

in this outpatient treatment service is part of the same provider's continuum of care.

(2) Conduct group or individual chemical dependency counseling sessions for each patient, each month, according to an individual treatment plan.

(3) Assess and document the adequacy of each patient's treatment and attainment of goals:

(a) Once a month for the first three months; and

(b) Quarterly thereafter or sooner if required by other laws.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-620, filed 11/21/00, effective 1/1/01.]

WAC 388-805-630 What are the requirements for outpatient services in a school setting? Any certified chemical dependency service provider may offer school-based services by:

(1) Meeting WAC 388-805-640 requirements; and

(2) Ensuring counseling is provided by a chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-630, filed 11/21/00, effective 1/1/01.]

WAC 388-805-640 What are the requirements for providing off-site chemical dependency treatment services? (1) If a certified service provider wishes to offer treatment services, for which the provider is certified, at a site where clients are located primarily for purposes other than chemical dependency treatment, the administrator must:

(a) Ensure off-site treatment services will be provided:

(i) In a private, confidential setting that is discrete from other services provided within the off-site location; and

(ii) By a chemical dependency professional (CDP) or CDP trainee under supervision of a CDP;

(b) Revise agency policy and procedures manuals to include:

(i) A description of how confidentiality will be maintained at each off-site location, including how confidential information and patient records will be transported between the certified facility and the off-site location;

(ii) A description of how services will be offered in a manner that promotes patient and staff member safety; and

(iii) Relevant administrative, personnel, and clinical practices.

(c) Maintain a current list of all locations where off-site services are provided including the name, address (except patient in-home services), primary purpose of the off-site location, level of services provided, and date off-site services began at the off-site location.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-640, filed 11/21/00, effective 1/1/01.]

WAC 388-805-700 What are the requirements for opiate substitution treatment providers? An opiate substitution treatment provider must meet requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-610 and 388-805-620; and

(3) WAC 388-805-700 through 388-805-750.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-700, filed 11/21/00, effective 1/1/01.]

WAC 388-805-710 What are the requirements for opiate substitution medical management? (1) A program physician must provide oversight for determination of opiate physical addiction for each patient before admission unless the patient is exempted by the Federal Food and Drug Administration, and:

(a) Be available for consultation when an opiate physical addiction determination is conducted by anyone other than the program physician; and

(b) Conduct the opiate physical addiction determination for all youth patients.

(2) A physical examination must be conducted on each patient:

(a) By a program physician or other medical practitioner; and

(b) Within twenty-one days of admission.

(3) Following the patient's initial dose of opiate substitution treatment, the physician must establish adequacy of dose, considering:

(a) Signs and symptoms of withdrawal;

(b) Patient comfort; and

(c) Side effects from over-medication.

(4) At the appropriate time, a program physician must approve an individual detoxification schedule for each patient being detoxified.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-710, filed 11/21/00, effective 1/1/01.]

WAC 388-805-720 What are the requirements for urinalysis in opiate substitution treatment? (1) The provider must obtain a urine sample from each patient for urinalysis:

(a) At least once each month; and

(b) Randomly, without notice to the patient.

(2) Staff must observe the collection of each urine sample and use proper chain of custody techniques when handling each sample;

(3) When a patient refuses to provide a urine sample or initial the log of sample numbers, staff must consider the urine positive; and

(4) Staff must document a positive urine and discuss the findings with the patient in a counseling session within seven days of receiving the results of the test.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-720, filed 11/21/00, effective 1/1/01.]

WAC 388-805-730 What are the requirements for opiate substitution treatment dispensaries? (1) Each opiate substitution treatment provider must comply with applicable portions of 21 CFR, Part 1301 requirements, as now or later amended.

(2) The administrator must ensure written policies and procedures to verify the identity of patients.

(3) Dispensary staff must maintain a file with a photograph of each patient. Dispensary staff must ensure pictures are updated when:

(a) The patient's physical appearance changes significantly; or

(b) Every two years, whichever comes first.

(4) In addition to notifying the Food and Drug Administration, the administrator must immediately notify the department and the state board of pharmacy of any theft or significant loss of a controlled substance.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-730, filed 11/21/00, effective 1/1/01.]

WAC 388-805-740 What are the requirements for opiate substitution treatment counseling? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must provide individual or group counseling sessions once each:

(a) Week, for the first ninety days, for a new patient or a patient readmitted more than ninety days since the person's most recent discharge from opiate substitution treatment;

(b) Week, for the first month, for a patient readmitted within ninety days of the most recent discharge from opiate substitution treatment; and

(c) Month, for a patient transferring from another opiate substitution treatment agency where the patient stayed for ninety or more days.

(2) A CDP, or a CDP trainee under supervision of a CDP, must conduct and document a continuing care review with each patient to review progress, discuss facts, and determine the need for continuing opiate substitution treatment:

(a) Between six and seven months after admission; and

(b) Once every six months thereafter.

(3) A CDP, or a CDP trainee under supervision of a CDP, must provide counseling in a location that is physically separate from other activities.

(4) The administrator must ensure at least one full-time CDP, or a CDP trainee under supervision of a CDP, for each fifty patients:

(a) A CDP with one or more CDP trainees may be assigned as primary counselor for up to seventy-five patients, including those assigned to the CDP trainee; and

(b) A CDP trainee may be assigned up to thirty-five patients.

(5) A pregnant woman and any other patient who requests, must receive at least one-half hour of counseling and education each month on:

(a) Matters relating to pregnancy and street drugs;

(b) Pregnancy spacing and planning; and

(c) The effects of opiate substitution treatment on the woman and fetus, when opiate substitution treatment occurs during pregnancy.

(6) Staff must provide at least one-half hour of counseling on family planning with each patient through either individual or group counseling.

(7) The administrator must ensure there is one staff member who has training in family planning, prenatal health care, and parenting skills.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-740, filed 11/21/00, effective 1/1/01.]

WAC 388-805-750 What are the requirements for opiate substitution treatment take-home medications? (1) An opiate substitution treatment provider may authorize take-home medications for a patient when:

(a) The medication is for a Sunday or legal holiday, as identified under RCW 1.16.050; or

(b) Travel to the facility presents a safety risk for patients or staff due to inclement weather.

(2) A service provider may permit take-home medications on other days for a stabilized patient who:

(a) Has received opiate substitution treatment medication for a minimum of ninety days;
and

(b) Had negative urines for the last sixty days.

(3) The provider must meet 21 CFR, Part 291 requirements.

(4) The provider may arrange for opiate substitution treatment medication to be administered by licensed staff or self-administered by a pregnant woman receiving treatment at a certified residential treatment agency when:

(a) The woman had been receiving treatment medication for ninety or more days; and

(b) The woman's use of treatment medication can be supervised.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-750, filed 11/21/00, effective 1/1/01.]

WAC 388-805-800 What are the requirements for free-standing ADATSA assessment providers and services? (1) A certified ADATSA assessment provider must conduct an ADATSA assessment for each eligible patient and be governed by the requirements under:

(a) WAC 388-805-001 through 388-805-310;

(b) WAC 388-805-020 and 388-805-325 (1), (2), (3), (5), (10), (16), (17), 388-805-330; and 388-805-350; and

(c) Chapter 388-800 WAC.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-800, filed 11/21/00, effective 1/1/01.]

WAC 388-805-810 What are the requirements for DUI assessment providers? (1) If located in a district or municipal probation department, each DUI service provider must meet the requirements of:

(a) WAC 388-805-001 through 388-805-135,

(b) WAC 388-805-145 (4), (5), and (6);

(c) WAC 388-805-150, the administrative manual, subsections (4), (7) through (11), (13), and (14);

(d) WAC 388-805-155, facilities, subsections (1)(b), (c), (d), and (2)(b);

(e) WAC 388-805-200 (1), (4), and (5);

(f) WAC 388-805-205 (1), (2), (3)(a) through (e), (4), (6), (7), and (8);

(g) WAC 388-805-220, 388-805-225, and 388-805-230;

(h) WAC 388-805-260, volunteers;

(i) WAC 388-805-300, clinical manual, subsections (1), (2), (3), (7), (14), (18), and (19)(e);

(j) WAC 388-805-305, patients' rights;

(k) WAC 388-805-310, assessments;

(l) WAC 388-805-320, patient record system, subsections (3)(a) through (f), and (4);

(m) WAC 388-805-325, record content, subsections (1), (2), (3), (5), (8), (10), (12), (16), and (17); and

(n) WAC 388-805-350, outcomes evaluation;

(o) WAC 388-805-815, DUI assessment services.

(2) If located in another certified chemical dependency treatment facility, the DUI service provider must meet the requirements of:

(a) WAC 388-805-001 through 388-805-260; 388-805-305 and 388-805-310;

(b) WAC 388-805-300, 388-805-320, 388-805-325 as noted in subsection (1) of this section, 388-805-350; and

(c) WAC 388-805-815.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-810, filed 11/21/00, effective 1/1/01.]

WAC 388-805-815 What are the requirements for DUI assessment services? (1) The administrator must limit clients to persons who have been arrested for a violation of driving while under the influence of intoxicating liquor or other drugs or in physical control of a vehicle as defined under chapter 46.61 RCW;

(2) A chemical dependency professional (CDP), or a CDP trainee under the supervision of a CDP, or a probation assessment officer must conduct each client assessment and ensure the assessment includes, in addition to the requirements under WAC 388-805-310:

(a) Evaluation of the client's blood alcohol level and other drug levels at the time of arrest, if available; and

(b) Assessment of the client's self-reported driving record and the abstract of the client's legal driving record.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-815, filed 11/21/00, effective 1/1/01.]

WAC 388-805-820 What are the requirements for alcohol and other drug information school? (1) Alcohol and other drug information school providers must be governed under:

(a) WAC 388-805-001 through 388-805-135; and

(b) This section.

(2) The provider must:

(a) Inform each student of fees at the time of enrollment; and

(b) Ensure adequate and comfortable seating in well-lit and ventilated rooms.

(3) A certified information school instructor must teach the course and:

(a) Advise each student there is no assumption the student is an alcoholic or drug addict, and this is not a therapy session;

(b) Discuss the class rules;

(c) Review the course objectives;

(d) Follow curriculum contained in "Alcohol and Other Drugs Information School Training Curriculum," published in 1991, or later amended;

(e) Ensure not less than eight and not more than fifteen hours of class room instruction;

(f) Administer the post-test from the above reference to each enrolled student after the course is completed;

(g) Ensure individual client records include:

(i) Intake form;

(ii) Hours and date or dates in attendance;

(iii) Source of referral;

(iv) Copies of all reports, letters, certificates, and other correspondence;

(v) A record of any referrals made; and

(vi) A copy of the scored post-test.

(h) Complete and submit reports required by the courts and the department of licensing, in a timely manner.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-820, filed 11/21/00, effective 1/1/01.]

WAC 388-805-830 What are the requirements for information and crisis services? (1) Information and crisis service providers must be governed under:

(a) WAC 388-805-001 through 388-805-135; and

(b) This section.

(2) The information and crisis service administrator must:

(a) Ensure a chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, is available or on staff;

(b) Maintain a current directory of certified chemical dependency service providers in the state;

(c) Maintain a current list of local resources for legal, employment, education, interpreter, and social and health services;

(d) Have services available twenty-four hours a day, seven days a week;

(e) Ensure all staff completes forty hours of training that covers the following areas before assigning unsupervised duties:

(i) Chemical dependency crisis intervention techniques;

(ii) Alcoholism and drug abuse; and

(iii) Prevention and control of TB and bloodborne pathogens.

(f) Have policies and procedures for provision of emergency services, by phone or in person, to a person incapacitated by alcohol or other drugs, or to the person's family, such as:

(i) General assessments;

(ii) Interviews for diagnostic or therapeutic purposes;

(iii) Crisis counseling; and

(iv) Referral.

(g) Maintain records of each patient contact, including:

(i) The presenting problem;

(ii) The outcome;

(iii) A record of any referral made;

(iv) The signature of the person handling the case; and

(v) The name, age, sex, and race of the patient.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-830, filed 11/21/00, effective 1/1/01.]

WAC 388-805-840 What are the requirements for emergency service patrol? (1) The emergency service patrol provider must ensure staff providing the service:

(a) Have proof of a valid Washington state driver's license;

(b) Possess annually updated verification of first aid and cardiopulmonary resuscitation training;

(c) Have completed forty hours of training in chemical dependency crisis intervention techniques, and alcoholism and drug abuse, to improve skills in handling crisis situations; and

(d) Have training on communicable diseases, including:

(i) TB prevention and control; and

(ii) Bloodborne pathogens such as HIV/AIDS and hepatitis.

(2) Emergency service patrol staff must:

(a) Respond to calls from police, merchants, and other persons for assistance with an intoxicated person in a public place;

(b) Patrol assigned areas and give assistance to a person intoxicated in a public place; and

(c) Conduct a preliminary assessment of a person's condition relating to the state of inebriation and presence of a physical condition needing medical attention:

(i) When a person is intoxicated, but subdued and willing, transport the person home, to a certified treatment provider, or a health care facility;

(ii) When a person is incapacitated, unconscious, or has threatened or inflicted harm on another person, staff must make reasonable efforts to:

(A) Take the person into protective custody; and

(B) Transport the person to an appropriate treatment or health care facility.

(3) Emergency service patrol staff must maintain a log including:

(a) The time and origin of each call received for assistance;

(b) The time of arrival at the scene;

(c) The location of the person at the time of the assist;

(d) The name and sex of the person transported;

(e) The destination of the transport and time of arrival; and

(f) In case of nonpickup of a person, a notation must be made about why the pickup did not occur.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-840, filed 11/21/00, effective 1/1/01.]

WAC 388-805-850 What are the requirements for treatment alternatives to street crime (TASC) providers and services? (1) A certified TASC provider must provide referral and case management services to each eligible patient and meet the requirements of:

(a) WAC 388-805-001 through 388-805-210;

(b) WAC 388-805-240, students;

(c) WAC 388-805-260, volunteers;

(d) WAC 388-805-300, clinical manual, subsections (1) through (7), (13) through (18), and (19)(a), (b), (d), (e), and (f);

(e) WAC 388-805-305, patients' rights, subsections (1) through (3), and (5) through (6);

(f) WAC 388-805-310, assessments, subsections (1) through (7);

(g) WAC 388-805-315, treatment, continuing care, transfer, and discharge plans, subsections (1), (2)(a), (c), (d), (e), and (f), (5), and (7) through (9);

(i) A CDP, or a CDP trainee under supervision of a CDP, must substitute referral and case management plans for treatment plan requirements in WAC 388-805-315 (1) and (2)(a)(d);

(ii) A CDP, or a CDP trainee under supervision of a CDP, must coordinate the referral of patients with the appropriate treatment provider for each identified problem, ensure they receive adequate treatment, and add new problems to the case management plan as they are identified;

(iii) A CDP, or a CDP trainee under supervision of a CDP, must coordinate the continuing care plan of the patient with appropriate treatment providers; and,

(iv) When transferring a patient to another treatment provider, a TASC provider will substitute a summary of the patient's progress toward each referral and case management goal.

(h) WAC 388-805-320, patient record system;

(i) WAC 388-805-325, patient record content, subsections (1) through (3), (5) through (10), and (12) through (19);

(j) WAC 388-805-330, reporting patient noncompliance; and

(k) WAC 388-805-350, outcomes evaluation.

(2) A CDP, or a CDP trainee under supervision of a CDP, must assess and document the adequacy of each client's referral and case management plan and attainment of goals once each month.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-850, filed 11/21/00, effective 1/1/01.]

WAC 388-805-900 What are the requirements for outpatient child care when a parent is in treatment? A certified outpatient chemical dependency service provider may offer child care services when the provider:

(1) Notifies the department of the provider's intent to offer child care services.

(2) Submits a plan indicating numbers of children to be served and physical space available for the child care service which meets WAC 388-805-155 requirements.

(3) Demonstrates capability of meeting WAC 388-805-905 through 388-805-935 requirements.

(4) Has an approval letter from the department to provide child care services.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-900, filed 11/21/00, effective 1/1/01.]

WAC 388-805-905 What are the requirements for outpatient child care admission and health history? (1) A chemical dependency service provider must have and implement written policies and procedures to ensure:

(a) A parent serves as the responsible caregiver; and

(b) Each child admitted is free of serious medical conditions and not in need of nursing care.

(2) The provider must have a file for each child which includes a health history of each child, obtained on admission, including:

(a) Name and phone number of the child's physician;

(b) Date of last physical examination;

(c) Statement of allergies and reactions, if any;

(d) Notation of special health problems;

(e) Immunization status; and

(f) Notation of medications currently being taken.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-905, filed 11/21/00, effective 1/1/01.]

WAC 388-805-910 What are the requirements for outpatient child care policies? The administrator must ensure implementation of childcare policies which include:

(1) Encouragement of each parent to obtain health care for each child when necessary.

(2) What to do in case of a medical emergency.

(3) Protection from child abuse, neglect, and exploitation.

(4) Reporting of child abuse and neglect.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-910, filed 11/21/00, effective 1/1/01.]

WAC 388-805-915 What are the requirements for an outpatient child care activity program? The person designated responsible for the child care program must:

(1) Address the developmental, cultural, and individual needs of each child served.

(2) Offer a variety of activity choices.

(3) Offer each child daily opportunities for small and large muscle activities.

(4) Implement a planned program of activities, as evidenced by a current, written activity schedule.

(5) Provide a variety of easily accessible, culturally and developmentally appropriate learning and play materials.

(6) Promote a nurturing, respectful, supportive, and responsive environment.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-915, filed 11/21/00, effective 1/1/01.]

WAC 388-805-920 What are the requirements for outpatient child care behavior management and discipline? (1) The provider and the person responsible for child care must ensure behavior management and disciplinary practices promote:

(a) Each child's developmentally appropriate social behavior, self-control, and respect for the rights of others; and

(b) Fair, reasonable, and consistent practices related to a child's behavior.

(2) The following practices are prohibited by any person:

(a) Corporal punishment, including biting, jerking, shaking, spanking, slapping, hitting, striking, or kicking a child, or other means of inflicting physical pain or causing bodily harm;

(b) Use of a physical restraint method injurious to a child;

(c) Use of a mechanical restraint, locked time-out room or closet;

(d) Withholding of food; and

(e) Use of derogatory terms.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-920, filed 11/21/00, effective 1/1/01.]

WAC 388-805-925 What are the requirements for outpatient child care diaper changing? The administrator must ensure diaper changing policies and procedures are approved by the person developing health care policies and include:

(1) A designated place for diaper changing that is:

(a) Separate from food preparation areas;

(b) Adjacent to a handwashing sink;

(c) Sanitized between use for different children;

(d) Impervious to moisture; and

(e) Safe, with safety rails or straps.

(2) Appropriateness of changing diapers in the child's bed.

(3) Posting of diaper changing procedures accessible to staff and parents.

(4) Removal of soiled disposable diapers from the premises daily.

(5) Removal of soiled reusable diapers according to a commercial diaper service schedule.

(6) Handwashing procedures.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-925, filed 11/21/00, effective 1/1/01.]

WAC 388-805-930 What are the requirements for outpatient child care food service? The service provider must have policies that address:

(1) Feeding schedules for infants and children.

(2) Safe and sanitary formula preparation and storage.

(3) Storage and handling of bottles and nipples in a sanitary manner, separate from diaper-changing areas.

(4) Identification of prepared bottles with each child's name and date of preparation.

(5) Promotion of a safe and nurturing method for child feeding including:

(a) Holding infants in a semi-sitting position unless against medical advice or the child is able to sit in a high chair;

(b) Interacting with the infant; and

(c) Not propping bottles.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-930, filed 11/21/00, effective 1/1/01.]

WAC 388-805-935 What are the staffing requirements for outpatient child care services? (1) The service provider must designate a person responsible for the child care program who:

(a) Meets relevant personnel requirements under WAC 388-805-200 and 388-805-205;

(b) Is eighteen years of age or older; and

(c) Is capable of implementing WAC 388-805-905 through 388-805-930.

(2) The service provider must maintain staffing ratios as follows:

(a) One adult for up to and including four infants through eleven months of age;

(b) One adult for up to and including five children twelve through twenty-nine months of age;

(c) One adult for every ten children thirty months through five years of age; and

(d) One adult for every fifteen children five years of age or older.

(3) When there are children of mixed ages, the service provider must maintain the ratio prescribed for the youngest child in the mixed group.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-935, filed 11/21/00, effective 1/1/01.]

Chapter 388-810 WAC

ADMINISTRATION OF COUNTY CHEMICAL DEPENDENCY PREVENTION, TREATMENT, AND SUPPORT PROGRAM

(Formerly chapter 440-25 WAC)

WAC

WAC 388-810-005 What is the purpose of this chapter? The purpose of this chapter is to describe the planning, contracting, and provision of chemical dependency prevention, treatment, and support services through counties (see chapter 70.96A RCW).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-005, filed 9/20/99, effective 10/21/99.]

WAC 388-810-010 What definitions apply to this chapter?

"County" means each county or two or more counties acting jointly.

"County chemical dependency program coordinator" means a person appointed by the county legislative authority as the chief executive officer responsible for carrying out the duties under chapter 70.96A RCW.

"County chemical dependency prevention, treatment, and support program" means services and activities funded by the department through a negotiated contract between a county and the department.

"Department" means the department of social and health services (DSHS).

"Designated chemical dependency specialist" means a person designated by the county chemical dependency program coordinator to perform the involuntary commitment duties under chapter 70.96A RCW.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-010, filed 9/20/99, effective 10/21/99.]

WAC 388-810-020 What are the qualifications to be a county chemical dependency program coordinator? A county chemical dependency program coordinator must have training and experience in:

(1) Chemical dependency prevention, intervention, and treatment strategies used in combating chemical dependency; and

(2) Administration of social and/or human services programs, sufficient to perform the following duties:

(a) Providing general supervision over the county chemical dependency prevention, treatment, and support program;

(b) Preparing plans and applications for funds to support the county chemical dependency prevention, treatment, and support program;

(c) Monitoring the delivery of services to assure conformance with plans and contracts;

(d) Providing staff support to the county alcoholism and other drug addiction board;

(e) Selecting the county designated chemical dependency specialist(s) to perform the intervention, involuntary detention and commitment duties as described under RCW 70.96A.120 and 70.96A.140; and

(f) Advising DSHS, county courts, law enforcement agencies, hospitals, chemical dependency programs, and other local health care and service agencies in the county as to who has been designated as the chemical dependency specialist(s).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-020, filed 9/20/99, effective 10/21/99.]

WAC 388-810-030 What are the qualifications to be a county-designated chemical dependency specialist? A county-designated chemical dependency specialist must:

(1) Be certified as a chemical dependency professional (CDP) by the department of health under chapter 18.205 RCW, or meet or exceed the requirements to be eligible to be certified as a CDP as described in chapter 246-811 WAC;

(2) Demonstrate knowledge of the laws regarding the involuntary commitment of chemically dependent adolescents and adults; and

(3) Demonstrate knowledge and skills in differential assessment of mentally ill and chemically dependant clients.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-030, filed 9/20/99, effective 10/21/99.]

WAC 388-810-040 Who determines the service priorities for the county chemical dependency prevention, treatment, and support program? (1) DSHS determines the service priorities for services funded by the department.

(2) DSHS must inform the county of the service priorities during the contract negotiation process.

(3) Counties must follow DSHS's service priorities when delivering chemical dependency program services supported by department funds.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-040, filed 9/20/99, effective 10/21/99.]

WAC 388-810-050 How are available funds allocated for the county chemical dependency program? (1) For the purposes of this section, "county" means the legal subdivi-

sion of the state, regardless of any agreement between two counties.

(2) The department shall allocate the funds available to the counties through funding formulas jointly developed with representatives of the counties, to carry out the intent of the federal and state legislated appropriations including any budget provisos.

(3) For information on current funding formulas, contact: Chief Financial Officer, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, Washington 98504-5330, Telephone: (360) 438-8088.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-050, filed 9/20/99, effective 10/21/99.]

WAC 388-810-060 How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program? A county may not use more than ten percent of the chemical dependency prevention, treatment, and support program funds managed by the county for administering the program.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-060, filed 9/20/99, effective 10/21/99.]

WAC 388-810-070 How will funds be made available to the county? (1) DSHS and each county negotiates and executes a county contract before the department reimburses the county for chemical dependency prevention, treatment, and support program services.

(2) DSHS may authorize the county to continue providing services according to a previous county contract and reimburse at the average level of the previous contract, in order to continue services until the department executes a new contract.

(3) DSHS may make advance payments to a county, if the payments facilitate sound program management.

(4) DSHS may require fiscal and program reports.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-070, filed 9/20/99, effective 10/21/99.]

WAC 388-810-080 May a county subcontract for chemical dependency prevention, treatment, and support services? A county may subcontract for services specified in the contract.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-080, filed 9/20/99, effective 10/21/99.]

WAC 388-810-090 How does a county request an exemption? (1) A county may request an exemption to these rules by sending a written request to the department.

(2) DSHS may grant an exemption if the department's assessment of the exemption request:

(a) Ensures the exemption does not undermine the legislative intent of chapter 70.96A RCW; and

(b) Shows that granting the exemption does not adversely affect the quality of the services, supervision, health, and safety of department customers.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-090, filed 9/20/99, effective 10/21/99.]

Chapter 388-815 WAC
DRUG-FREE WORKPLACE PROGRAMS
(Formerly chapter 440-26 WAC)

WAC

WAC 388-815-005 Purpose. Employer certification rules related to providing a drug-free work place program are hereby adopted under the authority and purposes of chapter 127, Laws of 1996.

[99-20-023, recodified as § 388-815-005, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-005, filed 7/25/96, effective 8/25/96.]

WAC 388-815-010 Definitions. Unless the context clearly indicates otherwise, the definitions in this section apply throughout this chapter.

(1) "Alcohol" means ethyl alcohol, hydrated oxide of ethyl, or spirits of wine, from whatever source or by whatever process produced.

(2) "Alcohol test" means a chemical, biological, or physical instrumental analysis administered for the purpose of determining the presence or absence of alcohol within an individual's body systems.

(3) "Clean card program" means a drug-free workplace program which allows employers with rotating groups of employees an alternative method of participating in the drug-free workplace discount program. In addition to the other requirements of this chapter, clean card programs require random testing instead of repetitive pre-employment testing.

(4) "Department" means the department of social and health services, division of alcohol and substance abuse.

(5) "Drug" means amphetamines, cannabinoids, cocaine, phencyclidine (PCP), methadone, methaqualone, opiates, barbiturates, benzodiazepines, propoxyphene, or a metabolite of any such substances.

(6) "Drug test" means a chemical, biological, or physical instrumental analysis administered on a specimen sample for the purpose of determining the presence or absence of a drug or its metabolites within the sample.

(7) "Drug-free workplace program" means a set of workplace-based policies and procedures designed to reduce workplace involvement with alcohol and other drugs, and increase safety, productivity, and worker health. For the purpose of these regulations, "drug-free workplace program" is

synonymous with "substance abuse testing program" as used in chapter 127, Laws of 1996.

(8) "Employee" means a person who is employed for salary, wages, or other remuneration by an employer.

(9) "Employee assistance program" means a program designed to assist in the identification and resolution of job performance problems associated with employees impaired by personal concerns. A minimum level of core services must include: Consultation and professional, confidential, appropriate, and timely problem assessment services; short-term problem resolution; referrals for appropriate diagnosis, treatment, and assistance; follow-up and monitoring; employee education; and supervisory training. Any employee assistance program under this chapter must contain a two-year employee follow-up and monitoring component.

(10) "Employer" means an employer subject to Title 51 RCW but does not include the state or any department, agency, or instrumentality of the state; any county; any city; any school district or educational service district; any municipal corporation, or any self-insured employer.

(11) "Injury" means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result and occurring from without, and such physical conditions as result therefrom.

(12) "Job applicant" means a person who has applied for employment with an employer and has been offered employment conditioned upon successfully passing a drug test and may have begun work pending the results of the drug test.

(13) "L & I" means the department of labor and industries.

(14) "Last-chance agreement" means a notice to an employee who is referred to the employee assistance program due to a verified positive alcohol or drug test or for violating an alcohol or drug-related employer rule that states the terms and conditions of continued employment with which the employee must comply.

(15) "Random testing" means a method of selecting employees for alcohol or drug testing through a scientifically valid method, such as computer-based generation of employee identification numbers, in which each employee has an equal chance of being chosen each time selections are made. Random testing is sometimes called "lottery" testing.

(16) "Random testing pool" means the total of all employees of the employers in a clean card program.

(17) "Rehabilitation program" means a chemical dependency treatment program approved by the department that is capable of providing expert identification, assessment, and treatment of employee drug or alcohol abuse in a confidential and timely service. Any rehabilitation program under this chapter must contain the capacity to provide a two-year continuing care component.

(18) "Substance abuse test" or "test" means a chemical, biological, or physical instrumental analysis administered on a specimen sample for the purpose of determining the presence or absence of a drug or its metabolites in a urine sample or of alcohol within a breath sample.

(19) "Verified positive test result" means a confirmed positive test result obtained by a laboratory meeting the standards specified in this chapter that has been reviewed and verified by a medical review officer in accordance with medical review officer guidelines promulgated by the United States Department of Health and Human Services.

(20) "Workers' compensation premium" means the medical aid fund premium and the accident fund premium under Title 51 RCW.

[99-20-023, recodified as § 388-815-010, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 49.82.130. 98-20-045, § 440-26-010, filed 9/30/98, effective 10/31/98. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-010, filed 7/25/96, effective 8/25/96.]

WAC 388-815-020 Eligible employers. (1) A private Washington state employer, as defined in WAC 440-26-010(9), who, prior to July 1, 1996, does not have in place a drug-free workplace program as described in subsection (2) of this section may be eligible for the worker compensation premium discount as described under chapter 127, Laws of 1996, provided the employer:

(a) Participates in the state workers compensation insurance fund, as described under chapter 51.16 RCW;

(b) Remains in good standing with L&I as of the certification date with respect to premium payment obligations;

(c) Has medical insurance which includes chemical dependency treatment benefits available to full-time employees otherwise eligible for benefits, whether through an employer, union, or jointly-sponsored plan; and

(d) Makes application for certification and agrees to provide a drug-free workplace program in accordance with these rules.

(2) An employer shall not be eligible for the discount program if, prior to July 1, 1996, the employer already has a drug-free workplace program in place that includes all the following elements:

(a) A policy statement including:

(i) Prohibitions concerning the possession, use, or being under any influence of drugs or alcohol during working hours; and

(ii) Assurance that an employee will not be terminated solely for a first-time verified positive drug or alcohol test, but will be given the opportunity for job retention through a last chance agreement.

(b) Drug testing in pre-employment and post-accident situations, and alcohol testing in post-accident situations; and

(c) An employee assistance program from the list approved by the division of alcohol and substance abuse which provides the employee assistance program services required by WAC 440-26-220.

[99-20-023, recodified as § 388-815-020, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-020, filed 7/25/96, effective 8/25/96.]

WAC 388-815-030 Certification of employer to L&I. The department shall notify the employer and the department of labor and industries of the employer's certification as a drug-free workplace when the department has:

(1) Received and approved the employer's application for certification or renewal of certification; and

(2) Received the required certification fee.

[99-20-023, recodified as § 388-815-030, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-030, filed 7/25/96, effective 8/25/96.]

WAC 388-815-100 Employer certification procedures. (1) An eligible employer shall:

(a) Obtain from the department an application packet of information on how to become certified as a drug-free workplace; and

(b) Ensure that the application materials demonstrate compliance with all the elements required in chapter 127, Laws of 1996.

(2) The applicant employer shall submit:

(a) A completed application;

(b) If applicable, a statement that:

(i) The employer's drug-free workplace policy has been negotiated with employee unions; or

(ii) The union has waived its right to bargain, as required by the National Labor Relations Board.

(c) An initial certification fee in accordance with the fee schedule included in the application packet.

[99-20-023, recodified as § 388-815-100, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-100, filed 7/25/96, effective 8/25/96.]

WAC 388-815-110 Certification maintenance. The department shall renew certification as a drug-free workplace program annually. An employer's continued certification and renewal shall be contingent upon:

(1) Submission of information requested by the department in an annual certification renewal process, including information from the employer's EAP and drug testing service;

(2) Correction of or department approval of a plan to correct deficiencies found during periodic on-site surveys and complaint investigations related to the drug-free workplace program. During on-site surveys and complaint investigations, employer representatives shall allow or assist department representatives to:

(a) Examine any part of the program as needed;

(b) Review and evaluate records, including employee personnel files, policies, procedures, fiscal records, data, and other documents as the department requires to determine compliance; and

(c) Conduct individual interviews with employees and management.

(3) Payment of annual certification renewal fees within thirty days of the date of billing.

[99-20-023, recodified as § 388-815-110, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-110, filed 7/25/96, effective 8/25/96.]

WAC 388-815-120 Program oversight. (1) The department shall provide ongoing program oversight and investigate apparent areas of employer noncompliance with the requirements of this chapter.

(2) The department may initiate such investigation as necessary to determine whether drug-free workplace certification should be maintained after:

(a) Initial review of the application;

(b) Review of complaints from employees; or

(c) Random site visits to participating employers.

(3) When an employer's program is found out of compliance with regulations herein, the department shall offer:

(a) Assistance to the employer in correcting any deficiency; and

(b) A plan of correction.

(4) If the employer fails to correct the deficiency within a time period specified by the plan of correction, the department may initiate procedures to decertify the employer from the premium discount program.

[99-20-023, recodified as § 388-815-120, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-120, filed 7/25/96, effective 8/25/96.]

WAC 388-815-130 Denial of certification. The department may deny an employer's application for certification or renewal when any of the following conditions occurs and is not satisfactorily resolved:

(1) The employer obtains or attempts to obtain or renew certification by fraudulent means or misrepresentation;

(2) The employer fails to provide all of the information or signed consents required in the application process in accordance with the department's request;

(3) The employer fails to pay the required fee;

(4) The employer's program is not in compliance with chapter 127, Laws of 1996.

[99-20-023, recodified as § 388-815-130, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-130, filed 7/25/96, effective 8/25/96.]

WAC 388-815-140 Decertification. The department shall decertify an employer from the premium discount program if the employer:

(1) Ceases to implement a drug-free workplace program for which the employer has been certified;

(2) Fails to correct deficiencies discovered and disclosed in writing to the employer by the department;

(3) Voluntarily cancels certification; or

(4) Fails to pay the required certification fee.

[99-20-023, recodified as § 388-815-140, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-140, filed 7/25/96, effective 8/25/96.]

WAC 388-815-160 Hearings, appeals. In the event of an employer's decertification, the department shall:

(1) Notify the employer and the department of labor & Industries of the decertification; and

(2) Inform the employer of hearing and appeal rights under the Administrative Procedure Act, chapter 34.05 RCW.

[99-20-023, recodified as § 388-815-160, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-160, filed 7/25/96, effective 8/25/96.]

WAC 388-815-200 Program requirements—Policy statement. To be certified for the worker compensation premium discount, an employer shall provide a drug-free workplace program that operates under written policy and procedures that:

(1) Notify employees that the use of or being under any influence of alcohol during working hours is prohibited;

(2) Notify employees that the use, purchase, possession, or transfer of drugs or having illegal drugs in their system is

prohibited and that prescription or nonprescription medications are not prohibited when taken in accordance with a lawful prescription or consistent with standard dosage recommendations;

(3) Identify the types of testing an employee or job applicant may be required to submit to and the criteria used to determine when such a test will be required;

(4) Identify the consequences of refusing to submit to a drug test required by the employer's policy;

(5) Identify the actions the employer may take against an employee or job applicant on the basis of a verified positive test result;

(6) Assure employees of the possibility of job retention through a last chance agreement;

(7) Describe the conditions of and process for implementing a last chance agreement;

(8) Contain a statement that an employee or job applicant who receives a verified positive test result may contest or explain the result to the employer through the employer's medical review officer within five working days after receiving written notification of the positive test result;

(9) Describe how the employer will provide information to an employee or job applicant advising them of the existence of the drug-free workplace program;

(10) Describe employee confidentiality;

(11) Describe how the employer will advise the employees of the employee assistance program required by this chapter;

(12) Describe how the employer will provide the supervisor training and employee education required by this chapter;

(13) Contain a statement informing employees of the provisions of the federal Drug-free Workplace Act, if applicable to the employer; and

(14) Notify employees that the employer may discipline an employee for failure to report an injury in the workplace, not for filing a claim.

[99-20-023, recodified as § 388-815-200, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-200, filed 7/25/96, effective 8/25/96.]

WAC 388-815-205 Program requirements—Notifications. (1) An employer who, prior to July 1, 1996, has not required drug or alcohol testing of employees shall give all employees at least sixty days notice before instituting drug and alcohol testing as part of the drug-free workplace program described in this chapter. The department shall not require employers with drug and alcohol testing policies in effect prior to July 1, 1996 to provide a sixty-day notice period.

(2) An employer shall include notice of substance abuse testing to all job applicants.

(3) An employer shall:

(a) Post notice of the employer's drug-free workplace policy, including its substance abuse testing provisions, in an appropriate and conspicuous location on the employer's premises; and

(b) Make copies of the employer's policy available without request for inspection by employees or job applicants of the employer during regular business hours.

(4) An employer shall make reasonable efforts to help non-English-speaking employees and job applicants understand provisions of the policy.

[99-20-023, recodified as § 388-815-205, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-205, filed 7/25/96, effective 8/25/96.]

WAC 388-815-210 Program requirements—Substance abuse testing. (1) To be certified for the worker compensation premium discount, an employer shall provide a drug-free workplace program that includes substance abuse testing. In conducting substance abuse testing the program shall:

(a) Require all job applicants not enrolled in a clean card program as described in WAC 440-26-215 to submit to a drug test after extending a conditional offer of employment. The employer may use a refusal to submit to a drug test or a verified positive test as a basis for not hiring the job applicant.

(b) Investigate each workplace injury that results in a worker needing off-site medical attention and require an employee to submit to drug and alcohol tests if the employer reasonably believes the employee has caused or contributed to an injury which resulted in the need for off-site medical attention. An employer need not require that an employee submit to drug and alcohol tests if a supervisor, trained in accordance with WAC 440-26-230, reasonably believes that the injury was due to the inexperience of the employee or due to a defective or unsafe product or working condition, or other circumstances beyond the control of the employee. Under this chapter, a first-time verified positive test result may not be used as a sole basis to terminate an employee's employment. However, nothing in this section prohibits an employee from being terminated for reasons other than the positive test result.

(c) Require employees referred to the employee assistance program as a result of a verified positive drug or alcohol test or an alcohol or drug-related incident in violation of employer rules to submit to drug and alcohol testing in conjunction with any recommended rehabilitation program. If the employee assistance program determines that the employee does not require treatment services, the employee shall still be required to participate in follow-up testing. However, if an employee voluntarily enters an employee assistance program, without a verified positive drug or alcohol test or a violation of any drug or alcohol related employer rule, follow-up testing is not required. If follow-up testing is conducted, the employer shall ensure the frequency of the testing is at least four times a year for a two-year period after completion of the rehabilitation program and advance notice of the testing date may not be given. A verified positive follow-up test result shall normally require termination of employment.

(2) This section does not prohibit an employer from conducting other drug or alcohol testing, such as upon reasonable suspicion or a random basis, although neither reasonable suspicion nor random testing is required under this chapter.

(3) Laboratory analysis of drug specimens, both initial and confirmatory, must be performed by laboratories approved either by the substance abuse and mental health

administration, or the College of American Pathologists under the Forensic Urine Drug Testing program (FUDT).

(4) Specimen collection and substance abuse testing under this section must be performed in accordance with regulations and procedures approved by the United States Department of Health and Human Services and/or the United States Department of Transportation Regulations as described in 49 C.F.R. Sec. 382.305 (1994). These regulations and procedures include:

(a) Cutoff levels for alcohol and drug testing; and

(b) Controlled substances for which testing must be done: Marijuana, cocaine, amphetamines, opiates, and phencyclidine.

Employers may test for any drug listed in WAC 440-26-010(4). Employers certified through a clean card program must also comply with department of transportation regulations regarding the selection process for random testing and conduct a minimum fifty percent annual random testing rate for controlled substances as described in 49 C.F.R. Sec. 382.305 (1994).

(5) Within five working days after receipt of a verified positive test result from the laboratory, an employer shall inform an employee or job applicant in writing of the positive test result, the consequences of the result, and the options available to the employee or job applicant, and shall furnish to the employee or job applicant, upon request, a copy of the test result.

(6) An employer shall pay the cost of all drug or alcohol tests that the employer requires of employees and job applicants under this chapter.

(7) An employee or job applicant shall pay the cost of additional tests not required by the employer.

[99-20-023, recodified as § 388-815-210, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 49.82.130. 98-20-045, § 440-26-210, filed 9/30/98, effective 10/31/98. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-210, filed 7/25/96, effective 8/25/96.]

WAC 388-815-215 Program requirements—How employers get certified through a clean card program. Employers wishing to be certified for the drug-free workplace discount program through a clean card program must observe the application procedures in WAC 440-26-100. They must submit application materials to the department which include:

(1) A signed application form which contains an assurance of the employer's involvement in a clean card program;

(2) A statement that the employer's policy has been negotiated with employee unions where applicable; and

(3) A policy statement which, in addition to the other requirements of WAC 440-26-200, also includes:

(a) A requirement that:

(i) New employees either verify status in the clean card program, or submit to a pre-employment test; and

(ii) All company employees be subject to random testing.

(b) A description of the major provisions of the employer's clean card program.

[99-20-023, recodified as § 388-815-215, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 49.82.130. 98-20-045, § 440-26-215, filed 9/30/98, effective 10/31/98.]

WAC 388-815-220 Program requirements—Employee assistance program. (1) To be certified for the worker compensation premium discount, an employer shall provide a drug-free workplace program that includes an employee assistance program approved by the department in accordance with section 7, chapter 127, Laws of 1996.

(2) The employer's employee assistance program shall provide the employer with a system for dealing with employees whose job performances are declining due to unresolved personal problems, including alcohol or other drug-related problems, marital problems, or legal or financial problems.

(3) The employer's employee assistance program shall have a primary focus on the rehabilitation of employees suffering from alcohol or drug addiction, and shall:

(a) Provide a professional chemical dependency evaluation to every employee given the opportunity for job retention through a last chance agreement after being found in violation of the employer's drug-free workplace policy, and to every employee at their request;

(b) Refer the employee for appropriate treatment according to an individualized treatment plan as indicated by the evaluation and required under section 8 of chapter 127, Laws of 1996. Only treatment programs approved by the department shall provide treatment under this chapter;

(c) Monitor the employee's progress for a minimum of two years both while in treatment and during the period of the last chance agreement, modifying the continuing care provisions as clinically indicated; and

(d) Notify the employer when an employee is not substantially compliant with the requirements of the last chance agreement, including ongoing treatment and continuing care recommendations.

(4) The employer's employee assistance program, in accordance with subsection (3) of this section, shall normally provide services required by this chapter in a face-to-face manner by staff who are:

(a) Certified as chemical dependency counselors by the National Association of Alcohol and Drug Abuse Counselors (NAADAC), the International Certification Reciprocity Consortium/Alcohol and Drug Abuse (ICRC), the Chemical Dependency Counselor Certification Board of Washington state, or the Northwest Indian Alcohol/Drug Specialist Certification Board; or

(b) Qualified as chemical dependency counselors as defined in chapter 440-22 WAC, Certification requirements for chemical dependency treatment service providers; or

(c) Qualified to perform Substance Abuse Professional (SAP) duties as defined in U.S. Department of Transportation Regulations.

(5) To encourage employee self-referral to the employee assistance program outside of drug-free workplace policy violations, the employer shall:

(a) Notify employees of the benefits and services of the employee assistance program;

(b) Publish notice of the employee assistance program in conspicuous places and explore effective means of publicizing the services; and

(c) Provide employees with notice of the policies and procedures regarding access to and use of the employee assistance program.

[99-20-023, recodified as § 388-815-220, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-220, filed 7/25/96, effective 8/25/96.]

WAC 388-815-230 Supervisor training. An employer shall provide all supervisory personnel with a minimum of two hours of supervisor training that includes but is not limited to, the following information:

(1) The relationship of job performance deficiencies to unresolved personal problems;

(2) How to recognize signs of employee substance abuse;

(3) How to document and corroborate signs of employee substance abuse;

(4) How to refer employees to the employee assistance program;

(5) Circumstances and procedures for post-injury testing;

(6) Supervisor responsibilities in a last chance agreement; and

(7) Employee confidentiality.

[99-20-023, recodified as § 388-815-230, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-230, filed 7/25/96, effective 8/25/96.]

WAC 388-815-240 Employee education. (1) An employer shall provide all employees with an annual education program on substance abuse, in general, and its effects on the workplace, specifically.

(2) The education program shall be a minimum of one hour during regular working hours and include, but not be limited to, the following information:

(a) The explanation of the disease model of addiction for alcohol and drugs;

(b) The effects and dangers of the commonly abused substances in the workplace;

(c) The employer's policies and procedures regarding substance abuse in the workplace;

(d) How to access the employer's employee assistance program for any appropriate assistance; and

(e) How employees who wish to obtain substance abuse treatment can do so.

(3) An employer with employees who have difficulty communicating in English shall make reasonable efforts to help the employees understand the substance of the education program.

[99-20-023, recodified as § 388-815-240, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-240, filed 7/25/96, effective 8/25/96.]

WAC 388-815-250 Confidentiality. In implementing a drug-free workplace program under this chapter, an employer shall observe all relevant federal and state laws and regulations concerning the confidentiality of information, in compliance with section 12, chapter 127, Laws of 1996.

[99-20-023, recodified as § 388-815-250, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-250, filed 7/25/96, effective 8/25/96.]

Chapter 388-818 WAC
DEAF AND HARD OF HEARING SERVICES
(Formerly chapter 388-43 WAC)

WAC

WAC 388-818-001 Scope. (1) The office of deaf and hard of hearing services (ODHHS) within the department of social and health services (DSHS):

(a) Provides DSHS information relating to deaf, hard of hearing, and/or deaf-blind;

(b) Provides DSHS technical assistance regarding deafness;

(c) Provides DSHS training and workshops on deafness; and

(d) Assists DSHS in securing sign language interpreters services for DSHS deaf clients.

(2) ODHHS maintains and oversees the telecommunication access services (TDD relay and distribution program), and serves as administrator responsible for the DSHS advisory committee on deafness.

[99-20-022, recodified as § 388-818-001, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-001, filed 12/30/93, effective 1/30/94.]

WAC 388-818-002 Regional centers. The office of deaf and hard of hearing services (ODHHS) shall contract with regional centers for the deaf and hard of hearing.

[99-20-022, recodified as § 388-818-002, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-002, filed 12/30/93, effective 1/30/94.]

WAC 388-818-003 Services. (1) Within the available funds, contractors shall provide quality human services for a person who is deaf or hard of hearing.

(2) Within available funds, and as specified by contract, the department shall ensure the Washington regional service centers provide:

(a) Information services relating to deafness services;

(b) Coordination among private and public agencies, the office of deaf and hard of hearing services (ODHHS), regions, and the deaf community;

(c) Training and consultative services to public and private agencies;

(d) Advocacy for a deaf or hard of hearing client;

(e) Assistance to a deaf or hard or hearing client in applying for and securing programs and services from DSHS;

(f) Assistance and perform other duties relating to deafness as required by the contract; and

(g) Share information among local deaf and hard of hearing organizations.

[99-20-022, recodified as § 388-818-003, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-003, filed 12/30/93, effective 1/30/94.]

WAC 388-818-005 Definitions. The following definitions shall apply in this chapter, unless the context otherwise requires:

(1) "Amplifier" means an electrical device for use with a telephone which amplifies the sounds being received during a telephone call or a telephone with built-in amplification.

(2) "Applicant" means a person who applies for a teletypewriter (hereinafter TTY), amplifier, telebraille, large visual display, or signal device.

(3) "Audiologist" means a person who has a masters or doctoral degree in audiology and a certificate of clinical competence in audiology from the American Speech, Hearing, and Language Association.

(4) "Deaf" means a condition of severe or complete absence of auditory sensitivity where the primary effective receptive communication mode is visual or tactile, or both.

(5) "Deaf-blind" means a hearing loss and a visual impairment that require use of a TTY to communicate effectively on the telephone, and may require a specific telecommunications device for a person with limited sight, as certified under WAC 388-43-010.

(6) "Department" means the department of social and health services.

(7) "Distribution center" means a facility under contract to DSHS services including but not limited to:

(a) Providing literature about TAS programs;

(b) Providing space for qualified trainers to instruct recipients in the use of telecommunications equipment;

(c) Point of contact for persons to communicate with ODHHS or TAS.

(8) "Federal poverty level guidelines" means the poverty level established by P.L. 97-35 § 52 (codified at 42 USC § 9747), § 673(2) (codified at 42 USC § 99202(2)) as amended; and the Poverty Income Guideline updated annually in the Federal Register.

(9) "Hard of hearing" means a condition of some absence of auditory sensitivity with residual hearing which may be sufficient to process linguistic information through audition with or without amplification under favorable listening conditions, or a condition of other auditory handicapping conditions.

(10) "Hearing disabled" means a hearing loss that requires use of either a TTY, telebraille, large visual display or an amplifier to communicate effectively on the telephone, and may require the use of a signal device to indicate when the telephone is ringing, as certified under WAC 388-43-010.

(11) "ODHHS" means the office of deaf and hard of hearing services, department of social and health services.

(12) "Official application date" means the date the department received the completed telecommunications equipment application form.

(13) "Qualified trainer" means a person knowledgeable about the appropriate use of TTYs, amplifiers, telebrailles, and/or signal devices, capable of instructing recipients with differing hearing and vision disabilities.

(14) "Recipient" means a person who or organization which has received a state-issued TTY, amplifier, telebraille, large visual display, or signal device.

(15) "School age" means a child five years to seventeen years of age.

(16) "Signal device" means a electronic device that alerts a hearing impaired or deaf-blind recipient of an incoming telephone call.

(17) "Speech disabled" means a speech disability that requires the use of a TTY to communicate effectively on the telephone.

(18) "TAS" means the telecommunications access service, governed by the office of deaf and hard of hearing services, department of social and health services.

(19) "Telebraille" means an electrical device for use with a telephone and TTY that utilizes a braille display to receive messages.

(20) "Telecommunications equipment/device" means amplifier, TTY, telebraille, large visual display, and signalling devices.

(21) "Telecommunications relay center" means a facility authorized by DSHS to provide telecommunications relay services.

(22) "Telecommunications relay service (TRS)" means a telephone service through facilities equipped with specialized equipment and staffed by communications assistants who relay conversations between people who use TTYs and people who use the general telephone network.

(23) "Teletypewriter (TTY)" means an electrical device for use with a telephone that utilizes a keyboard, acoustic coupler, and display screen to transmit and receive messages. Also known as "TDD" (telecommunications device for the deaf) or "TT" (text telephone).

[99-20-022, recodified as § 388-818-005, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-005, filed 12/30/93, effective 1/30/94.]

WAC 388-818-010 Eligibility requirements. (1) An eligible applicant shall:

(a) Be hearing or speech disabled or deaf-blind; and

(b) Be a resident of Washington state; and

(c) Be at least school age as defined under WAC 388-43-005(15); or

(d) Be the parent/guardian applying on behalf of a child four years of age or younger who has been certified in writing, as specified under subsection (2)(a) through (f) of this section; and

(e) Meet total annual family income and family size requirements as set forth under section 020 of this chapter.

(2) An eligible applicant shall be certified in writing as hearing disabled, speech disabled, or deaf-blind by one of the following:

(a) A person licensed to practice medicine in the state of Washington;

(b) An audiologist in Washington as specified under WAC 388-43-005;

(c) A vocational rehabilitation counselor in a local division of vocational rehabilitation office;

(d) A deaf specialist or coordinator at one of the community service centers for the deaf and hard of hearing in the state;

(e) A deaf-blind specialist or coordinator at Helen Keller regional office, Washington deaf-blind service center, or an eye specialist; or

(f) A certified speech pathologist practicing in the state of Washington.

(3) TAS may require additional documentation to determine if the applicant meets the eligibility requirements under sections 010 and 020 of this chapter.

(4) At the time an applicant applies for equipment, the applicant shall provide the department information on family income and family size.

(5) At the time an applicant applies for equipment, the department shall notify the applicant of the legal consequences if the applicant provides false information.

(6) The department shall ensure an eligible organization meets the following criteria:

(a) The organization must provide a copy of the certificate of incorporation as a nonprofit organization and its bylaws, to indicate that the intent of the organization is to represent the hearing or speech disabled or deaf-blind persons statewide;

(b) The organization must have represented hearing or speech disabled or deaf-blind persons statewide in the last three years; and

(c) The organization must have a telephone number which is either listed or available through statewide publicity for the hearing disabled.

[99-20-022, recodified as § 388-818-010, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-010, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-010, filed 12/30/93, effective 1/30/94.]

WAC 388-818-020 Approval of application for initial device or request for replacement device. (1) An applicant shall fill out:

(a) An application form; and

(b) A declaration of income statement.

(2) If the department determines an applicant is eligible, TAS shall approve the application except as provided under WAC 388-43-030 (1)(a) or (b).

(3) An eligible applicant's reported total family income and family size described under this subsection shall determine the applicant's level of financial responsibility in obtaining the equipment:

(a) The department shall determine client participation by a sliding scale based on zero percent to two hundred percent of the most recent federal poverty level; and

(b) The department shall ensure the sliding scale is adjusted yearly following the new federal poverty level publication.

(4) A recipient of equipment shall own the equipment, with the exception of a telebraille and tactile signalling device, if the department distributed the equipment before May 15, 1993. When a telecommunications device distributed before May 15, 1993 breaks after warranty has expired, the recipient shall renew the equipment application as an original application as described under this chapter.

(5) The department shall provide an eligible recipient initial or replacement equipment based on the availability of equipment and/or funds.

(6)(a) "DEC" means a deductible employee contribution;

(b) "Dependent" means a relative who depends on the family income for at least half of the relative's support;

(c) "Family size" means a person or a person and the person's spouse, if not legally separated, and the person's dependents;

(d) "S corporation" means a domestic corporation with one class of stock having thirty-five or less shareholders who are United States citizens;

(e) "SEP" means a simplified employee pension.

(7) Income includes, but is not limited to:

(a) Earned income, such as wages and tips;

(b) Unearned income, such as interest, dividends, and pensions;

(c) Family's share of income from S corporations, partnerships, estates, and trusts;

(d) Gains from the sale or exchange (including barter) of real estate, securities, coins, gold, silver, gems, or other property;

(e) Gain from the sale or exchange of the family's main home;

(f) Accumulation distributions from trusts;

(g) Original issue discount, distribution from SEPs and DECs;

(h) Amounts received in place of wages from accident and health plans if the employer paid for the policy;

(i) Bartering income;

(j) Tier 2 and supplemental annuities under the Railroad Retirement Act;

(k) Life insurance proceeds from a policy the family cashed in if the proceeds are more than the premiums paid;

(l) Endowments;

(m) Lump-sum distribution;

(n) Prizes and awards;

(o) Gambling winnings;

(p) Social Security;

(q) Capital gains;

(r) Child support received.

[99-20-022, recodified as § 388-818-020, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-020, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-020, filed 12/30/93, effective 1/30/94.]

WAC 388-818-030 Denial of initial application or request for replacement device. (1) Denial of initial application. TAS shall deny an original application for a TTY, amplifier, telebraille, large visual display, or signal device if an applicant:

(a) Does not meet the eligibility requirements of WAC 388-43-010; or

(b) Has already been issued a similar device from TAS.

(2) Denial of replacement request. TAS shall deny a request for replacement of a TTY, amplifier, telebraille, large visual display, or signal device if the recipient:

(a) Reported a family income of one hundred sixty-five percent and above on the federal poverty level; or

(b) Subjected a previously issued device, either through negligence or intent, to abuse, misuse, unauthorized repair, or other negligent or intentional conduct which resulted in damage to the equipment; or

(c) Failed to file with the police a report of stolen equipment within fifteen working days of discovering the theft; or

(d) Failed to file with the police or the fire department a report of fire having damaged the equipment within fifteen working days of the incident of the fire; or

(e) Lost the equipment; or

(f) Failed to obtain approval from the department before moving or traveling out of state with state-loaned equipment.

[99-20-022, recodified as § 388-818-030, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-030, filed 12/30/93, effective 1/30/94.]

WAC 388-818-040 Application renewal process. (1) An applicant may renew application for telecommunications equipment when two years have elapsed since the initial distribution or when the equipment breaks, whichever comes later.

(2) When either two years have elapsed since initial distribution or the equipment breaks, the applicant shall:

(a) Complete a new application including recent information on total annual family income and family size.

(b) Undergo the same procedures as first-time applicants.

[99-20-022, recodified as § 388-818-040, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-040, filed 12/30/93, effective 1/30/94.]

WAC 388-818-050 Notice of approval or denial. (1) Approved applications. When an original application has been approved, TAS shall inform the applicant in writing of:

(a) The official date the department received the applicant's completed application form;

(b) The time line by which a qualified trainer will contact the applicant.

(2) A qualified trainer shall notify the eligible applicant:

(a) That the applicant was approved to receive a TTY, amplifier, telebraille, large visual display, or signal device; and

(b) To arrange for training and distribution.

(3) Denied applications. If the department denies an original application, TAS shall inform the applicant in writing of:

(a) The official date the applicant's completed application form was received by the department;

(b) The reasons for the denial; and

(c) Any applicable procedures for appeal, as well as the circumstances under which the applicant may re-apply.

[99-20-022, recodified as § 388-818-050, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-050, filed 12/30/93, effective 1/30/94.]

WAC 388-818-060 Review by department. (1) An applicant or recipient, whose application for an original or replacement device governed under this chapter has been denied, may request the department to review this decision. The applicant or recipient shall:

(a) Submit this request in writing to TAS specifying the basis for the request; and

(b) Ensure TAS receives this request within thirty days of the receipt of the denial notice.

(2) Within thirty days after TAS has received the request for review by ODHHS, the department shall inform the applicant or recipient in writing of the disposition of the request.

(3) If the applicant or recipient disagrees with the decision by the department, the applicant or recipient may appeal as described under chapters 10-08 and 388-08 WAC.

[99-20-022, recodified as § 388-818-060, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-060, filed 12/30/93, effective 1/30/94.]

WAC 388-818-070 Distribution. (1) The department shall issue personal service contracts to qualified persons or agencies to act as qualified trainers. The department shall ensure reasonable accessibility to such training for a person with a hearing or speech disability or for a person who is deaf-blind.

(2) A qualified trainer shall have various responsibilities, which include, but are not limited to:

(a) Conducting individual and group training for the applicants in the use of the equipment;

(b) Conducting individual and group training for the applicants in the use of the telecommunications relay service;

(c) Requiring all recipients, legal guardians, or legal custodians to sign:

(i) A conditions of acceptance form for state-owned equipment; or

(ii) A statement of rights and responsibilities for client-owned equipment.

(d) Distributing TTYs, amplifiers, telebrailles, large visual displays, and signal devices to applicants; and

(e) Submitting monthly reports and billing as required by TAS.

(3) In the use of any devices distributed under this chapter, neither the TAS nor the contracted qualified trainers shall provide:

(a) Replacement batteries for any telecommunications equipment;

(b) Replacement paper for TTYs;

(c) Replacement light bulbs for signal devices;

(d) Payment of the recipient's telephone bill; or

(e) Any other extraneous cost incurred by the recipient.

[99-20-022, recodified as § 388-818-070, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-070, filed 12/30/93, effective 1/30/94.]

WAC 388-818-080 Training. (1) The qualified trainers shall provide training on proper equipment use and care to all recipients, legal guardians, or legal custodians.

(2) The qualified trainers shall be responsible for determining the training needs of the recipients and the time and length of training that would be most appropriate.

(3) The department shall not issue a device until an applicant has demonstrated ability to properly utilize all equipment issued to the applicant. The department may waive this requirement through a written release in which the applicant attests that the applicant has the ability to properly utilize all equipment issued to the applicant.

(4) If the applicant is seventeen years of age or younger, the applicant's legal guardian or legal custodian shall attend the training on appropriate equipment use and care.

[99-20-022, recodified as § 388-818-080, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-080, filed 12/30/93, effective 1/30/94.]

WAC 388-818-090 Ownership and liability. (1) The department shall provide TTYs, amplifiers, telebrailles, large visual displays, and signal devices to a person eligible under subsection (1)(a), (b), and (c) of this section at no charge in addition to the basic exchange rate if:

(a) The person is eligible for participation in the Washington telephone assistance program under RCW 80.36.470;

(b) The person's annual family income is equal to or less than one hundred sixty-five percent of the federal poverty level; or

(c) The person is a child five years to seventeen years of age whose parent or guardian has a family income less than or equal to two hundred percent of the federal poverty level.

(2) After determining the person may be eligible to receive the telecommunications equipment at no charge, the department shall:

(a) Loan the equipment as needed by the applicant; and

(b) Ensure the applicant understands that the equipment remains the sole property of the state of Washington.

(3) A recipient, the recipient's legal guardian, or the recipient's legal custodian shall return a state-loaned TTY and/or other device to the TAS or appropriate distribution center when the recipient:

(a) Moves from a permanent Washington residence to a location outside of Washington;

(b) Does not have need of the state-loaned telecommunications device; or

(c) Has been notified by TAS to return the device.

(4) A recipient, the recipient's legal guardian, or the recipient's legal custodian shall be liable for any damage to or loss of any device issued under this chapter.

(5) TAS may deny a replacement request if a previously issued device:

(a) Was neglected, abused, misused, or abused through unintentional conduct causing damage;

(b) Was not reported as stolen or burned to either police or fire department within fifteen working days; or

(c) Was lost.

(6) TAS shall establish policies for the sale or salvage of any device returned and not appropriate for reassignment.

(7) A person shall not remove a state-owned TTY, amplifier, telebraille, large visual display, or other signal device from the state of Washington for a period longer than ninety days without the written permission of TAS.

(8) TAS may grant permission to remove a state-owned TTY, amplifier, telebraille, large visual display, or signal device from the state for more than ninety days after determining it is in the best interest of the recipient and the department.

(9) A person eligible under subsection (1)(b) of this section with a family income greater than one hundred sixty-five percent and less than or equal to two hundred percent of the federal poverty level shall be assessed a charge for the cost of TTYs, amplifiers, telebrailles, large visual displays, and signal devices based on a sliding scale of charges established under WAC 388-43-020 (2)(a) and (b).

(10) The department shall determine all TTYs, amplifiers, telebrailles, large displays, and signal devices under chapter 304, Laws of 1987, for which the recipient paid all or part of the equipment's cost to be the sole property of the recipient. The department shall determine the level of financial responsibility toward the purchase of the equipment by the federal poverty level guidelines as described under WAC 388-43-020 (2)(a) and (b).

(11) The department shall provide an eligible recipient a two-year warranty on equipment valued at four hundred dollars or more.

(12) Limiting the number of TTYs per household. The department shall consider that the telecommunications equipment needs of all household members have been met when one TTY has been issued to that household, unless exceptional circumstances are defined and approved by the department.

(13) The department shall receive payment before an eligible recipient receives a TTY, amplifier, telebraille, large visual display, or a signal device.

(14) A recipient shall sign and agree to warranty requirements on a TTY, telebraille, or large visual display at the time the recipient purchases this equipment.

(15) A recipient shall not receive a financial refund for the return of a TTY, amplifier, telebraille, large visual display, or signal device unless:

(a) The equipment is returned to the TAS office within thirty days after it was received by the client; and

(b) The equipment is clean, in good condition and in its original packaging.

(16) The department shall charge a person, eligible under subsection (1)(b) of this section whose income exceeds two hundred percent of the federal poverty level, the entire cost to the department of purchasing the equipment provided to that person.

(17) The department may waive part or all of the charges assessed under sections 010 and 020 if the department finds that:

(a) The eligible person requires telebraille equipment or other equipment of similar cost; or

(b) The charges normally assessed for the equipment under this subsection would create an exceptional or undue hardship on the eligible person.

(18) The department may determine certification of family income by the eligible person, the person's guardian, or head of household as sufficient to determine eligibility.

[99-20-022, recodified as § 388-818-090, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-090, filed 12/30/93, effective 1/30/94.]

WAC 388-818-110 Telecommunications relay service. The department shall award contracts for the operation and maintenance of the statewide telecommunications relay service.

[99-20-022, recodified as § 388-818-110, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-110, filed 12/30/93, effective 1/30/94.]

WAC 388-818-130 Uses for returned equipment. (1) TAS shall issue, as available, the clean and working equipment, which has little or no warranty time left and has been returned to TAS by clients, free of charge to:

(a) Organizations serving hearing/speech disabled, deaf, and/or deaf-blind persons statewide; and

(b) Lending libraries of hospitals and/or hospice facilities.

(2) Organizations receiving used TAS equipment free of charge shall be thereafter responsible for equipment maintenance.

[99-20-022, recodified as § 388-818-130, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-130, filed 1/11/95, effective 2/11/95.]

Chapter 388-820 WAC
COMMUNITY RESIDENTIAL SERVICES AND SUPPORT

(Formerly chapter 275-26 WAC)

WAC

WAC 388-820-005 Purpose. (1) The purpose of these standards is to specify measures which shall carry out the legislative intent of Title 71A RCW authorizing the department to provide or contract for the provision of services to clients with developmental disabilities residing in community residential settings.

(2) Residential services shall provide eligible clients the opportunity to:

(a) Enjoy all rights and privileges under the Constitution and laws of the United States and the state of Washington;

(b) Participate in community life with nonhandicapped and less-handicapped persons to the greatest extent possible; and

(c) Achieve a greater measure of independence and fulfillment.

[99-19-104, recodified as § 388-820-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-005, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-005, filed 2/9/83.]

WAC 388-820-010 Definitions. (1) "Agency" means the department-certified entity providing residential instruction and support services to clients.

(2) "Certification" means the determination of satisfactory compliance with the rules and regulations outlined as referenced under this chapter.

(3) "Client" means a person the division determines under RCW 71A.16.040 and WAC 275-27-026 eligible for division-funded services.

(4) "Client/provider account" means an account in the name of one client where the client or client's provider has the authority to make deposits or withdrawals. The banking laws under RCW 30.22.040 refer to this as an "agency account."

(5) "Client services" means instruction and support activities promoting the following client-centered benefits:

(a) Health and safety:

(i) Needing and using health services;

(ii) Dealing with illness and injury and first aid procedures;

(iii) Learning about basic nutrition;

(iv) Maintaining good health;

(v) Obtaining mental health services when needed;

(vi) Learning about human sexuality;

(vii) Being aware of fire evacuation plans;

(viii) Knowing emergency procedures, including how to use 911 or a local emergency number;

(ix) Being aware of burglary protection strategies; and

(x) Learning self-protection.

(b) Personal power and choice:

(i) Securing housing and furnishings reflecting personal preferences, life style, and financial means;

(ii) Expressing opinions and making decisions;

(iii) Learning and exercising rights and responsibilities;

(iv) Improving communication skills;

(v) Participating in various activities, including new experiences;

(vi) Exercising a voter's rights;

(vii) Learning about available protection and advocacy services; and

(viii) Making career choices.

(c) Positive recognition by self and others:

(i) Creating positive self-esteem and feelings of self-worth;

(ii) Choosing valued social roles; and

(iii) Having choices influencing valued perception of self and others.

(d) Integration in the physical and social life of the community:

(i) Residing in areas convenient to shopping, banking, eating, worshiping, learning, making friends, and otherwise participating in community life;

(ii) Assisting people to use available transportation;

(iii) Meeting new people and participating with other members of the community in shared activities; and

(iv) Accessing educational and vocational opportunities.

(e) Positive relationships:

(i) Establishing, maintaining, expanding, and improving relationships by providing personal interaction opportunities with people;

(ii) Involving the client's family, guardian, or representative in planning and decision making which affect the client;

(iii) Resolving disagreements among clients or among clients and family, friends, neighbors, and co-workers;

(iv) Coping with the loss of a significant relationship, such as the death of a friend or family member, end of a relationship, loss of a job, or change of staff.

(f) Competence and self-reliance:

(i) Learning and using skills useful to the client, such as meal planning, grocery shopping, meal preparation, cleaning laundry, using household appliances, money management and budgeting, and use of leisure time in settings where the skills are needed;

(ii) Identifying situations in which the client needs or desires assistance from others;

(iii) Accomplishing tasks requiring the assistance of staff or others; and

(iv) Acquiring and using adaptive devices and equipment.

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

(7) "Depositor," when utilized in determining the rights of persons to funds in an account, means a person who owns the funds.

(8) "Division" means the division of developmental disabilities of the department of social and health services.

(9) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

(10) "Facility based" means a residence which is owned, leased, or rented by an entity other than the client.

(11) "Frequency" means how often a designated event has occurred.

(12) "Group home" means a residence licensed by the applicable state authority and operated by an agency certified by the division of developmental disabilities.

(13) "Group training home" means a residence meeting the definition of RCW 71A.22.020(2) and which is operated by an agency certified by the division of developmental disabilities as defined under RCW 71A.22.040.

(14) "Imprest fund" means a petty cash fund which has a pre-established limit. The total of the cash in the fund and receipts from withdrawals from the fund equal the pre-established limit.

(15) "Individual account" means one account in the name of one client primarily managed by a provider.

(16) "Individual client cash" means one client's cash controlled by the provider.

(17) "Instruction" means goal-oriented teaching addressing skill acquisition and skill enhancement.

(18) "Nonfacility based" means the client owns, leases, sub-leases, or rents a residence although others, except the department, may guarantee the client's credit.

(19) "Nursing assistant" means a nursing assistant-registered under chapter 18.88A RCW, or a nursing assistant-certified under chapter 18.88A RCW.

(20) "Provider" means the agency or individual with which the department contracts for providing client instruction and support services.

(21) "Reprisal" means any negative action taken as retaliation against an employee. A rebuttable presumption is raised that reprisal has occurred if a negative action occurs within a year of a refusal to delegate or accept delegation. Occurring as a result of a lawful employee action, "reprisal" includes, but is not limited to:

(a) Harassment;

(b) Firing;

(c) Demotion; or

(d) Disciplinary action.

(22) "Residence" means the place or home where a client resides.

(23) "Residential service" means work or duties performed by the provider to meet clients' daily living needs and enhance clients' lives.

(24) "Secretary" means the secretary of social and health services or the secretary's designee.

(25) "Severity" means the seriousness of the occurrence as determined by the:

(a) Actual or potential negative outcomes for residents; or

(b) Extent to which the resident's physical, mental, or psychosocial well-being is compromised or threatened.

(26) "Support" means:

(a) Assistance to a client in performance of necessary functions or tasks; or

(b) The performance of a task on behalf of a client, that is, someone else does the client's task.

(27) "Trust account" means an account containing two or more clients' funds where the provider has the authority to make deposits or withdrawals.

[99-19-104, recodified as § 388-820-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-010, filed 5/1/96, effective 6/1/96. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-010, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-010, filed 2/9/83.]

WAC 388-820-015 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 275-26-010(9) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[99-19-104, recodified as § 388-820-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-019, filed 8/9/91, effective 9/9/91.]

WAC 388-820-020 Certification. (1) Initial certification.

(a) The agency's application for initial certification shall include a mission statement, budget forecast, staff coverage schedule, staff in-service training plan, and agency policies and procedures. The department shall provide the county a copy of the agency's application. The department shall review the recommendations from the county.

(b) The agency shall file with the department a statement of assurance stating the agency shall not:

(i) Refuse a client's admission to the agency;

(ii) Deny participation in the activities of the agency; or

(iii) Deny employment at the agency on the grounds of:

(A) Race;

(B) Religion;

(C) Marital status;

(D) Age;

(E) Sexual orientation;

(F) Color;

(G) Creed;

(H) National origin; or

(I) Handicapping condition, including communicable diseases and HIV/AIDS.

(c) The agency shall comply with:

(i) Relevant federal, state, and local laws and ordinances; and

(ii) Department-established standards of care, instruction, and support.

(d) Initial certification may be granted upon assurance the agency shall comply with the rules and regulations outlined under chapter 275-26 WAC within one hundred eighty days of the effective date.

(e) Upon receipt of initial certification, the agency shall be approved for receiving referrals and serving clients.

(f) In the event initial certification expires before the date of formal evaluation and review, the department may extend initial certification for a specified period of time, not to exceed one hundred eighty days.

(2) Regular certification.

(a) Upon the department's determination of satisfactory compliance with the rules and regulations described and referenced herein, through formal evaluation and review under WAC 275-26-030, the department may certify an agency as approved for continued referral of and service provision to clients.

(b) The agency's certification may be granted for either a one-year or two-year period, but the department may require a more frequent certification review.

(c) The county may submit recommendations to the department before certification.

(d) Regular certification may be extended for a period not to exceed one hundred eighty days.

(3) Provisional certification.

(a) An agency found out of compliance with the provisions of this chapter may be subject to provisional certification not to exceed one hundred eighty days.

(b) When the agency does not comply with the requirements of chapter 275-26 WAC within the one hundred eighty days, the department shall initiate certification revocation. If the agency contests the department's ruling, the agency may request an administrative review conference as described under WAC 275-26-022.

(c) The department's notice of denial, modification, suspension, or revocation of certification is governed by chapter 43.20A RCW and section 95, chapter 175, Laws of 1989.

(d) When an agency comes into compliance with the requirements of chapter 275-26 WAC within one hundred eighty days, the department may grant a regular one-year or two-year certification.

(4) Decertification:

(a) When the department determines the agency does not comply with this chapter the department may revoke the agency's certification as governed under chapter 43.20A RCW and section 95, chapter 175, laws of 1989;

(b) If the agency contests the department's decision, the agency may request an administrative review conference as described under WAC 275-26-022.

[99-19-104, recodified as § 388-820-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-020, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 86-08-003 (Order 2349), § 275-26-020, filed 3/20/86; 83-05-017 (Order 1945), § 275-26-020, filed 2/9/83.]

WAC 388-820-025 Review and evaluation. (1) The department shall review and/or evaluate the agency's services as set forth by law or this chapter. Evaluation shall occur biennially, but the department may require more frequent evaluations.

(2) The department may, at any time, review each client's records and activities to ensure the agency continues serving the client's needs, interests, and welfare.

(3) The department shall file a report of the evaluation results. When the agency is out of compliance with the standards and regulations contained in chapter 275-26 WAC and department contracts, the report shall specify the corrective action to be implemented within a specific time. When corrective action is not implemented within the specified time, the department may withdraw the agency's certification as described under WAC 275-26-020.

(4) The department shall have the right to conduct additional evaluations or audits of the agency as the department deems necessary.

[99-19-104, recodified as § 388-820-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-021, filed 8/9/91, effective 9/9/91.]

WAC 388-820-030 Administrative review conference—Adjudicative proceeding process. (1) Within twenty-eight days after a community residential support agency is notified of a certification determination it wishes to challenge, the agency shall request, in writing, that the division director or the division director's designee review such determination. The agency shall:

(a) Sign the request;

(b) Identify the challenged determination and the date thereof; and

(c) State as specifically as practicable the issues and regulations involved and the grounds for the agency's contention that the determination is erroneous. The agency shall include

with the request copies of any documentation the agency intends to rely on to support its position.

(2) After receiving a timely request meeting the criteria of this section, the director shall contact the agency to schedule a conference for the earliest mutually convenient time. The director shall schedule the conference for no later than thirty days after a properly completed request is received, unless both parties agree, in writing, to a specific later date. The conference may be conducted by telephone unless either the department or the agency requests, in writing, the conference be held in person.

(3) The agency and appropriate representatives of the department shall attend the conference. The agency shall bring to the conference, or provide to the department in advance of the conference, any documentation the agency intends to rely on to support the agency's contentions. The parties shall clarify and attempt to resolve the issues at the conference. If additional documentation is needed to resolve the issues, a second session of the conference shall be scheduled for not later than thirty days after the initial session unless both parties agree in writing to a specific later date.

(4) Unless informal agreement has been reached at the conference, a written decision by the director of the division of developmental disabilities shall be furnished to the agency within sixty days after the conclusion of the conference.

(5)(a) An agency contesting the director's determination shall within twenty-eight days of receipt of the determination:

(i) File a written application for an adjudicative proceeding by a method showing proof of receipt with the office of appeals; and

(ii) Include in or with the application:

(A) A specific statement of the issue or issues and law involved;

(B) The grounds for contesting the director's determination; and

(C) A copy of the director's determination being contested.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20A.205, this chapter, and chapter 388-08 WAC. If any provision in this chapter conflicts with chapter 388-08 WAC, the provision in this chapter governs.

[99-19-104, recodified as § 388-820-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-022, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-26-022, filed 2/5/90, effective 3/1/90. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-022, filed 2/9/83.]

WAC 388-820-035 Eligibility for residential services and support. Any client authorized by the division of developmental disabilities shall be eligible for residential services as defined by this chapter.

[99-19-104, recodified as § 388-820-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-025, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-025, filed 2/9/83.]

WAC 388-820-040 Client remuneration. Clients performing work for the agency shall be given remuneration in accordance with wage and hour laws and requirements stipulated by federal and state law, unless the United States Department of Labor or state department of labor and industries has granted written exemption.

[99-19-104, recodified as § 388-820-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-050, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-050, filed 2/9/83.]

WAC 388-820-045 Administration. (1) The owner or board of directors of the agency shall have department-approved written statements including, but not limited to, the following:

(a) Agency philosophy, objectives, and goals;

(b) Program description and admission criteria;

(c) Policies and procedures describing the following:

(i) Division administrative policy number one prohibiting abuse:

(A) The agency administrator shall complete and file with the division the document entitled division of developmental disabilities administrative policy number one prohibiting a client's mistreatment, neglect, or abuse. The agency shall retain a copy of the document; and

(B) All agency staff working with clients shall sign a similar department-approved document. The agency shall keep the document on record.

(ii) Organizational chart and description showing all supervisory relationships;

(iii) Definition of staff roles and responsibilities, including the person designated to act in the absence of the administrator;

(iv) Criminal background inquiries required under chapter 388-330 WAC;

(v) Client confidentiality and release of information;

(vi) Client rights and grievance procedure;

(vii) Protection of client's financial interests, including management of client accounts, if applicable;

(viii) Drug administration, supervision, handling, storage, and disposal;

(ix) Self-administration of drugs, prescribed or not;

(x) Response to and contingency planning for:

(A) Medical emergencies;

(B) Natural or other disasters;

(C) Missing persons;

(D) Clients involved with law enforcement; and

(E) Unmanageable client behavior.

(xi) Notification of client's guardian and/or relatives in case of emergency.

(2) Following emergencies, as defined under WAC 275-27-020, the agency shall:

(a) Immediately notify the department orally of a serious incident or emergency as described in department policy;

(b) Submit a written incident report to the department as required by law or policy; and

(c) Notify the client's guardian or legal representative.

[99-19-104, recodified as § 388-820-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-055, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-055, filed 2/9/83.]

WAC 388-820-050 Personnel. (1) The owner or board of directors of the agency shall maintain current written personnel policies and procedures which shall be made available to all employees.

(2) Personnel policies and practices shall not discriminate against any employee or applicant for employment because of race, color, sex, religion, national origin, creed, marital status, sexual orientation, age, Vietnam era or disabled veteran status, or the presence of any sensory, mental, or physical handicap, including communicable diseases, and HIV/AIDS, provided the sensory, mental, or physical handicap does not prevent the job's specific performance.

(3) Agency-employed staff shall meet the following minimum requirements:

(a) Have a background inquiry clearance by the authorized state agency;

(b) Exhibit mature behavior and the ability to make independent judgments;

(c) Be twenty-one years of age or older when employed as an administrator;

(d) Be eighteen years of age or older when employed as a direct care staff; and

(e) Have attained a high school diploma or GED equivalent. Current employees are exempt from subsection (3)(e) effective the date of this amendatory act.

(4) Agency employees shall treat a client with dignity and consideration, respecting the client's civil and human rights at all times.

(5) The performance of the administrator and each employee shall be evaluated, in writing, annually or more often by the agency. An owner/administrator is exempt from this requirement.

(6) The administrator or administrator's designee shall be responsible for:

(a) Recruiting, employing, and arranging for residential services staff training;

(b) Terminating from employment any employee performing in an unsatisfactory manner; and

(c) Preparing and maintaining policies and procedures pertaining to clients personnel and financial records; and

(d) Securely storing client, personnel and financial records.

(7) Clients shall not be routinely involved in the instruction and support of other clients.

[99-19-104, recodified as § 388-820-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-060, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-060, filed 2/9/83.]

WAC 388-820-055 Staffing. (1) An agency shall provide sufficient staff to administer the program and perform instruction and support services.

(2) An agency shall provide the client with immediate access to staff or the means to contact staff twenty-four hours a day, seven days each week.

(3) An agency required to have twenty-four-hour, on-duty staff coverage shall have a department-approved staff coverage schedule:

(a) At the time of certification; and

(b) When substantial changes occur. The agency shall retain a copy of department approval of their staffing schedule.

(4) Staff availability.

(a) An agency operating a residential program shall have a designated administrator.

(b) Each facility-based residence shall maintain staffing requirements applicable to the specific licensing regulations and contract requirements under which the agency operates.

(c) When only one direct care staff member is on duty, the agency shall make or have provisions for a second person on call in case of an emergency.

[99-19-104, recodified as § 388-820-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 93-04-029 (Order 3504), § 275-26-065, filed 1/27/93, effective 2/27/93; 91-17-005 (Order 3230), § 275-26-065, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-065, filed 2/9/83.]

WAC 388-820-060 Staff training. (1) The agency shall orient the new employee to the agency's philosophy, goals, policies, procedures, and program services within the first:

(a) Two weeks of employment for staff scheduled to work twenty hours or more per week; or

(b) Four weeks of employment for staff scheduled to work less than twenty hours per week.

(2) The agency shall ensure new employees receive a minimum of twelve hours of training during the first six weeks of employment. Such training shall include a combination of orientation, instruction, and on-the-job training.

(3) The agency shall provide a minimum of twenty training hours to each direct service employee during the subsequent five employment months. Such staff training shall include, but not be limited to:

(a) Basic first aid/CPR;

(b) Knowledge and transmission of Hepatitis B; and

(c) Knowledge and transmission of human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS).

(4) The agency shall review and explain the current instruction and support plan for each client for whom the employee provides direct services before the employee works alone with the client.

(5) The agency shall document orientation, review, and training activities.

[99-19-104, recodified as § 388-820-060, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-070, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-070, filed 2/9/83.]

WAC 388-820-065 Individual service plan. The agency shall participate with department staff, the client, the client's guardian or legal representative, and other interested persons in the development of the individual service plan (ISP), under RCW 71A.18.010 and WAC 275-27-060, as required for each client.

[99-19-104, recodified as § 388-820-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-071, filed 8/9/91, effective 9/9/91.]

WAC 388-820-070 Instruction and support. (1) The agency shall develop a written individual instruction and support plan (IISP) for each client:

(a) Based on the goals established in the department's individual service plan (ISP);

(b) Reflecting the client's preferences and concurrence;

(c) Identifying activities promoting one or more of the following client services:

(i) Health and safety;

(ii) Personal power and choice;

(iii) Positive recognition by self and others;

(iv) Integration in the physical and social life of the community;

(v) Positive relationships; and

(vi) Competence and self-reliance.

(d) Identifying the specific goal and describing the methods of instruction and support promoting client-centered benefits and independence in the community.

(2) The agency shall:

(a) Implement the individual instruction and support plan (IISP) in a manner:

(i) Appropriate to the age of the client;

(ii) Taking place or occurring in typical community settings; and

(iii) Resulting in opportunities for:

(A) Positive change;

(B) Personal growth; and

(C) Development toward maximum independence.

(b) Document progress toward achieving the benefits described in the individual instruction and support plan (IISP);

(c) Review the plan semi-annually or more often;

(d) Consult with other providers serving the client and other interested persons as needed to coordinate and promote the individual instruction and support plan (IISP); and

(e) Revise the individual instruction and support plan (IISP) as benefits are achieved.

[99-19-104, recodified as § 388-820-070, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-072, filed 8/9/91, effective 9/9/91.]

WAC 388-820-075 Health services. (1) The agency shall have a means and procedure for ensuring a client has access to personal care and hygiene services, health services, mental health services, and dental services. For a client for whom the agency provides an average of thirty hours or more of service per month, the agency shall provide instruction and support to the client by:

(a) Maintaining health records;

(b) Assisting the client to arrange appointments with health professionals;

(c) Assisting and ensuring transportation for the client to health services;

(d) Monitoring the client's implementation of medical treatment prescribed by health professionals; and

(e) Communicating directly with health professionals, when indicated.

(2) For each client for whom the agency provides an average of thirty hours or more a month, the agency shall ensure the client receives an annual physical and dental examination unless an exemption is granted, in writing, from the appropriate medical professional.

(3) The agency shall document client refusal to participate in health care services. Documentation shall include:

(a) A written description of events concerning client refusal to participate in health services; and

(b) A written plan to teach the client the benefits of health care participation.

[99-19-104, recodified as § 388-820-075, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-073, filed 8/9/91, effective 9/9/91.]

WAC 388-820-080 Nurse delegation. (1) Before being authorized to perform a delegated nursing care task, staff shall:

(a) Be a nursing assistant-registered or nursing assistant-certified;

(b) Complete nurse delegation core training as approved by the department. The training includes but is not limited to:

(i) Nurse delegation laws and protocols;

(ii) Basic medical knowledge; and

(iii) Medication administration.

(c) The certified community residential services agency shall document this training activity and a certificate shall be issued to the nursing assistant upon completion of the required training.

(2) Nursing assistants delegated a nursing care task in compliance with the nursing care quality assurance commission requirements shall perform the task:

(a) In compliance with all requirements and protocols established by the commission in chapter 246-840 WAC;

(b) Only for the specific client who was the subject of the delegation; and

(c) Only with the consent of the client or a person authorized to provide consent for health care on behalf of the client under this section and RCW 7.70.065. "Persons authorized to provide consent for health care" shall be a member of one of the following classes of persons in the following order of priority:

(i) Legal guardian, if any;

(ii) An individual who holds a durable power of attorney for health care decisions;

(iii) The client's spouse;

(iv) The client's children who are at least eighteen years of age;

(v) The client's parents; and

(vi) The client's adult siblings.

(3) The nursing assistant shall not transfer delegated authority to perform the nursing care tasks to another nursing assistant.

(4) The nursing assistant:

(a) May consent or refuse to consent to perform a delegated nursing care task;

(b) Shall be responsible for the nursing assistant's own actions with regard to the decision to consent or refuse to consent to the performance of the delegated task; and

(c) The nursing assistant shall not be subject to any employer reprisal for refusing to accept delegation of a nursing care task.

(5) The agency shall post and keep posted in a conspicuous place or places where notices to employees are customarily posted, the toll free telephone number established by aging and adult services administration for receiving complaints regarding delegation of specific nursing tasks to nursing assistants.

[99-19-104, recodified as § 388-820-080, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-074, filed 5/1/96, effective 6/1/96.]

WAC 388-820-085 Client records. (1) The client's records shall include, but not be limited to, the following:

(a) The client's name, address, and Social Security number;

(b) The client's guardian or legal representative's name, address, and telephone number;

(c) Copies of legal guardianship papers, if any;

(d) Client health records:

(i) Names, addresses, and telephone numbers of relatives or responsible persons and the name, address, and telephone number of the client's:

(A) Physician;

(B) Dentist;

(C) Mental health provider; or

(D) Others providing client health care services.

(ii) Health care providers' instructions regarding health care needed, including appointment dates and date of next appointment if appropriate;

(iii) Written documentation that the health care providers' instructions have been followed; and

(iv) A record of prosthesis and other artificial parts;

(e) A copy of the department's individual service plan (ISP); and

(f) The client's agency-developed individual instruction and support plan (IISP).

(2) The agency shall maintain and keep current documentation of:

(a) Instruction and support activities for each client as a basis for review, study, and evaluation of the overall progress in programs provided by the agency to the participating clients;

(b) Semi-annual review of the IISP;

(c) Consultation with other service providers and other interested persons;

(d) IISP revisions and changes; and

(e) Other activities relevant to the client.

(3) The agency serving a client an average of thirty hours or more a month shall assist the client in maintaining a current, written property record. The record shall include:

(a) A list of personal possessions, including clothing the client purchases, with a value of one hundred dollars or more per item;

(b) A list of items the client owns when moving into the program;

(c) Description and identifying numbers, if any;

(d) The date of acquisition of items purchased after moving into the program;

(e) The date and reason for addition or removal from the record; and

(f) The signature of the staff making the entry.

(4) Individual providers shall maintain records as required by the department.

(5) The agency shall consider all client record information:

(a) Privileged and confidential;

(b) Available to the department, to the client, and to residential services staff, as needed, to provide client services;

(c) Available to the county developmental disabilities board when the department requests it as allowed under RCW 71A.14.070.

(6) The agency shall prepare and record all record entries:

(a) In ink;

(b) At the time of or immediately following the occurrence of the event recorded, in legible writing, dated, and signed by the person making the entry.

(7) Any transfer or inspection of records, except under subsection (5) of this section, shall be authorized by a release of information form, specific to the transfer or inspection signed by the client or guardian.

[99-19-104, recodified as § 388-820-085, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-075, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-075, filed 2/9/83.]

WAC 388-820-090 Nurse delegation—Penalties. (1) The department shall impose a civil fine of not less than two hundred fifty dollars and not more than one thousand dollars on any provider that knowingly performs or knowingly permits an employee to perform a nursing task except as delegated by a nurse under:

(a) Chapter 18.88A RCW; and

(b) Chapter 246-840 WAC (nursing care quality commission regulations).

(2) When assessing civil fines, the investigator shall consider:

(a) Severity of occurrence;

(b) Frequency of occurrence; and

(c) Other relevant factors relating to the occurrence.

(3) The department shall make technical assistance available to providers for purposes of education and assistance in order to help providers comply with nurse delegation rules and protocols.

(a) The department's technical assistance program shall include:

(i) Requested or voluntarily accepted technical assistance visits during which or soon after which the department informs the provider of violation of law or agency rules;

(ii) How to access the technical assistance;

(iii) Printed information;

(iv) Information and assistance by phone;

(v) Training meetings;

(vi) Other appropriate methods to provide technical assistance; and

(vii) A list of organizations that provide technical assistance.

(b) The provider shall be given a reasonable period of time to correct violations identified during a technical assistance visit before any civil penalty provided by law is

imposed for those violations except as provided in subsection (3)(c) of this section;

(c) A civil penalty may be issued during a technical assistance visit if:

(i) The provider has previously been:

(A) Subject to an enforcement action for the same or similar type of violation of the same statute or rule; or

(B) Given previous notice of the same or similar type of violation of the same statute or rule; or

(ii) The violation has a probability of placing a person in danger of death or bodily harm.

(d) Nothing in these rules obligates the department to conduct a technical assistance visit.

(4) Before imposition of a civil fine and for clarification purposes, the department may take substantially the following steps:

(a) Notify the agency of the concern;

(b) Give the agency an opportunity to explain circumstances or present additional information which may clarify concern;

(c) Request the agency to provide additional information if necessary;

(d) Nothing in this rule shall be construed to require the department to impose a fine if a determination is made that no unlawful delegation occurred.

[99-19-104, recodified as § 388-820-090, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-076, filed 5/1/96, effective 6/1/96.]

WAC 388-820-095 Notice of fine and appeal rights. (1) The department shall give the provider written notice of the civil fine. The department shall ensure the notice:

(a) States the amount and reasons for the fine and the applicable law under which the fine is imposed; and

(b) Informs the provider of the right to request an adjudicative hearing.

(2) A civil fine becomes due twenty-eight days after the service of the written notice of the fine unless the provider requests a hearing in compliance with chapter 34.05 RCW and RCW 43.20A.215. If a hearing is requested, the department shall stay the fine pending a final decision on the matter.

(3) A provider contesting the department's decision to impose a civil fine shall, within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt with the Office of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(b) Include in or with the application:

(i) The grounds for contesting the department decision; and

(ii) A copy of the contested department decision.

(4) Administrative proceedings shall be governed by chapter 34.05 RCW, RCW 43.20A.215, and chapter 388-08 WAC. If any provision in this section conflicts with chapter 388-08 WAC, the provision in this section governs.

(5) When a provider disagrees with the department's finding of a violation under this chapter, the provider shall have the right to have the violation reviewed under the department's dispute resolution process.

(6) Upon request by the provider, the department shall expedite the dispute resolution process to review the imposition of a civil fine.

(7) No agency may discriminate or retaliate in any manner against a person because the person made a complaint or cooperated in the complaint investigation.

[99-19-104, recodified as § 388-820-095, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-077, filed 5/1/96, effective 6/1/96.]

WAC 388-820-100 Transportation. (1) The agency shall ensure or provide transportation for medical emergencies and medical appointments and therapies.

(2) The agency shall assist the client with or arrange transportation, in conjunction with the client and the division, for:

(a) Implementation of the individual service plan (ISP);

(b) Implementation of the individual instruction and support plan (IISP);

(c) Work, school or other publicly-funded services;

(d) Leisure or recreation activities; and

(e) Client-requested activities.

(3) An agency vehicle used to transport clients shall be:

(a) In safe operating condition; and

(b) Properly insured for its usage.

[99-19-104, recodified as § 388-820-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-087, filed 8/9/91, effective 9/9/91.]

WAC 388-820-105 Physical requirements. (1) The agency shall ensure facility-based residential services provide clients the following conditions or necessary equipment:

(a) A clean, safe, and healthful environment;

(b) A location in a residential neighborhood within reasonable distance of necessary physical resources, such as stores, banks, laundromats, churches, job opportunities, and other public services;

(c) An adequate first-aid kit or supplies and a first-aid manual; and

(d) Compliance with all licensing regulations, when applicable.

(e) Current facility-based agencies are exempt from subsection 1(b) effective the date of this amendatory act.

(2) The agency shall ensure nonfacility-based residential services provide clients with the following conditions or necessary equipment:

(a) A clean, safe, and healthful environment;

(b) Access to client-usable telephone equipment;

(c) A working smoke detector, light-alarmed if clients are hearing impaired, located in proximity to sleeping rooms;

(d) A flashlight or other nonelectrical light source in working condition;

(e) Basic first-aid supplies;

(f) An evacuation plan, developed and practiced with the client, placed or stored within the living unit;

(g) A safe storage area for flammable and combustible materials;

(h) Unblocked exits; and

(i) Accessibility by customary forms of ingress and egress for space utilized for residential purposes, excluding ladders, folding stairs, or trap doors.

(3) The agency providing nonfacility-based residential services shall document activities with a client relevant to subsection (2) of this section.

[99-19-104, recodified as § 388-820-105, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-095, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-095, filed 2/9/83.]

WAC 388-820-110 Exceptions when allowed. The department may permit the provider to exceed payment for service and payment for additional expenses. Exceptions will be based on a review by the division of the participating tenant's need for extraordinary level of tenant support services. The exception must be approved by the secretary and included in the contract.

[99-19-104, recodified as § 388-820-110, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-097, filed 2/9/83.]

WAC 388-820-115 Payment for service. (1) The department shall pay for residential services provided to eligible clients under department contract or policy.

(2) For a client receiving facility-based residential services and support:

(a) The client shall pay for cost of care or service from earnings or financial resources under department policy;

(b) Department payments under this chapter shall be supplemental to other financial resources of the client; and

(c) When a client's guardian controls the client's income, estate, or trust fund, the guardian shall reimburse the agency as described under this section.

(3) A client receiving nonfacility-based residential services shall pay for their own housing, utilities, food, clothing, and other personal and incidental expenses from earnings and other financial resources.

(4) The department shall require a client to participate in defraying the cost of services when mandated by federal or state statute or regulation.

(5) The provider shall inform the department when the client requires services beyond levels described under chapter 275-26 WAC. The department may approve and provide payment for additional expenses or services. The provider shall retain a copy of department approval.

(6) To ensure a client is not charged for services provided by state-funded programs, any payment made for health services with client funds shall be supported by the department's written denial.

[99-19-104, recodified as § 388-820-115, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-100, filed 8/9/91, effective 9/9/91.]

WAC 388-820-120 Program set-up cost. (1) The department may enter into a contractual agreement to reimburse the provider for costs incurred to establish the program. The provider's costs shall:

(a) Be based on a budget negotiated with the department; and

(b) Include client costs of establishing a residence.

(2) The provider shall submit the department-required billing documents.

[99-19-104, recodified as § 388-820-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-107, filed 8/9/91, effective 9/9/91.]

WAC 388-820-125 Change of ownership. (1) An agency shall inform the department in writing sixty days prior to a change of ownership.

(2) On the effective date of a change of ownership, the department shall terminate the department's certification with the previous provider.

(3) The department shall withhold final payment to the previous provider until the previous provider submits and the department accepts all reports and required documents.

[99-19-104, recodified as § 388-820-125, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-110, filed 8/9/91, effective 9/9/91.]

WAC 388-820-130 Accounting procedures for client accounts. (1) Clients' cash or bank accounts controlled by a provider shall be subject to the provisions of this chapter. Clients' accounts shall include, but not be limited to:

(a) Trust accounts;

(b) Client/provider accounts;

(c) Individual accounts;

(d) Individual client cash; and

(e) Imprest fund(s).

(2) An account the client independently manages shall not be subject to the provisions of this section.

(3) The provider shall protect a client's financial interests by:

(a) Making available to the requesting client the money held for the client unless a client's guardian or legal representative makes other arrangements;

(b) Securing a client's or client's guardian's or legal representative's written consent for the management of the client's account;

(c) Keeping the client's account current by maintaining a running balance;

(d) Reconciling the client's account to the bank statement monthly;

(e) Making deposits to the client's account within one week of receiving the client's money;

(f) Preventing the client's account from becoming overdrawn or showing a debit;

(g) Limiting imprest and individual client cash funds to a reasonable amount necessary for the needs of the client, not to exceed fifty dollars per client;

(h) Maintaining documentation to support financial transactions for the specific type of account:

(i) Trust account records shall include:

(A) A control journal;

(B) Monthly bank statements and reconciliations;

(C) Checkbook registers and bankbooks;

(D) Deposit receipts;

(E) Canceled checks;

(F) Receipts for purchases; and

(G) Itemized subsidiary ledgers showing deposits, withdrawals, and interest payments to individual clients.

(ii) Client/provider accounts or individual accounts shall include the following records:

(A) Monthly bank statements and reconciliations;

(B) Checkbook registers and bankbooks showing deposits, withdrawals, and interest payments to the client;

(C) Deposit receipts;

(D) Canceled checks; and

(E) Receipts for purchases.

(iii) Individual client cash fund records shall include:

(A) A detailed ledger;

(B) Monthly reconciliation to the cash amount;

(C) Detailed accounting of money received on behalf of the client, including cash received from writing checks over the purchase amount and disposition of money spent; and

(D) Receipts for purchases costing over twenty dollars.

(iv) Imprest fund records shall include:

(A) A subsidiary ledger;

(B) A monthly reconciliation to the cash amount;

(C) A detailed accounting of money received on behalf of the client and disposition of money spent;

(D) Receipts for purchases over the amount of twenty dollars;

(E) Itemized ledgers showing a client's deposits and withdrawals, and interest payments paid to clients.

(i) Notifying the department when the client's account reaches three hundred dollars less than the maximum amount allowable by federal or state law; and

(j) Making each client's account available for the secretary's audit and inspection.

(k) Making client funds available to the client or a new provider on the day of transfer or movement when there is change of ownership or a client moves.

(4) When a client's provider receives a check made out to the client, the provider assisting the client shall:

(a) Secure the client's signature and designation "for deposit only" and deposit the check to the client's account; or

(b) Secure the client's "x" mark in the presence of another witness; and

(i) Co-sign the check with the designation "for deposit only"; and

(ii) Deposit the check to the client's account.

(5) When a provider manages client/provider accounts and individual accounts, the agency and client checks shall:

(a) Be signed at the time of purchase only;

(b) Be signed by the client;

(c) Be initialed or signed by the staff assisting the client; and

(d) Not be written for amounts greater than a purchase unless the provider maintains required documentation described under subsection (3)(h)(ii) of this section.

(6) A provider shall pay overdraft charges, fees resulting from the provider's error or mismanagement when they control:

(a) Trust accounts;

(b) Client/provider accounts; and

(c) Imprest funds.

(7) A provider shall pay service charges for trust accounts and imprest funds when they control them.

(8) The agency shall retain all clients' financial records for a minimum of six years after audit, settlement or contract termination, including but not limited to:

(a) Client's related bankbooks;

(b) Bank statements;

(c) Checkbooks;

(d) Check registers; and

(e) All voided and canceled checks.

(9) The client's provider may loan money to the client from the provider's funds and collect the debt from the client by installments.

(10) The client's provider shall not:

(a) Charge the client interest for money loaned; or

(b) Borrow funds from the client.

(11) Upon a provider's transfer of ownership or movement of the client the previous provider shall within thirty days:

(a) Give the client, the client's guardian, or the client's legal representative a written accounting of all client's funds held by the provider;

(b) When applicable give the new provider a written accounting, in accordance with generally accepted accounting principles, of all transferred client funds;

(c) Obtain the client's, client's guardian's, or client's legal representative's written receipt for all the transferred funds; and

(d) When applicable, obtain the new provider's written receipt for the transferred funds.

(12) When a client becomes incapacitated or a client's whereabouts are unknown, the client's provider shall within thirty days transfer the client's funds to the client's legal guardian or to the department.

(13) When a client dies, the clients provider shall within thirty days transfer the client's funds to the client's legal guardian or to the department if the client does not have a legal heir.

(14) The provider shall not release client funds to a person other than the client or the client's guardian or legal representative without the written consent of the client or the secretary.

[99-19-104, recodified as § 388-820-130, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-115, filed 8/9/91, effective 9/9/91.]

Chapter 388-825 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES RULES

(Formerly chapter 275-27 WAC)

WAC

WAC 388-825-020 Definitions. "Abandonment" means action or inaction by a person or entity with a duty to care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Adolescent" means a DDD eligible child age thirteen through seventeen years.

"Attendant care" means provision of physical and/or behavioral support to protect the safety and well being of a client.

"Best interest" includes, but is not limited to, client-centered benefits to:

(1) Prevent regression or loss of skills already acquired;

(2) Achieve or maintain economic self-support;

(3) Achieve or maintain self-sufficiency;

(4) Prevent or remedy neglect, abuse, or exploitation of individuals unable to protect their own interest;

(5) Preserve or reunite families; and

(6) Provide the least-restrictive setting that will meet the person's medical and personal needs.

"Client or person" means a person the division determines under RCW 71A.16.040 and WAC 388-825-030 eligible for division-funded services.

"Community support services" means one or more of the services listed in RCW 71A.12.040 including, but not limited to the following services: Architectural, case management, early childhood intervention, employment, counseling, family support, respite care, information and referral, health services and equipment, therapy services, and residential support.

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

"Director" means the director of the division of developmental disabilities.

"Division or DDD" means the division of developmental disabilities of the department of social and health services.

"Emergency" means a sudden, unexpected occurrence demanding immediate action.

"Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

"Family" means individuals, of any age, living together in the same household and related by blood, marriage, adoption or as a result of sharing legal custody of a minor child.

"Family resources coordinator" means the person who is:

(1) Recognized by the IDEA Part C lead agency; and

(2) Responsible for:

(a) Providing family resources coordination;

(b) Coordinating services across agencies; and

(c) Serving as a single contact to help families receiving assistance and services for their eligible children who are under three years of age.

"ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide services to the mentally retarded or persons with related conditions.

"ICF/MR Eligible" for admission to an ICF/MR means a person is determined by DDD as needing active treatment as defined in CFR 483.440. Active treatment requires:

(1) Twenty-four hour supervision; and

(2) Continuous training and physical assistance in order to function on a daily basis due to deficits in the following areas: Toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication.

"Individual" means a person applying for services from the division.

"Individual alternative living" means provision of community-based individualized client training, assistance and/or ongoing support to enable a client to live as independently as possible with minimal services.

"Individual supportive living service" (also known as companion home) means provision of twenty-four hour residential support in a nonlicensed home for one adult person with developmental disabilities.

"Intelligence quotient score" means a full scale score on the Wechsler, or the intelligence quotient score on the Stanford-Binet or the Leiter International Performance Scale.

"Medicaid personal care" is the provision of medically necessary personal care tasks as defined in chapter 388-15 WAC.

"Nonresidential programs" means programs including, but not limited to, county-funded habilitation services.

"Nursing facility eligible" means a person is assessed by DDD as meeting the requirements for admission to a licensed nursing home as defined in WAC 388-97-235. The person must require twenty-four hour care provided by or under the supervision of a licensed nurse.

"Other resources" means resources that may be available to the client, including but not limited to:

(1) Private insurance;

(2) Medicaid;

(3) Indian health care;

(4) Public school services through the office of the superintendent of public instruction; and

(5) Services through the department of health.

"Part C" means early intervention for children from birth through thirty-five months of age as defined in the Individuals with Disabilities Education Act (IDEA), Part C and 34 CFR, Part 303 and Washington's federally approved grant.

"Residential habilitation center" or **"RHC"** means a state-operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities.

"RHC capacity" means the maximum number of eligible persons that can reside in a residential habilitation center without exceeding its 1997 legislated budgeted capacity.

"Residential programs" means provision of support for persons in community living situations. Residential programs include DDD certified community residential services and support, both facility-based such as, licensed group homes, and non-facility based, i.e., supportive living, intensive tenant support, and state-operated living alternatives (SOLA). Other residential programs include individual alternative living, intensive individual supportive living services, adult family homes, adult residential care services, nursing homes, and children's foster homes.

"Respite care" means temporary residential services provided to a person and/or the person's family on an emergency or planned basis.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"Vacancy" means an opening at a RHC, which when filled, would not require the RHC to exceed its 1997 biannually budgeted capacity, minus:

(1) Twenty-six beds designated for respite care use; and

(2) Any downsizing related to negotiations with the Department of Justice regarding community placements.

"Vulnerable adult" means a person who has a developmental disability as defined under RCW 71A.10.020.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, amended and recodified as § 388-825-020, filed 11/9/99, effective 12/10/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-020, filed 2/1/99, effective 3/4/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-020, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-27-020, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-020, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-020, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-020, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-020, filed 3/16/78; Order 1143, § 275-27-020, filed 8/11/76.]

WAC 388-825-025 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 275-27-020(9) provided an:

(a) Assessment of the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely effect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

(3) Exemption requests are not subject to appeal.

[99-19-104, recodified as § 388-825-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-023, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-023, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-023, filed 8/9/91, effective 9/9/91.]

WAC 388-825-030 Eligibility for services. (1) A developmental disability is a condition which meets all of the following:

(a) A condition defined as mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition as described under WAC 275-27-026;

(b) Originates before the individual reaches eighteen years of age;

(c) Is expected to continue indefinitely; and

(d) Results in a substantial handicap.

(2) Mental retardation is a condition resulting in significantly subaverage general intellectual functioning as evidenced by:

(a) A diagnosis of mental retardation documented by a licensed psychologist or certified school psychologist; and

(b) A substantial handicap when the individual has an intelligence quotient score of more than two standard deviations below the mean using the Stanford-Binet, Wechsler, or Leiter International Performance Scale; and

(c) An intelligence quotient score which is not:

(i) Expected to improve with treatment, instruction, or skill acquisition above the established level; or

(ii) Attributable to mental illness or other psychiatric condition; and

(d) Meeting the requirements of developmental disability under subsection (1)(b) and (c) of this section.

(3) Cerebral palsy is a condition evidenced by:

(a) A diagnosis of cerebral palsy by a licensed physician; and

(b) A substantial handicap when, after forty-eight months of age:

(i) An individual needs direct physical assistance in two or more of the following activities:

(A) Eating;

(B) Dressing;

(C) Bathing;

(D) Toileting; or

(E) Mobility; or

(ii) An individual meets the requirements under subsection (6)(b) of this section; and

(c) Meeting the requirements under subsection (1)(b) and (c) of this section.

(4) Epilepsy is a condition evidenced by:

(a) A diagnosis of epilepsy by a board-eligible neurologist, including documentation the condition is chronic; and

(b) The presence of partially controlled or uncontrolled seizures; and

(c) A substantial handicap when the individual:

(i)(A) Requires the presence of another individual to monitor the individual's medication, and is certified by a physician to be at risk of serious brain damage/trauma without direct physical assistance from another individual; or

(B) In the case of individuals eighteen years of age or older only, requires the presence of another individual to monitor the individual's medication, and is unable to monitor the individual's own medication resulting in risk of medication toxicity or serious dosage side effects threatening the individual's life; or

(ii) Meets the requirements under subsection (6)(b) of this section; and

(d) Meeting the requirements under subsection (1)(b) and (c) of this section.

(5) Autism is a condition evidenced by:

(a) A specific diagnosis, by a board-eligible psychiatrist or licensed clinical psychologist, of autistic disorder, a particular diagnostic subgroup of the general diagnostic category pervasive developmental disorders; and

(b) A substantial handicap shown by:

(i) The presence of significant deficits of social and communication skills and marked restriction of activities of daily living, as determined by one or more of the following persons with at least one year's experience working with autistic individuals:

(A) Licensed psychologists;

(B) Psychiatrists;

(C) Social workers;

(D) Certified communication disorder specialists;

(E) Registered occupational therapists;

(F) Case managers;

(G) Certificated educators; and

(H) Others; or

(ii) Meeting the requirements under subsection (6)(b) of this section; and

(c) Meeting the requirements under subsection (1)(b) and (c) of this section.

(6) Another neurological or other condition closely related to mental retardation, or requiring treatment similar to that required for individuals with mental retardation is a condition evidenced by:

(a)(i) Impairment of the central nervous system as diagnosed by a licensed physician; and

(ii) A substantial handicap when, after forty-eight months of age, an individual needs direct physical assistance with two or more of the following activities:

(A) Eating;

(B) Dressing;

(C) Bathing;

(D) Toileting; or

(E) Mobility; and

(iii) An intelligence quotient score of at least one and one-half standard deviations below the mean, using the Wechsler Intelligence Scale, the Stanford-Binet, or the Leiter International Performance Scale; and

(iv) Meeting the requirements under subsection (1)(b) and (c) of this section; or

(b) A condition evidenced by:

(i) An intelligence quotient score at least one and one-half standard deviations below the mean, using the Wechsler Intelligence Scale, the Stanford-Binet, or the Leiter International Performance Scale; or

(ii) If the individual's intelligence score is higher than one and one-half standard deviations below the mean, then current or previous eligibility for participation in special education, under WAC 392-171-376 through 392-171-451, shall be demonstrated. Such participation shall not currently or at eighteen years of age be solely due to one or more of the following:

(A) Psychiatric impairment;

(B) Serious emotional/behavioral disturbance; or

(C) Orthopedic impairment; and

(iii) A substantial handicap when a standard score of more than two standard deviations below the mean in each of four domains of the adaptive behavior section of the Inventory for Client and Agency Planning (ICAP) is obtained, the domains identified as:

(A) Motor skills;

(B) Social and communication skills;

(C) Personal living skills;

(D) Community living skills; and

(iv) The ICAP is administered at least every twenty-four months; and

(v) Is not attributable to mental illness, personality and behavioral disorders, or other psychiatric conditions; and

(vi) Meets the requirements under subsection (1)(b) and (c) of this section; or

(c) A child under six years of age at risk of developmental disability, as measured by developmental assessment tools and administered by qualified professionals, showing a substantial handicap as evidenced by one of the following:

(i) A delay of at least twenty-five percent of the chronological age in one or more developmental areas between birth and twenty-four months of age; or

(ii) A delay of at least twenty-five percent of the chronological age in two or more developmental areas between twenty-five and forty-eight months of age; or

(iii) A delay of at least twenty-five percent of the chronological age in three or more developmental areas between forty-nine and seventy-two months of age; and

(iv) Such eligibility shall be subject to review at any time, but at least at thirty-six months of age and at least seventy-two months of age;

(v) Developmental areas as described in subsection (6)(c) of this section are:

(A) Fine or gross motor skills;

(B) Self-help skills;

(C) Expressive and receptive communication skills, including American sign language skills;

(D) Social skills; and

(E) Cognitive, academic, or problem-solving skills.

(vi) Qualified professionals, as described in subsection (6)(c) of this section, include, but are not limited to, the following professionals with at least one year's experience and training in the field of child development and preferably in the area of developmental disabilities:

(A) Licensed physicians;

(B) Licensed psychologists;

(C) Certified communication disorder specialists;

(D) Registered occupational therapists;

(E) Licensed physical therapists;

(F) Case managers;

(G) Registered public health nurses; and

(H) Educators.

(vii) Any standardized developmental assessment tool may be used if the tool:

(I) Is reasonably reliable and valid by professional standards; and

(II) Demonstrates the information required to make a determination of the developmental delay; or

(d) A child under six years of age having a diagnosis of Down Syndrome.

[99-19-104, recodified as § 388-825-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.10.020. 92-04-004 (Order 3319), § 275-27-026, filed 1/23/92, effective 2/23/92. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-026, filed 2/28/89.]

WAC 388-825-035 Determination of eligibility. (1) The department shall determine an individual eligible for services upon application if the individual meets developmental disability criteria as defined under WAC 275-27-026.

(2) The department may require appropriate documents substantiating the presence of a developmental disability.

(3) When the department uses or requires the Wechsler Intelligence Test for the purposes of this chapter, the department may consider any standardized Wechsler Intelligence Test as a valid measure of intelligence, assuming a full scale score can be obtained.

(4) If, in the opinion of the testing psychologist, an individual is not able to complete all of the subtests necessary to achieve a full scale score on the Wechsler, the department shall make a professional judgment about the person's intellectual functioning, based upon the information available.

(5) When an applicant has a significant hearing impairment, the department may use or require the Leiter International Performance Scale to determine the individual's intelligence quotient for the purposes of WAC 275-27-026.

(6) When an applicant has a significant vision impairment, the department may use or require the Wechsler verbal intelligence quotient score as the intelligence quotient score for the purposes of WAC 275-27-026.

(7) When an Inventory for Client and Agency Planning (ICAP) is required by the department to demonstrate a substantial handicap, the department shall provide or arrange for the administration of the ICAP.

(8) The department shall determine an applicant's eligibility for services within ten working days of receipt of the completed application and supporting documents.

(9) Any documentation the department requires shall be subject to departmental review. The department may also review client eligibility at any time.

(10) The secretary or designee may authorize eligibility under subsection (1) of this section under the following conditions:

(a) To register a child under eighteen years of age who is eligible for medically intensive home care services, under the department's Title XIX Model 50 waiver program; or

(b) To eliminate the department's requirement for documentation of disability prior to eighteen years of age when:

(i) The applicant is otherwise eligible under WAC 275-27-026; and

(ii) The department and applicant are unable to obtain any documentation of disability originating prior to eighteen years of age; and

(iii) The department has determined the applicant's condition occurred prior to eighteen years of age.

[99-19-104, recodified as § 388-825-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-030, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-030, filed 7/18/84; Order 1143, § 275-27-030, filed 8/11/76.]

WAC 388-825-040 Application for services. (1) Individuals applying for division services shall file an application with one of the division field services offices in the form and manner required by the director.

(2) An individual, advocate, parent, or guardian of such an individual may file an application for services.

(3) DDD shall inform all applicants about the complete spectrum of service options provided by the division, including the existence and availability of residential habilitation centers and community support services.

[99-19-104, recodified as § 388-825-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-040, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-040, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-040, filed 3/16/78; Order 1143, § 275-27-040, filed 8/11/76.]

WAC 388-825-045 Determination for necessary services. (1) Within sixty days from the date of the division's decision that a person is eligible for division funded services, the appropriate division field services office shall evaluate the person's needs to determine which services, if any, are necessary to serve the client's best interest. DDD shall explain to the person/family their available service options. In addition, DDD shall do what is reasonable to:

(a) Provide choice of service options within available funding that assists people to remain in their homes and communities;

(b) Plan and develop community support services that take into consideration the unique needs of the individual and family.

(2) After the evaluation is completed, and if appropriate, the division will develop an individual service plan pursuant to WAC 275-27-060.

(3) Determination of necessary services is not a guarantee of service authorization or delivery. Service authorization and delivery of services are pursuant to WAC 275-27-230.

(4) The department will develop an outreach program to ensure that eligible persons are aware of all of the services provided by DDD, including community support services and residential habilitation centers.

[99-19-104, recodified as § 388-825-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-050, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-050, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-050, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-050, filed 3/16/78; Order 1143, § 275-27-050, filed 8/11/76.]

WAC 388-825-050 Individual service plan. (1) The division may develop a written individual service plan (ISP) or other planning documents for each person determined eligible for division and department services within ninety days of the eligibility date. Interim services may be provided if necessary.

(2) An ISP shall be based on an assessment of a person's needs and will specify the services adjudged to be in the best interests of the person and meet the person's habilitation needs. The ISP shall be in the form and manner specified by the director.

(3) A person, the parent if a person is seventeen years of age or younger, or the person's guardian, or an advocate, or the service provider may request review or modification of the service plan at any time based on changed circumstances.

(4) The department's implementation of specific provisions of the plan shall require the development, review, and may require significant modifications of the ISP and shall include, to the maximum extent possible:

(a) Appropriate division staff;

(b) The person;

(c) The person's parent or guardian;

(d) Advocate; and

(e) Representatives of the agency or facility which is, or will be, primarily responsible for the implementation of specific provisions of the plan.

(5) An ISP shall be a planning document, and shall not be an authorization for services. An ISP shall not guarantee the authorization or delivery of services. The authorization of such services is described under WAC 275-27-230.

[99-19-104, recodified as § 388-825-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-060, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-060, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-060, filed 3/16/78; Order 1143, § 275-27-060, filed 8/11/76.]

WAC 388-825-055 Authorization of services. (1) The division's field services section shall be responsible for authorizing services agreed to by the person/family including, but not limited to:

(a) Placement to and from residential habilitation centers;

(b) Community residential services;

(c) Family support services; and

(d) Nonresidential programs.

(2) The division's authorization of services shall be based on the availability of services and funding.

(3) The division will include the following persons when determining authorized services:

(a) The person;

(b) The person's parent or guardian and may include:

(i) The person's advocate; or

(ii) Other responsible parties.

(4) Per RCW 71A.116.010 the division shall offer adults the choice of admittance to a residential habilitation center if all of the following conditions exist:

(a) An RHC vacancy is available;

(b) Funding, specifically designated for this purpose in the state operating budget, is available for alternative community support services;

(c) The person or their family is requesting residential services;

(d) The person meets ICF/MR or nursing facility eligibility for the available RHC vacancy;

(e) The person is the most in need of residential services as determined by DDD after reviewing all persons determined eligible for ICF/MR or nursing facility level of care. DDD will make this selection based on the following criteria:

(i) The person is age eighteen or older;

(ii) The person's/family's health and safety is in jeopardy due to the lack of necessary residential support and supervision:

(A) Priority is given to eligible persons/families currently without necessary residential supports;

(B) Other eligible persons will be considered based on their risk of losing residential supports due to unstable or deteriorating circumstances.

(f) The person's alternative DDD funded community support services would cost seventy percent or more of the average RHC rate, assuming a minimum household size of three persons.

(5) If RHC capacity is not being used for permanent residents, the division will make these vacancies available for respite care or any other services the department determines are needed and allowable within the rules governing the use of federal funds.

(a) Admission of a child or adolescent to an RHC for respite care requires the written approval of the division director or designee.

(b) Respite care exceeding thirty days in a calendar year is subject to subsection (6) of this section.

(6) The division shall not make an emergency or temporary admission of a person to a residential habilitation center for thirty-one days or more without the written approval of the division director or the director's designee if the admission is not a choice provided under subsection (4) of this section.

(a) Children twelve years of age and younger shall not be admitted to an RHC.

(b) Admission of an adolescent to an RHC can only occur if:

(i) DDD determines that foster placement services cannot meet the emergency needs of the child/family; and

(ii) A voluntary placement plan is in place with DDD with the goal of community placement or family reunification; and

(iii) Progress towards placement planning is reported to the division director at least every ninety days.

(7) The division shall authorize county-funded services only when the:

(a) Service is included in a department contract; and

(b) Person is at least twenty-one years of age and graduated from school during their twenty-first year; or

(c) Person is twenty-two years of age or older; or

(d) Person is two years of age or younger and eligible for early intervention services.

(8) The department shall require a person to participate in defraying the cost of services provided when mandated by state or federal regulation or statute.

[99-19-104, recodified as § 388-825-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-230, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-230, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-230, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-230, filed 7/18/84. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-27-230, filed 3/1/82. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-230, filed 3/16/78; Order 1143, § 275-27-230, filed 8/11/76.]

WAC 388-825-065 Financial services. The division's field services may include services to protect the financial interests of developmentally disabled individuals.

[99-19-104, recodified as § 388-825-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-240, filed 7/18/84; Order 1143, § 275-27-240, filed 8/11/76.]

WAC 388-825-080 Guardianship services. If it appears an eligible individual requires a guardian, the division's field services may assure initiation of and/or assist in guardianship proceedings.

[99-19-104, recodified as § 388-825-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-250, filed 7/18/84; Order 1143, § 275-27-250, filed 8/11/76.]

WAC 388-825-100 Notification. (1) The department shall notify the client or applicant, the parent when the client or applicant is a minor, and the guardian when the client or applicant is an adult, of the following decisions:

(a) Denial or termination of eligibility set forth in WAC 275-27-030;

(b) Development or modification of the individual service plan set forth in WAC 275-27-060;

(c) Authorization, denial, reduction, or termination of services set forth in WAC 275-27-230; and

(d) Admission or readmission to, or discharge from, a residential habilitation center.

(2) The notice shall set forth appeal rights pursuant to WAC 275-27-500 and a statement that the client's case manager can be contacted for an explanation of the reasons for the action.

(3)(a) The department shall provide notice of a denial or partial authorization of a family support services request and a statement of reason for denial or partial authorization, or reduction to the person or persons described in subsection (1) of this section. The department shall send such notice no later than five working days before the end of the month previous to the month for which service was requested;

(b) The department shall make available an administrative review of a decision to deny or partially authorize services upon receipt of a written request by a person or persons described in subsection (1) of this section to the administrator of the region in which the client is living. The regional office must receive a request for administrative review by the last working day of the month;

(c) The client shall state in the written request why the client or client's family believes their service priority designation is not correct;

(d) Upon receipt of request for administrative review, the regional administrator or designee shall review the request and the client file; and

(e) The department shall send the results of the administrative review to the client and/or family within the first five working days of the service month for which the client is being denied or receiving a partial authorization for services.

(4) The department shall provide at least thirty days' advance notice of action to terminate a client's eligibility, terminate or reduce a client's service, or discharge a client from a residential habilitation center to the community. Transfer or removal of a client from a service set forth in WAC 275-27-500 (5)(f) is governed by that section, and reduction of family support funding during the service authorization period is covered by subsection (3)(a) of this section.

(5) All parties affected by such department decision shall be consulted, whenever possible, during the decision process by the responsible field services regional office in person and/or by telephone.

(6) The division shall ensure notification to the school district in which a school-aged child is to be placed when a placement decision is reached.

[99-19-104, recodified as § 388-825-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-400, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-400, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-400, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-400, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-400, filed 3/16/78; Order 1143, § 275-27-400, filed 8/11/76.]

WAC 388-825-120 Adjudicative proceeding. (1) A client, former client, or applicant acting on the applicant's own behalf or through an authorized representative has the right to an adjudicative proceeding to contest the following department actions:

(a) Denial or termination of eligibility set forth in WAC 275-27-030;

(b) Development or modification of the individual service plan set forth in WAC 275-27-060;

(c) Authorization, denial, reduction, or termination of services set forth in WAC 275-27-230;

(d) Admission or readmission to, or discharge from, a residential habilitation center;

(e) A claim the client, former client, or applicant owes an overpayment debt;

(f) A decision of the secretary under RCW 71A.10.060 or 71A.10.070;

(g) A decision to change a client's placement from one category of residential services to a different category of residential services.

(2) Adjudicative proceedings are governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 71A.10.050, the rules in this chapter, and by chapter 388-08 WAC. If any provision in this chapter conflicts with chapter 388-08 WAC, the provision in this chapter shall govern.

(3) The applicant's application for an adjudicative proceeding shall be in writing and filed with the DSHS office of appeals within twenty-eight days of receipt of the decision the appellant wishes to contest.

(4) The department shall not implement the following actions while an adjudicative proceeding is pending:

(a) Termination of eligibility;

(b) Reduction or termination of service, except when the action to reduce or terminate the service is based on the availability of funding and/or service; or

(c) Removal or transfer of a client from a service, except when a condition in subsection (5)(f) of this section is present.

(5) The department shall implement the following actions while an adjudicative proceeding is pending:

(a) Denial of eligibility;

(b) Development or modification of an individual service plan;

(c) Denial of service;

(d) Reduction or termination of service when the action to reduce or terminate the service is based on the availability of funding or service;

(e) After notification of an administrative law judge's (or review judge) ruling that the appellant has caused an unreasonable delay in the proceedings; or

(f) Removal or transfer of a client from a service when:

(i) An immediate threat to the client's life or health is present;

(ii) The client's service provider is no longer able to provide services due to:

(A) Termination of the provider's contract;

(B) Decertification of the provider;

(C) Nonrenewal of provider's contract;

(D) Revocation of provider's license; or

(E) Emergency license suspension.

(iii) The client, the parent when the client is a minor, or the guardian when the client is an adult, approves the decision.

(6) When the appellant files an application to contest a decision to return a resident of a state residential school to the community, the procedures specified in RCW 71A.10.050(2) shall govern the proceeding. These procedures include:

(a) A placement decision shall not be implemented during any period during which an appeal can be taken or while an appeal is pending and undecided unless the:

(i) Client's or the client's representative gives written consent; or

(ii) Administrative law judge (or review judge) after notice to the parties rules the appellant has caused an unreasonable delay in the proceedings.

(b) The burden of proof is on the department; and

(c) The burden of proof is whether the specific placement proposed by the department is in the best interests of the resident.

(7) The initial order shall be made within sixty days of the department's receipt of the application for an adjudicative proceeding. When a party files a petition for administrative review, the review order shall be made within sixty days of the department's receipt of the petition. The decision-rendering time is extended by as many days as the proceeding is continued on motion by, or with the assent of, the appellant.

[99-19-104, recodified as § 388-825-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-500, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-27-500, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-500, filed 8/29/86. Statutory Authority: RCW 72.33.161. 84-15-038 (Order 2122), § 275-27-500, filed 7/13/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-500, filed 3/16/78; Order 1143, § 275-27-500, filed 8/11/76.]

WAC 388-825-170 Community alternatives program (CAP). Purpose—Legal basis.

(1) The purpose of this program is to authorize certain home and community-based services for persons with developmental disabilities to provide an alternative to care in an institution for the mentally retarded (IMR).

(2) Community alternatives program (CAP) is a Medicaid program authorized by P.L. 97-35 Section 2176 as approved by the secretary of the U.S. Department of Health and Human Services.

[99-19-104, recodified as § 388-825-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-800, filed 3/14/84.]

WAC 388-825-180 Eligible persons. (1) To be eligible to apply for community alternatives program (CAP) services, the individual must:

(a) Meet the criteria for the division of developmental disabilities (DDD) eligibility.

(b) Meet the criteria for disability as established in the Social Security Act.

(c) Have an income of less than three hundred percent of the federal Supplemental Security Income (SSI) benefit amount.

(d) Need an IMR level of care as determined by a DDD nursing care consultant.

(i) Require twenty-four hour care and require services that cannot be provided by a family member, and

(ii) Have a documented need for habilitation services and training.

(2) Participation in CAP is by choice of the otherwise IMR-eligible person.

[99-19-104, recodified as § 388-825-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-810, filed 3/14/84.]

WAC 388-825-190 Community alternatives program (CAP)—Services. (1) The department may authorize the fol-

lowing services under 42 CFR Part 435 as specified in the ISP:

(a) Case management services, including intake, eligibility determination, assessment of need, service coordination, service authorization, placement and case monitoring;

(b) Habilitation services, including instruction, support, and supervision in developing a person's physical skills, personal care, social and community integration skills;

(c) Family support for an eligible person needing support and supervision which the person's family cannot provide; and

(d) Other community-based services.

(2) The department cost of a person's services under CAP shall not exceed one hundred percent of the cost of care in an ICF/MR.

(3) The division shall review CAP eligibility under 42 CFR Part 435 on forms specified by the division director.

[99-19-104, recodified as § 388-825-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-820, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-820, filed 3/14/84.]

WAC 388-825-200 What is the purpose of the family support opportunity program? The purpose of the family support opportunity program is to:

(1) Strengthen family functioning through use of the program elements;

(2) Provide a wide range of supports that will assist and stabilize families;

(3) Encourage individuals and local communities to provide support for the persons with developmental disabilities that live with families;

(4) Complement other public and private resources in providing supports;

(5) Recognize the ability of communities to participate in a variety of ways;

(6) Allow families to make use of all program elements according to the individual and family needs; and

(7) Provide assistance to as many families as possible.

[99-19-104, recodified as § 388-825-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-180, filed 2/1/99, effective 3/4/99.]

WAC 388-825-205 Who is eligible to participate in the family support opportunity program? (1) All individuals living with their families determined to be developmentally disabled according to WAC 275-27-026 are eligible to participate in the program if their family requires assistance in meeting their needs. However, the program will fund or provide support services only as funding is available.

(2) Persons currently receiving services under WAC 275-27-220 and 275-27-223, Family support services, may volunteer to participate in the program.

(3) Families will receive program services based on the date of application.

[99-19-104, recodified as § 388-825-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-185, filed 2/1/99, effective 3/4/99.]

WAC 388-825-210 What basic services can my family receive from the family support opportunity program? A number of basic services are available. Some services have their own eligibility requirements. Specific services are:

(1) **Case management services:** Your family will benefit from case management services. The family and the case manager will develop a family support plan which includes needs assessment, referral, service coordination, service authorization, case monitoring and coordination for community guide services.

(2) **Community guide services:** Once your case manager assesses your family situation, you will be offered access to the services of a community guide. The community guide will assist your family in using the natural and informal community supports relevant to the age of your family member with developmental disabilities and the specific needs of your family. Community guide services will support your family and help develop connections to your community.

(3) **Short-term intervention services:** Your family may be eligible for up to eleven hundred dollars in short-term intervention funding if necessary services are not otherwise available. This funding is not intended to cover basic subsistence such as food or shelter costs. Short-term intervention funding is available only for those specialized costs directly related to and resulting from your child's disability.

(4) **Personal care services:** Medicaid personal care can provide your family with long-term in-home personal assistance. (See WAC 388-15-880 and 388-15-890.) In home personal assistance may be available through Medicaid personal care or through a state-funded alternative.

(5) **Community alternatives program (CAP) waiver:** If eligible, your family may participate in the CAP waiver program. The CAP waiver gives eligible clients the opportunity to participate in the federal Medicaid program and DDD the opportunity to obtain federal funds for community based services. (See WAC 275-27-800, 275-27-810 and 275-27-820.)

(6) **Early intervention services:** These services are for your children (from birth through thirty-five months old) and include early childhood programs, birth through two public school programs, children with special health care needs programs, and Part C services (IDEA).

(7) **Emergency services:** Your family can request emergency funds to be used to respond to a single incident, situation or short term crisis such as care giver hospitalization, absence, or incapacity. Your request must be made through your case manager and include an explanation of how you plan to resolve the emergency situation. Your request will be reviewed by the regional administrator or designee. If approved, you will receive emergency services for a limited time period, not to exceed two months.

(8) **Serious need services:** Your family may request serious need funds to take care of needs not met by other basic services, including short-term intervention services, personal care services or use of a community guide. Serious need funds are short or long-term funds used to provide additional support to allow the individual with disabilities to continue living at home.

[99-19-104, recodified as § 388-825-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-190, filed 2/1/99, effective 3/4/99.]

WAC 388-825-220 What is the purpose of community guide services? (1) Community guide services are available to support your family and help you become well connected to resources or supports in your community. After an assessment, your case manager will give you information about a community guide, whose services can be used, if desired by the family.

(2) This guide will assist your family in using the natural and informal community supports relevant to the age of your child with developmental disabilities and your family's specific needs.

[99-19-104, recodified as § 388-825-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-191, filed 2/1/99, effective 3/4/99.]

WAC 388-825-222 Who can become a community guide? To be a guide, a person must demonstrate his/her connections to the informal structures of their community. The department may contract with an individual, agency or organization. Guides must be knowledgeable about resources in their community and comfortable assisting families and persons with developmental disabilities. DDD will provide appropriate training for community guides within available resources.

[99-19-104, recodified as § 388-825-222, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-192, filed 2/1/99, effective 3/4/99.]

WAC 388-825-224 Does my family have a choice in selecting its community guide? Your family will be offered a choice of community guides that best meets the needs of your family. At your family's discretion, your family resources coordinator may serve as your community guide if your developmentally disabled child is thirty-five months of age or younger.

[99-19-104, recodified as § 388-825-224, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-193, filed 2/1/99, effective 3/4/99.]

WAC 388-825-226 Can the family support opportunity program help my family obtain financial assistance for community guide services? The program will authorize up to two hundred eight dollars per year for community guide services for your family.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-226, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-226, filed 4/5/00, effective 5/6/00; 99-19-104, recodified as § 388-825-226, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-194, filed 2/1/99, effective 3/4/99.]

WAC 388-825-228 How can short-term intervention services help my family? If your family is eligible, you may receive up to one thousand three hundred dollars per year in short-term intervention funds to pay for necessary services not otherwise available. Short-term intervention funding cannot be used for basic subsistence such as food or shelter but is available for those specialized costs directly related to and resulting from your child's disability. Short-term intervention funds can be authorized for a one-time only need or for an episodic service need that occurs over a one-year period.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-228, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-228, filed 4/5/00, effective 5/6/00; 99-19-104, recodified as § 388-825-228, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-195, filed 2/1/99, effective 3/4/99.]

WAC 388-825-230 Specifically how can short-term intervention funds be used? Short-term intervention funds can be used to purchase a wide range of services and supports, such as:

(1) Respite care, including community activities providing respite, attendant care or nursing care;

(2) Training such as parenting classes and supports such as disability related support groups;

(3) The purchase, rental, loan or refurbishment of specialized equipment, adaptive equipment or supplies not covered by other resources, including Medicaid. Specific examples are mobility devices such as walkers and wheelchairs, communication devices and medical supplies. Diapers may be approved only for those three years of age and older.

(4) Environmental modifications including home damage repairs caused by the client and home modifications made necessary because of a family member's disability;

(5) Occupational therapy, physical therapy, communication therapy, behavior management, visual and auditory services, or counseling needed by developmentally disabled individuals but not covered by another resource such as public schools and child development services funding;

(6) Medical/dental services not covered by any other resource. These services may include the payment of insurance premiums and deductibles but are limited to the portion of the premium or deduction that applies to the client.

(7) Nursing services, not covered by another resource, that cannot be provided by an unlicensed care giver but can only be rendered by a registered or licensed practical nurse. Examples of such services are ventilation, catheterization, and insulin shots;

(8) Special formulas or specially prepared foods necessary because of the client's disability;

(9) Parent/family counseling for grief and loss issues, genetic counseling or behavior management;

(10) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(11) Specialized utility costs including extraordinary utility costs resulting from the client's disability or medical condition;

(12) If another resource is not available, transportation costs, including gas, ferry or transit cost, so a client can receive essential services and maintain appointments; per diem costs may be reimbursed for medical appointments; and

(13) Other services approved by a DDD regional administrator or designee, according to established department guidelines.

[99-19-104, recodified as § 388-825-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-196, filed 2/1/99, effective 3/4/99.]

WAC 388-825-232 How can serious need funds help my family? Your family may need extraordinary support for children or adults with developmental disabilities living in your home in addition to the basic family support services. The purpose of serious need funds is to help you get that support when you need it. If funding is available, it may be short or long-term in nature and can be used for services such as additional personal care, respite care, behavior management and licensed nursing care.

[99-19-104, recodified as § 388-825-232, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-197, filed 2/1/99, effective 3/4/99.]

WAC 388-825-234 How can my family qualify for serious need funds? Your family may qualify for serious need funds if the following conditions are met:

(1) The basic program services outlined in WAC 275-27-190 (community guide, personal care services, short-term intervention services, etc.) are currently being used by your family or they have been exhausted;

(2) You and your case manager have examined other resources like the medically intensive home care program; private insurance, local mental health programs and programs available through the public schools and have found them either unavailable, inappropriate or insufficient for your needs; and

(3) The support is crucial for the child or adult with developmental disabilities to continue living in your home.

[99-19-104, recodified as § 388-825-234, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-198, filed 2/1/99, effective 3/4/99.]

WAC 388-825-236 How does my family request serious need funds? You must contact your case manager who will submit a written request to the appropriate DDD regional administrator. The request must:

(1) Indicate the type of services your family needs;

(2) Explain why those services can only be obtained through the use of serious need funds;

(3) Outline the changes you anticipate in your family situation if the requested services are not received;

(4) Estimate the length of time your family will need the requested services; and

(5) Propose funding review dates.

[99-19-104, recodified as § 388-825-236, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-199, filed 2/1/99, effective 3/4/99.]

WAC 388-825-238 What amount of serious need funding is available to my family? (1) The maximum amount of funding available is four hundred twenty-two dollars per month or two thousand five hundred thirty-two dollars in a six-month period, unless the department determines your family member requires licensed nursing care and the funding is used to pay for nursing care. If licensed care is required, the maximum funding level is two thousand four hundred dollars per month.

(2) **REMEMBER:**

(a) Funding must be available in order to receive serious need services.

(b) Services paid for by serious needs funds will be reviewed by DDD every six months.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-238, filed 11/21/00, effective 12/22/00; 99-19-104, recodified as § 388-825-238, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-200, filed 2/1/99, effective 3/4/99.]

WAC 388-825-240 Who determines what family support services my family can receive? Your family and your case manager determine what services your family needs. The department has final approval over service authorization.

[99-19-104, recodified as § 388-825-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-202, filed 2/1/99, effective 3/4/99.]

WAC 388-825-242 What department restrictions apply to family support payments? (1) All family support service payments must be authorized by the department.

(2) The department may contract directly with:

(a) A service provider, or

(b) A parent for the reimbursement of goods or services purchased by the parent, or

(c) An agency to purchase goods and services on behalf of a client.

(3) The department's authorization period will start when you agree to be in this program. The period will last one year and may be renewed if you continue to need services.

[99-19-104, recodified as § 388-825-242, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-204, filed 2/1/99, effective 3/4/99.]

WAC 388-825-244 What are regional family support advisory councils? (1) Each division of developmental disabilities regional administrator must appoint a family support advisory council which may serve as a subcommittee of the regional advisory council. The membership of the family support advisory council must include at least one parent representative and at least one case manager.

(2) The purpose of these family support advisory councils is to advise the regional administrator regarding:

(a) Family support issues;

(b) Guidelines for approving or denying short term intervention requests;

(c) Community needs; and

(d) Recommendations for community service grants.

(3) Family support advisory councils must meet at least twice a year.

[99-19-104, recodified as § 388-825-244, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-211, filed 2/1/99, effective 3/4/99.]

WAC 388-825-246 What are community service grants? (1) Community service grants are funded by the division of developmental disabilities family support program to promote community oriented projects that benefit families. Community service grants may fund long-term or short-term projects that benefit children and/or adults.

Agencies or individuals may apply for funding. The department will announce the availability of funding.

(2) To qualify for funding, a proposed project must address one or more of the following topics:

(a) Provider support and development;

(b) Parent helping parent; or

(c) Community resource development for inclusion of all.

(3) Goals for community service projects are as follows:

(a) Enable families to use generic resources;

(b) Reflect geographic, cultural and other local differences;

(c) Support families in a variety of noncrisis-oriented ways;

(d) Prioritize support for unserved families;

(e) Address the diverse needs of Native Americans, communities of color and limited or non-English speaking groups;

(f) Be family focused;

(g) Increase inclusion of persons with developmental disabilities;

(h) Benefit families who have children or adults eligible for services from DDD; and

(i) Promote community collaboration, joint funding, planning and decision making.

(4) Decisions to approve or reject community service grant requests are made by DDD regional administrators considering the recommendations of their regional family support advisory councils. The DDD director has the discretion to award community service grants that have statewide significance.

(5) DDD may sponsor two family support conferences in different areas of the state each year. The purpose of these conferences is to discuss areas addressed by community service grants and other issues of importance to families.

[99-19-104, recodified as § 388-825-246, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-212, filed 2/1/99, effective 3/4/99.]

WAC 388-825-248 Who is covered under these rules? These sections (WAC 275-27-180 through 275-27-212) apply to persons enrolled in family support after June 1996. Those enrolled before June 1996 are covered under WAC 275-27-220 through 275-27-223.

[99-19-104, recodified as § 388-825-248, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-213, filed 2/1/99, effective 3/4/99.]

WAC 388-825-250 Continuity of family support services. (1) It is the policy of the department to recognize the dependence of individuals currently receiving family support services at a given level of services, and to avoid disruption of those services at that given level when possible.

(2) In order for the department to maximize the continuity of service while remaining within appropriated funds for family support services, when appropriated funds for family support services do not permit serving new applicants or increasing services to current recipients without reducing services to existing clients, the department may deny requests for new or increased services based on the lack of funds pursuant to WAC 275-27-230.

(3) These requests may be denied even if the service need levels, as described in WAC 275-27-223, of new applicants or current recipients are of a higher priority than those currently receiving services.

[99-19-104, recodified as § 388-825-250, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.040. 92-13-024 (Order 3394), § 275-27-219, filed 6/9/92, effective 7/10/92.]

WAC 388-825-252 Family support services. (1) The purpose of the family support program is to:

(a) Reduce or eliminate the need for out-of-home residential placement of a client where the in-home placement is in the client's best interest;

(b) Allow a client to live in the most independent setting possible; and

(c) Have access to services best suited to a client's needs.

(2) The department's family support services shall include, the following services:

(a) Respite care, including the use of community activities which provide respite;

(b) Attendant care;

(c) Nursing services provided by a registered nurse or licensed practical nurse, that cannot be provided by an unlicensed caregiver, including but not limited to, ventilation, catheterization, insulin injections, etc., when not covered by another resource;

(d) Therapeutic services, provided these therapeutic services are not covered by another resource such as medicaid, private insurance, public schools, or child development services funding, including:

(i) Physical therapy;

(ii) Occupational therapy;

(iii) Behavior management therapy; and

(iv) Communication therapy; or

(v) Counseling for the client relating to a disability.

(3) Up to nine hundred dollars of the service need level amount in WAC 275-27-222 may be used during a one year period for flexible use as follows. The requested service must be necessary as a result of the disability of the client.

(a) Training and supports including parenting classes and disability related support groups;

(b) Specialized equipment and supplies including the purchase, rental, loan or refurbishment of specialized equipment or adaptive equipment not covered by another resource including Medicaid. Mobility devices such as walkers and wheelchairs are included, as well as communication devices and medical supplies such as diapers for those more than three years of age;

(c) Environmental modification including home repairs for damages, and modifications to the home needed because of the disability of the client;

(d) Medical/dental services not covered by any other resource. This may include the payment of insurance premiums and deductibles and is limited to the premiums and deductibles of the client;

(e) Special formulas or specially prepared foods needed because of the disability of the client;

(f) Parent/family counseling dealing with a diagnosis, grief and loss issues, genetic counseling and behavior management;

(g) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(h) Specialized utility costs including extraordinary supplemental utility costs related to the client's disability or medical condition;

(i) Transportation costs for gas or tickets (ferry fare, transit cost) for a client to get to essential services and appointments, if another resource is not available;

(j) Other services approved by the DDD regional administrator or designee that will replace or reduce ongoing departmental expenditures and will reduce the risk of out-of-home placement. Exemption requests under this section are not subject to appeal.

(4) Recommendations will be made to the regional administrator by a review committee. The regional administrator will approve or disapprove the request and will communicate reasons for denial to the committee.

(5) Payment for services specified in subsection (3), except (3)(a) and (h), shall cover only the portion of cost attributable to the client.

(6) Requests must be received by DDD no later than midway through the service authorization period unless circumstances exist justifying an emergency.

(7) A plan shall be developed jointly by the family and the department for each service authorization period. The department may choose whether to contract directly with the vendor, to authorize purchase by another agency, or may reimburse the parent of the client.

(8) Emergency Services. Emergency funds may be requested for use in response to a single incident or situation or short term crisis such as care giver hospitalization, absence, or incapacity. The request shall include anticipated resolution of the situation. Funds shall be provided for a limited period not to exceed two months. All requests are to be reviewed and approved or denied by the regional administrator or designee.

(9) A departmental service authorization shall state the type, amount, and period (duration) of service. Each department authorization shall constitute a new service for a new period.

(10) If the client becomes eligible and begins to receive Medicaid Personal Care services as defined in WAC 388-15-880 through 388-15-890, the family support funding will be reduced at the beginning of the next month of service. The family will receive notice of the reconfiguration of services at least five working days before the beginning of the month.

(11) If requested family support services are not authorized, such actions shall be deemed a denial of services.

(12) Family support services may be authorized below the amount requested by the family for the period. When, during the authorized service period, family support services are reduced or terminated below the amount specified in service authorizations, the department shall deem such actions as a reduction or termination of services.

[99-19-104, recodified as § 388-825-252, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-220, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-220, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-220, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-220, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-220, filed 8/29/86.]

WAC 388-825-254 Service need level rates. (1) The department shall base periodic service authorizations on:

(a) Requests for family support services described in WAC 388-825-252(2) of this section;

(b) Service need levels as described in WAC 388-825-252(3) of this chapter. Service need level lid amounts are as follows:

(i) Clients designated for service need level one (WAC 388-825-256) may receive up to one thousand eighty dollars per month or two thousand four hundred eleven dollars per month if the client requires licensed nursing care in the home:

(A) If a client is receiving funding through Medicaid Personal Care or other DSHS in-home residential support, the maximum payable through family support shall be four hundred seventy-nine dollars per month;

(B) If the combined total of family support services at this maximum plus in-home support is less than one thousand eighty dollars additional family support can be authorized to bring the total to one thousand eighty dollars.

(ii) Clients designated for service need level two may receive up to four hundred twenty-six dollars per month if not receiving funding through Medicaid personal care:

(A) If a client is receiving funds through Medicaid personal care or other DSHS in-home residential support service, the maximum receivable through family support shall be two hundred thirty-nine dollars per month;

(B) If the combined total of family support services at this maximum plus in-home support is less than four hundred four dollars, additional family support can be authorized to bring the total to four hundred twenty-six dollars.

(iii) Clients designated for service need level three may receive up to two hundred thirty-nine dollars per month provided the client is not receiving Medicaid personal care. If the client is receiving Medicaid personal care or other DSHS in-home residential support service, the maximum receivable through family support shall be one hundred twenty dollars per month; and

(iv) Clients designated for service level four may receive up to one hundred twenty dollars per month family support services.

(c) Availability of family support funding;

(d) Authorization by a review committee, in each regional office, which reviews each request for service;

(e) The amounts designated in subsection (1)(b)(i) through (iv) of this section are subject to periodic increase if vendor rate increases are mandated by the legislature.

(2) The department shall authorize family support services contingent upon the applicant providing accurate and complete information on disability-related requests.

(3) The department shall ensure service authorizations do not exceed maximum amounts for each service need level based on the availability of funds.

(4) The department shall not authorize a birth parent, adoptive parent, or stepparent living in the same household as the client as the direct care provider for respite, attendant, nursing, therapy, or counseling services for a child seventeen years of age or younger.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-254, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-254, filed 4/5/00, effective 5/6/00; 99-19-104, recodified as § 388-825-254, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-222, filed 6/13/97, effective 7/14/97.]

WAC 388-825-256 Service need levels. (1) The department shall use service need levels to determine periodic family support service authorizations.

(2) The department shall determine service need levels in order of priority for funding as follows:

(a) Service need level 1: Client is at immediate risk of out-of-home placement without the provision of family support services. The client needs intensive residential support to assist the client's family to care for the family's child or adult requiring nursing services, attendant care, or support due to difficult behaviors. A client shall:

(i) Have received, over the past three months, at least ten days or eighty hours of service; or

(ii) Requires at least ten days or eighty hours per month of service to prevent immediate out-of-home placement, based upon an assessment conducted by the department;

(b) Service need level 2: Client is at high risk of out-of-home placement without the provision of family support services and has one or more of the following documented in writing:

(i) The client:

(A) Currently receives adult protective services or division of children and family services as an active:

(I) Child protective service client;

(II) Child welfare service client; or

(III) Family reconciliation service client.

(B) Has returned home from foster care or group care placement within the last six months;

(C) Has a serious medical problem requiring close and ongoing monitoring and/or specialized treatment, such as:

(I) Apnea monitor;

(II) Tracheotomy;

(III) Heart monitor;

(IV) Ventilator;

(V) Constant monitoring due to continuous seizures;

(VI) Immediate life-saving intervention due to life threatening seizures;

(VII) Short bowel syndrome; or

(VIII) Brittle bone syndrome.

(D) Has a dual diagnosis based on current mental health DSM Axis I diagnosis;

(E) Has an extreme behavioral challenge resulting in health and safety issues for self and/or others which:

(I) Resulted in serious physical injury to self or others within the last year;

(II) For a client who is two years of age or older, requires constant monitoring when awake for personal safety reasons; or

(III) Is of imminent danger to self or others as determined by a psychiatrist, psychologist, or other qualified professional.

(F) Is ten years of age or older or weighs forty pounds or more, requires lifting, and needs direct physical assistance in three or more of the following areas:

(I) Bathing;

(II) Toileting;

(III) Feeding;

(IV) Mobility; or

(V) Dressing.

(ii) The caregiver:

(A) Is a division of developmental disabilities client;

(B) Has a physical or medical problem that interferes with providing care; or

(C) Has serious mental health or substance abuse problems and:

(I) Is receiving counseling for these problems; or

(II) Has received or applied for counseling within the past six months.

(c) Service need level 3: The family is at risk of significant deterioration which could result in an out-of-home placement of the client without provision of family support services due to the following:

(i) The client requires direct physical assistance, above what is typical for such client's age, in three or more of the following areas:

(A) Bathing;

(B) Toileting;

(C) Feeding;

(D) Mobility; or

(E) Dressing.

(ii) The client has current behavioral episodes resulting in:

(A) Physical injury to the client or others;

(B) Substantial damage to property; and/or

(C) Chronic sleep pattern disturbances or chronic continuous screaming behavior.

(iii) The client has medical problems requiring substantial extra care; and/or

(iv) The family is:

(A) Experiencing acute and/or chronic stress;

(B) Has acute or chronic physical limitations; or

(C) Has acute or chronic mental or emotional limitations.

(d) Service need level 4: Family needs temporary or ongoing services in order to:

(i) Receive support to relieve and/or prevent stress of caregiver/family; or

(ii) Enhance the current functioning of the family.

(3) The department, through regional review committees, shall determine service need level of the client's service request by reviewing information received from the client, family, and other sources about:

(a) Whether client is an active recipient of services from the division of children and family services or adult protective services;

(b) Whether indicators of risk of out-of-home placement exist, and the imminence of such an event. The department's assessment of such risk may include:

(i) Review of family's requests for placement;

(ii) History of family's involvement with children's protective services or adult protective services;

(iii) Client's current adjustment;

(iv) Parental history of psychiatric hospitalization;

(v) Clinical assessment of family's condition; and

(vi) Statements from other professionals.

(c) Caregiver conditions, such as acute and/or chronic:

(i) Stress;

(ii) Physical limitations; and

(iii) Mental and/or emotional impairments.

(d) Client's need for intense medical, physical, or behavioral support;

(e) Family's ability to use typical community resources;

(f) Availability of private, local, state, or federal resources to help meet the need for family support;

(g) Severity and chronicity of family or client problems; and

(h) Degree to which family support services will:

(i) Ameliorate or alleviate such problems; and

(ii) Reduce the risk of out-of-home placement.

[99-19-104, recodified as § 388-825-256, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-223, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-223, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-223, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-223, filed 2/5/88.]

WAC 388-825-260 What are qualifications for individual service providers? The following rules establish qualifications for:

(1) Persons whom DDD pays to provide services to individuals with developmental disabilities including children; and

(2) Agencies contracted to provide services in the home of the DDD client.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-260, filed 11/9/99, effective 12/10/99.]

WAC 388-825-262 What services do individuals provide for persons with developmental disabilities? Individual providers contract directly with DDD to provide services such as respite care, Medicaid personal care, attendant care, individual alternative living and companion home services.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-262, filed 11/9/99, effective 12/10/99.]

WAC 388-825-264 If I want to provide services to persons with developmental disabilities, what do I do? You must contact your local DDD office and ask for a contract application package.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-264, filed 11/9/99, effective 12/10/99.]

WAC 388-825-266 If I want to provide respite care in my home, what is required? All out-of-home respite care funded through DDD must take place in a DSHS licensed home unless you meet criteria listed in the "exemption" section below (WAC 388-825-270). You must have a child foster care, family day care, or adult family home license.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-266, filed 11/9/99, effective 12/10/99.]

WAC 388-825-268 What is required for agencies wanting to provide care in the home of a person with developmental disabilities? Agencies must be a home care agency or a home health agency licensed through the department of health. If a DDD-certified residential agency wishes to provide Medicaid personal care or respite care in the client's home, the agency must have home care agency certification or a home health license.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-268, filed 11/9/99, effective 12/10/99.]

WAC 388-825-270 Are there exceptions to the licensing requirement? Relatives of a specified degree are exempt from the licensing requirement and may provide out-of-home respite in their home. Relatives of specified degree include parents, grandparents, brother, sister, stepparent, stepbrother, stepsister, uncle, aunt, first cousin, niece or nephew (WAC 388-76-030).

In addition, RCW 70.128.010 defines adult family home as "more than one, not more than six unrelated adults." If the person requiring out-of-home respite or attendant care is an adult, care may be provided in the nonrelative provider's home without an adult family home license when:

(1) Care is provided for no more than one unrelated person at a time; and

(2) The person or his/her legal guardian signs a statement saying they have seen the home where care will be provided and think it is an appropriate place for the care of the adult. If the person does not have a legal guardian, the parent or other relative with whom the person resides may sign a statement.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-270, filed 11/9/99, effective 12/10/99.]

WAC 388-825-272 What are the minimum requirements to become an individual provider? (1) Be at least eighteen years of age;

(2) Successfully pass a criminal history background check;

(3) Not be the spouse of the client receiving services or the natural/step/adoptive parent of a child age seventeen or younger;

(4) Have no findings of fact or conclusions of law or agreed orders related to abuse, neglect, financial exploitation or abandonment of a minor or vulnerable adult, as defined in RCW 74.39A.050(8);

(5) Have not had a child foster care, daycare, adult family home or other license issued by the department of social and health services (DSHS) revoked, denied, suspended or terminated for noncompliance with state and federal regulations. Any existing contracts you hold with DDD will be terminated for cause if such an action exists;

(6) Be able to prove you can work in the United States, provide your social security card and official picture identification or by providing other approved documentation of eligibility to work;

(7) Speak in the language of the person served or have a viable means of communication, such as translation services;

(8) Provide three satisfactory references, unless you are a relative or a Medicaid personal care provider. References are checked prior to the issuance of the initial contract; and

(9) At DDD discretion, a waiver of references may be granted under the following conditions:

(a) The service provider is recruited to provide service exclusively to a specific person;

(b) A request to waive references is submitted in writing by the person, his or her parents, or legal guardian.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-272, filed 11/9/99, effective 12/10/99.]

WAC 388-825-276 What are required skills and abilities for this job? You must be able to:

(1) Adequately maintain records of services performed and payments received;

(2) Read and understand the person's service plan. Translation services may be used if needed;

(3) Be kind and caring to the DSHS client for whom services are authorized.

(4) Identify problem situations and take the necessary action;

(5) Respond to emergencies without direct supervision;

(6) Understand the way your employer wants you to do things and carry out instructions;

(7) Work independently;

(8) Be dependable and responsible;

(9) Know when and how to contact the client's representative and the client's case manager;

(10) Participate in any quality assurance reviews required by DSHS.

(11) If you are working with an adult client of DSHS as an individual alternative living, attendant care or individual supportive living provider, you must also:

(a) Be knowledgeable about the person's preferences regarding the care provided;

(b) Know the resources in the community the person prefers to use and enable the person to use them;

(c) Know who the person's friends are and enable the person to see those friends; and

(d) Enable the person to keep in touch with his/her family as preferred by the person.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-276, filed 11/9/99, effective 12/10/99.]

WAC 388-825-278 Are there any educational requirements for individual providers? Training is mandated only for Medicaid personal care providers of adults (WAC 388-15-19650 through 388-15-19680). DSHS retains the authority to require training of any provider.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-278, filed 11/9/99, effective 12/10/99.]

WAC 388-825-280 What are the requirements for an individual supportive living service (also known as a companion home) contract? (1) General knowledge of acceptable standards of performance, including the necessity to be dependable, report punctually, maintain flexibility and to demonstrate kindliness and caring to any DSHS client for whom services are authorized.

(2) Twenty hours of training approved by DDD must be completed during the first year of the contract; ten hours must be completed during the second year and all subsequent years.

(3) A clean, safe and healthful environment must be available for the client, including:

(a) A telephone the client can use;

(b) A flashlight or other nonelectrical light source in working condition;

(c) Basic first aid supplies;

(d) An evacuation plan;

(e) A safe storage area for flammable and combustible materials;

(f) Unblocked exits;

(g) Accessibility by customary forms of ingress and egress for space used for residential purposes; and

(h) Smoke alarms in the residence.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-280, filed 11/9/99, effective 12/10/99.]

WAC 388-825-282 What is "abandonment of a vulnerable adult"? State law makes it a crime to abandon a vulnerable adult. "Abandon" means leaving a person without the means or ability to obtain any of the basic necessities of life. If you wish to "quit" or terminate your employment, you must give at least two weeks written notice to your employer, their representative (if applicable) and the DDD case manager. You will be expected to continue working until the termination date unless otherwise determined by DSHS.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-282, filed 11/9/99, effective 12/10/99.]

WAC 388-825-284 Are providers expected to report abuse? You are expected to report any abuse or suspected abuse immediately to child protective services, adult protective services or local law enforcement and make a follow-up call to the person's case manager.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-284, filed 11/9/99, effective 12/10/99.]

Chapter 388-830 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES PROGRAM OPTION RULES

(Formerly chapter 275-31 WAC)

WAC

WAC 388-830-005 Purpose. (1) In order for developmentally disabled individuals to live in the most independent settings possible, and in order for these individuals and families to have access to services best suited to their needs, the division of developmental disabilities may approve alternative service plans for individuals.

(2) Measurable outcomes producing a positive result for individuals will be demonstrated as a result of services provided under such alternative plans.

(3) Cost savings will be demonstrated when costs of services under alternative plans are compared with costs of services provided prior to alternative plans.

[99-19-104, recodified as § 388-830-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-005, filed 1/18/84.]

WAC 388-830-010 Definitions. (1) "Department" means the department of social and health services of the state of Washington.

(2) "Division" means the division of developmental disabilities of the department of social and health services.

(3) "Field services" means the section of the division providing case management services and resource management to division clients living in the community.

(4) "Individual" means the person for whom an alternative plan is being developed.

(5) "Individual habilitation plan" means an individual written plan of care prepared by an interdisciplinary team that sets measurable goals or objectives stated in terms of desirable behavior and that prescribes an integrated program of activities, experiences, or therapies necessary for the individual to reach those goals or objectives. The overall purpose of the plan is to help the individual function at the greatest physical, intellectual, social, or vocational level the individual can presently or potentially achieve.

(6) "Individual program plan" means an individual service plan or individual habilitation plan.

(7) "Individual service plan" means the written plan, specifying goals and objectives, developed by division staff, parent or parents and/or guardian, the individual, and others whose participation is relevant to identifying needs of the individual.

(8) "Less dependent program" means an alternative program which will provide increased numbers and variety of community contacts for the individual or will require fewer hours of staff supervision/support for the individual.

(9) "Provider" means the person or agency contracted by the department to provide training, support, or other services as designated in the alternative plan.

(10) "Secretary" means the secretary of the department of social and health services or such officer of the department as the secretary may designate to carry out administration of the provision of these rules.

[99-19-104, recodified as § 388-830-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-010, filed 1/18/84.]

WAC 388-830-015 Determination of eligibility. An individual shall be eligible for services under an alternative plan, provided that the division has determined the individual has a disability as defined in WAC 275-27-030 and the individual is receiving current services from the department.

[99-19-104, recodified as § 388-830-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-020, filed 1/18/84.]

WAC 388-830-020 Notification to potential applicants. (1) Field services shall, prior to March 15, 1984, contact by mail all individuals determined to have a disability as defined in WAC 275-27-030, along with the guardians and agencies entitled to custody of such disabled individuals and parents of disabled individuals who are minors. Thereafter, the aforementioned persons shall be advised once in each calendar year.

(2) Potential applicants shall be informed of the process by which they may develop an alternative plan for services.

[99-19-104, recodified as § 388-830-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-030, filed 1/18/84.]

WAC 388-830-025 Application for services. (1) In the case of a minor individual, an application can be made by the parent or parents, the guardian or limited guardian, or by the person or agency legally entitled to custody.

(2) In the case of an adult, an application can be made by the individual, by the guardian or limited guardian, or by the person or agency legally entitled to custody.

(3) Application will be made on the forms supplied by the department and the applicant will state the following:

(a) The outline of services proposed;

(b) Service providers for each service;

(c) Tasks necessary to the delivery of each service and the person/organization responsible for each task;

(d) All costs of services currently provided for the individual;

(e) The cost of each service component proposed in the alternative plan;

(f) Information explaining why the alternative plan is a less dependent program than the current program; and

(g) Information explaining why the alternative plan is appropriate under the goals and objectives of the individual program plan.

(4) Applicants must be notified within ninety days after the alternative plan has been received by the department of the secretary's approval or denial of the plan.

(5) The notification of the department's decision is subject to appeal rights pursuant to WAC 275-27-400 and 275-27-500.

[99-19-104, recodified as § 388-830-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-040, filed 1/18/84.]

WAC 388-830-030 Individual service plan. The division shall ensure a current individual service plan is available for each individual prior to approval of application.

[99-19-104, recodified as § 388-830-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-050, filed 1/18/84.]

WAC 388-830-035 Implementation of necessary services. (1) Plans meeting all the criteria specified in RCW 72.33.125(5) shall be implemented as soon as reasonable, but not later than one hundred twenty days after the completion of the determination process.

(2) Approval and reasonableness may be reviewed for a new determination if the plan has not been implemented within one hundred twenty days.

[99-19-104, recodified as § 388-830-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-070, filed 1/18/84.]

WAC 388-830-040 Criteria for determining costs. (1) The term "all costs" includes, but is not limited to: Residential support, habilitation, medical care, income grants to the persons, support to assist their families or other caregivers, and nonrecurring start-up expenses. All residential costs will recognize capital investment, using federal or professional accounting conventions. The department will take the following costs into account:

(a) All costs paid by the department, including costs borne by the federal government. Income grants paid by the federal government directly to the person (or payee) will be considered.

(b) All costs of the current or proposed program.

(2) The department will estimate a monthly average cost based on a two-year prospective cost period.

(3) Where costs are paid or records kept for a group of individuals rather than for one individual in question, the department will primarily use average cost for that group, such as all individuals living at the particular group home or particular residential habilitation center, or all the persons supported by the particular day habilitation program. Exceptions will be considered for persons receiving substantial services above the services received by the typical person in the group.

(4) The analysis of the proposed alternative service plan should show that proposed services can be provided at eighty percent of the current service cost. Exceptions will be considered for persons needing substantial services.

[99-19-104, recodified as § 388-830-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-080, filed 1/18/84.]

WAC 388-830-045 Method of rate determination. Prevailing rates for comparable services will ordinarily be utilized in determining reimbursement for cost components of the alternative plan.

[99-19-104, recodified as § 388-830-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-090, filed 1/18/84.]

Chapter 388-835 WAC

ICF/MR PROGRAM AND REIMBURSEMENT SYSTEM

(Formerly chapter 275-38 WAC)

WAC

WAC 388-835-010 Terms—Definitions. Unless the context clearly requires otherwise, the following terms shall have the meaning set forth in this section when used in this chapter.

(1) "Accrual method of accounting" means a method of accounting where revenues are reported in the period when earned, regardless of when collected, and expenses are reported in the period incurred, regardless of when paid.

(2) "Active treatment" means "active treatment" as defined under 42 CFR 483.440(a) including implementation of an individual program plan for each client as outlined under 42 CFR 483.440 (c) through (f).

(3) "Administration and management" means activities employed to maintain, control, and evaluate the efforts and resources of a facility or organization for the accomplishment of the objectives and policies of that facility or organization.

(4) "Admission" means entering and being authorized to receive services from a state-certified facility.

(5) "Allowable costs" are described under WAC 275-38-680.

(6) "Appraisal" means the process of establishing the fair market value or reconstruction of the historical cost of an asset acquired in a past period as performed by a person professionally designated either by the American Institute of Real Estate Appraisers as a member, appraisal institute (MAI), or by the Society of Real Estate Appraisers as a senior real estate analyst (SREA) or a senior real property appraiser (SRPA). The process includes a systematic, analytic determination, the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

(7) "Arm's-length transaction" means a transaction resulting from good-faith bargaining between a buyer and seller who have adverse positions in the market place. Sales or exchanges of ICF/MR or nursing home facilities among two or more parties where all parties subsequently continue to own one or more of the facilities involved in the transaction shall not be considered arm's-length transactions. Sale of an ICF/MR facility which is subsequently leased back to the seller within five years of the date of sale shall not be considered an arm's-length transaction for purposes of chapter 275-38 WAC.

(8) "Assets" means economic resources of the contractor, recognized, and measured in conformity with accounting principles. Assets also include deferred charges which are not resources, but recognized and measured in accordance with accounting principles. The value of assets acquired in a change of ownership entered into after September 30, 1984, shall not exceed the acquisition cost of the owner of record as of July 18, 1984.

(9) "Bad debts" means amounts considered uncollectable from accounts and notes receivable.

(10) "Beds" means unless otherwise specified, the number of set-up beds in the ICF/MR facility, not exceeding the number of licensed beds.

(11) "Beneficial owner" means any person:

(a) Directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares:

(i) Voting power including the power to vote, or to direct the voting of such ownership interest; and/or

(ii) Investment power including the power to dispose, or to direct the disposition of such ownership interest.

(b) Directly or indirectly, who creates or uses a trust, proxy, power of attorney, pooling arrangement, or any other contract, arrangement, or device with the purpose or effect of divesting to the same person of beneficial ownership of an ownership interest or preventing the vesting of such beneficial ownership as part of a plan or scheme to evade the reporting requirements of this chapter;

(c) Subject to subsection (5) of this section, with the right to acquire beneficial ownership of such ownership interest within sixty days, including but not limited to any right to acquire:

(i) Through the exercise of any option, warrant, or right;

(ii) Through the conversion of an ownership interest;

(iii) Under the power to revoke a trust, discretionary account, or similar arrangement; or

(iv) Under the automatic termination of a trust, discretionary account, or similar arrangement.

Except, any person acquiring an ownership interest or power specified in subsection (11)(c)(i), (ii), or (iii) of this section shall be deemed the beneficial owner of the ownership interest acquired through the exercise or conversion of such ownership interest or power;

(d) Who in the ordinary course of business is a pledgee of ownership interest under a written pledge agreement and shall not be deemed the beneficial owner of such pledged ownership interest except under the following conditions:

(i) The pledgee shall take all formal steps necessary and be required to:

(A) Declare a default and determine the power to vote; or

(B) Direct the vote; or

(C) Dispose or direct the disposition of how such pledged ownership interest will be exercised.

(ii) The pledge agreement is bona fide and was not entered into with the purpose nor with the effect of changing or influencing the control of the contractor, nor in connection with any transaction having such purpose or effect, including any transaction with persons who meet the conditions set forth in subsection (11)(b) of this section; and

(iii) The pledge agreement, before default, does not grant to the pledgee the power to:

(A) Vote or direct the vote of the pledged ownership interest; or

(B) Dispose or direct the disposition of the pledged ownership interest, other than the grant of such power or powers under a pledge agreement where credit is extended and where the pledgee is a broker or dealer.

(12) "Boarding home" means any home or other institution licensed in accordance with chapter 18.20 RCW.

(13) "Capitalization" means the recording of an expenditure as an asset.

(14) "Capitalized lease" means a lease required to be recorded as an asset and associated liability in accordance with generally accepted accounting principles.

(15) "Cash method of accounting" means a method of accounting where revenues are recognized only when cash is received, and expenditures are expensed, and asset items are not recorded until cash is disbursed.

(16) "Change of ownership" means a change in the individual or legal organization responsible for the daily operation of an ICF/MR facility.

(a) Events changing ownership include but are not limited to:

(i) The form of legal organization of the owner is changed, such as a sole proprietor forms a partnership or corporation;

(ii) Title to the ICF/MR enterprise is transferred by the contractor to another party;

(iii) The ICF/MR facility is leased, or an existing lease is terminated;

(iv) Where the contractor is a partnership, any event occurring dissolving the partnership;

(v) Where the contractor is a corporation, the corporation is dissolved, merges with another corporation which is the survivor, or consolidates with one or more other corporations to form a new corporation.

(b) Ownership does not change when the following occurs:

(i) A party contracts with the contractor to manage the enterprise as the contractor's agent, that is, subject to the contractor's general approval of daily operating decisions;

(ii) If the contractor is a corporation, some or all of its stock is transferred.

(17) "Charity allowances" means reductions in charges made by the contractor because of the indigence or medical indigence of a resident.

(18) "Client or person" means a person the division determines, under RCW 71A.16.040 and WAC 275-27-026, eligible for division-funded services.

(19) "Consent" means the process through which a person's agreement is obtained for procedures and for taking actions affecting that person.

(20) "Contract" means a contract between the department and a contractor for the delivery of ICF/MR services to eligible Medicaid recipients.

(21) "Contractor" means an entity contracting with the department to deliver ICF/MR services to eligible Medicaid recipients.

(22) "Courtesy allowances" means reductions in charges in the form of an allowance to physicians, clergy, and others for services received from the contractor. Employee fringe benefits are not considered courtesy allowances.

(23) "Custody" means immediate physical attendance, shelter, and supervision of a person for purposes of the person's care and welfare.

(24) "DDD" means the division of developmental disabilities of the department.

(25) "Department" means the department of social and health services (DSHS) and its employees.

(26) "Depreciation" means the systematic distribution of the cost or other base of a tangible asset, less any salvage, over the estimated useful life of the asset.

(27) "Discharge" means the resident's leaving the residential facility and the facility's relinquishment of responsibilities acquired by reason of the acceptance for admission of the resident.

(28) "Donated asset" means an asset the contractor acquired without making any payment in the form of cash, property, or services. An asset is not a donated asset if the contractor made even a nominal payment in acquiring the asset. An asset purchased using donated funds is not a donated asset.

(29) "Entity" means an individual, partnership, corporation, public institution established by law, or any other association of individuals, capable of entering enforceable contracts.

(30) "Equity capital" means total tangible and other assets necessary, ordinary, and related to resident care from the most recent provider cost report minus related total long-term debt from the most recent provider cost report plus working capital as defined in this section.

(31) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

(32) "Facility" means a residential setting certified as an ICF/MR by the department in accordance with federal regulations. A state facility is a state-owned and operated residential habilitation center or a state-operated living alternative (SOLA). A nonstate facility is a residential setting licensed in accordance with chapter 18.51 RCW as a nursing home or chapter 18.20 RCW as a boarding home.

(33) "Fair market value" means the price the asset would have been purchased for on the date of acquisition in an arm's-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

(34) "Financial statements" means statements prepared and presented in conformity with accounting principles and this chapter including, but not limited to, balance sheet, statements of operations, statements of changes in financial position, and related notes.

(35) "Fiscal year" means the operating or business year of a contractor. All contractors report on the basis of a twelve-month fiscal year, but provision is made in this chapter for reports covering abbreviated fiscal periods.

(36) "Funded capacity" for a state facility means the number of beds on file with the office of financial management by the first day of each biennium for operation during each ensuing fiscal year.

(37) "Generally accepted accounting principles" means accounting principles currently approved by the financial accounting standard board (FASB).

(38) "Generally accepted auditing standards" means auditing standards approved by the American Institute of Certified Public Accountants (AICPA).

(39) "Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired. "Goodwill" also means the excess of the price paid for an asset over fair market value.

(40) "Habilitative services" means those services required by the individual habilitation plan provided or directed by qualified therapists.

(41) "Harmful" means situations when the individual is at immediate risk of serious bodily harm.

(42) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies.

(43) "Imprest fund" means a fund:

(a) That is regularly replenished in exactly the amount expended from the fund[; and]

[(b) In which the cash and expended receipts always equal a predetermined amount].

(44) "ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide services to the mentally retarded or persons with related conditions.

(45) "Interest" means the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user.

(46) "Joint facility costs" means any costs representing expenses incurred benefiting more than one facility, or one facility and any other entity.

(47) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not under a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee shall not be considered modification of a lease term.

(48) "Medicaid program" means the state medical assistance program provided under RCW 74.09.500 or authorized state medical services.

(49) "Medical assistance recipient" means an individual determined eligible for medical assistance by the department for the services provided in chapter 74.09 RCW.

(50) "Modified accrual method of accounting" means a method of accounting in which revenues are recognized only when cash is received, and expenses are reported in the period in which incurred, regardless of when paid.

(51) "Net book value" means the historical cost of an asset less accumulated depreciation.

(52) "Nonallowable costs" means costs not allowed under WAC 275-38-680.

(53) "Nonrestricted funds" means donated funds not restricted to a specific use by the donor, for example, general operating funds.

(54) "Nursing home" means a home, place, or institution, licensed in accordance with chapter 18.51 RCW, where skilled nursing, intermediate care, and ICF/MR services are delivered.

(55) "Operating lease" means a lease under which rental or lease expenses are included in current expenses in accordance with accounting principles.

(56) "Owner" means a sole proprietor, general or limited partner, or beneficial interest holder of five percent or more of a corporation's outstanding stock.

(57) "Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form such beneficial ownership takes.

(58) "Per diem (per resident day) costs" means total allowable costs for a fiscal period divided by total resident days for the same period.

(59) "Prospective daily payment rate" means the daily amount the department assigns to each contractor for providing services to ICF/MR residents. The rate is used to compute the maximum participation of the department in the contractor's costs.

(60) "Qualified mental retardation professional (QMRP)" means QMRP as defined under 42 CFR 483.430(a).

(61) "Qualified therapist" means any of the following:

(a) An activities specialist having specialized education, training, or experience as specified by the department;

(b) An audiologist eligible for a certificate of clinical competence in audiology or having the equivalent education and clinical experience;

(c) A dental hygienist as defined by chapter 18.29 RCW;

(d) A dietitian: Eligible for registration by the American Dietetic Association under requirements in effect on January 17, 1974; or having a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management; having one year supervisory experience in the dietetic service of a health care institution; and participating annually in continuing dietetic education;

(e) An occupational therapist being a graduate of a program in occupational therapy, or having the equivalent of such education or training, and meeting all requirements of state law;

(f) A pharmacist as defined by chapter 18.64 RCW;

(g) A physical therapist as defined by chapter 18.74 RCW;

(h) A physician as defined by chapter 18.71 RCW or an osteopathic physician as defined by chapter 18.57 RCW;

(i) A psychologist as defined by chapter 18.83 RCW;

(j) A qualified mental retardation professional;

(k) A registered nurse as defined by chapter 18.88 RCW;

(l) A social worker who is a graduate of a school of social work.

(m) A speech pathologist eligible for a certificate of clinical competence in speech pathology or having the equivalent education and clinical experience.

(62) "Regression analysis" means a statistical technique through which one can analyze the relationship between a dependent or criterion variable and a set of independent or predictor variables.

(63) "Regional services" means services of a local office of the division of developmental disabilities.

(64) "Related organization" means an entity which is under common ownership and/or control with, or has control of or is controlled by, the contractor. An entity is deemed to "control" another entity if one entity has a five percent or greater ownership interest in the other, or if an entity has capacity, derived from any financial or other relationship, and whether or not exercised, to influence directly or indirectly the activities of the other.

(65) "Relative" means spouse; natural parent, child, or sibling; adopted child or adoptive parent; stepparent, stepchild, stepbrother, stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; uncle, aunt, nephew, niece, or cousin.

(66) "Resident day" means a calendar day of resident care. In computing calendar days of care, the day of admission is always counted. The day of discharge is counted only when the resident was admitted on the same day. A person is admitted for purposes of this definition when the person is assigned a bed and a resident record is opened.

(67) "Resident living staff (also known as resident care and training staff)" means staff whose primary responsibility is the care and development of the residents, including:

(a) Resident activity program;

(b) Domiciliary services; and

(c) Habilitative services under the supervision of the QMRP.

(68) "Restricted fund" means a fund where the use of the principal or income is restricted by agreement with or direction by the donor to a specific purpose, in contrast to a fund over which the owner has complete control. These generally fall into three categories:

(a) Funds restricted by the donor to specific operating purposes;

(b) Funds restricted by the donor for additions to property, plant, and equipment; and

(c) Endowment funds.

(69) "Secretary" means the secretary of DSHS.

(70) "Start-up costs" means the one-time preopening costs incurred from the time preparation begins on a newly constructed or purchased building until the first resident is admitted. Start-up costs include administrative and nursing salaries, utility costs, taxes, insurance, repairs and maintenance, training costs, etc. Start-up costs do not include expenditures for capital assets.

(71) "Superintendent" means the superintendent or the superintendent's designee of a residential habilitation center.

(72) "Title XIX" means the 1965 amendments to the Social Security Act, P.L. 89-07, as amended.

(73) "Uniform chart of accounts" means a list of account titles identified by code numbers established by the department for contractors to use in reporting costs.

(74) "Vendor number (also known as provider number)" means a number assigned to each contractor delivering ICF/MR services to ICF/MR Medicaid recipients.

(75) "Working capital" means total current assets necessary, ordinary, and related to resident care as reported in the most recent cost report minus total current liabilities necessary, ordinary, and related to resident care from the most recent cost report.

[99-19-104, recodified as § 388-835-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-001, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-001, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-001, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-001, filed 9/17/84; 82-16-080 (Order 1853), § 275-38-001, filed 8/3/82.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-835-015 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 275-38-001(31) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely effect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[99-19-104, recodified as § 388-835-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-003, filed 8/9/91, effective 9/9/91.]

WAC 388-835-020 ICF/MR care. (1) The department has the administrative and legal authority to purchase and provide ICF/MR the services for eligible developmentally disabled persons. The department has the responsibility to assure adequate care, service, and protection are provided through licensing and certification procedures.

(2) This chapter establishes standards for habilitative training, health related care, supervision, and residential services to eligible persons.

(3) Each state and nonstate ICF/MR facility shall be certified as a Title XIX ICF/MR facility.

(4) Each nonstate ICF/MR facility with a certified capacity of sixteen beds or more shall be licensed as a nursing home in accordance with chapter 18.51 RCW.

(5) Each nonstate ICF/MR facility with a certified capacity of fifteen beds or less shall be licensed as a boarding home for the aged in accordance with chapter 18.20 RCW.

(6) Facilities certified to provide ICF/MR services must comply with all applicable federal regulations under Title XIX, Section 1905 of the Social Security Act 42 U.S.C. as amended, and nonstate-operated facilities must comply as well with state regulations governing the licensing of nursing homes or boarding homes for the aged, and other relevant state regulations.

(7) Certified facilities shall admit only developmentally disabled persons as residents.

(8) State facilities may not exceed funded capacity, unless otherwise authorized by the secretary in accord with RCW 71A.20.090.

(9) The sections of this chapter will supersede and replace any and all sections affecting ICF/MR facilities or programs in chapters 388-88 and 388-96 WAC except where specifically referenced in this chapter.

[99-19-104, recodified as § 388-835-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-005, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-005, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-005, filed 8/3/82.]

WAC 388-835-025 Name of IMR. The division will recognize only the official name of an IMR as shown on the license.

[99-19-104, recodified as § 388-835-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-015, filed 8/3/82.]

WAC 388-835-030 Closure of an IMR facility. When a facility is due to cease operations, the facility has the responsibility of notifying the department in writing, giving sixty days notice. Upon receipt of notice of closure of a facility, the department shall cease referral of clients to the facility and proceed in the orderly relocation of the residents.

[99-19-104, recodified as § 388-835-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-020, filed 8/3/82.]

WAC 388-835-035 Adequate IMR care. Care and services rendered must be justified as essential to the resident's habilitation and health care needs, with the overall goal of the resident attaining the highest level of independence. Each IMR is obligated to assure the provision of adequate habilitative training and health care to include but not limited to:

(1) Active treatment as defined in WAC 275-38-001.

(2) Services to the resident by or under the supervision of qualified therapists in accordance with the identified needs of the individual resident.

(3) Provide routine items and supplies uniformly used for all residents.

(4) Surgical appliances, prosthetic devices, and aids to mobility required for the exclusive use of an individual resident are available to the recipient pursuant to WAC 388-86-100.

(5) Nonreusable supplies not usually provided for all residents may be individually ordered in accordance with WAC 388-86-005(2). Requests for such supplies must be authorized by a department representative.

(6) Each IMR facility is responsible for providing transportation to and from the day training programs. Responsibility for transportation may include assurance of resident's use of public transportation.

[99-19-104, recodified as § 388-835-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-025, filed 8/3/82.]

WAC 388-835-040 Continuity of resident care. When a resident is transferred from one IMR facility to another, from an IMR facility to the hospital, from the hospital to an IMR facility, or to alternative community placement, essential information concerning the resident, his or her condition, regimen of care and training must be transmitted in writing by the sending facility to the receiving facility at the time of the resident's transfer.

[99-19-104, recodified as § 388-835-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-030, filed 8/3/82.]

WAC 388-835-045 IMR contract—Noncompliance. When a facility is in violation of the terms of the contract, the department may temporarily suspend the referral of residents to the facility. Whenever referral is suspended under this section, the facility will immediately be notified in writing of the suspension and of the basis for the department's action. Suspension may continue until the department determines the infraction has been corrected.

[99-19-104, recodified as § 388-835-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-035, filed 8/3/82.]

WAC 388-835-050 Minimum staff requirements. Each ICF/MR shall provide staff adequate in numbers and qualifications to meet the needs of the residents.

[99-19-104, recodified as § 388-835-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-045, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-045, filed 8/3/82.]

WAC 388-835-055 Placement of client. (1) Placement into an ICF/MR facility is the responsibility of the division of developmental disabilities and shall be accomplished in accordance with the applicable federal and state regulations.

(2) The client's eligibility for ICF/MR services shall be determined by department representatives before payment can be approved, provided a facility may not admit a client requiring services the facility is not able to provide.

[99-19-104, recodified as § 388-835-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-050, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-050, filed 8/3/82.]

WAC 388-835-060 Transfer of client—Relocation. (1) The department is responsible for assuring the client's health care and habilitative training needs are identified and met, as provided by state and federal regulations. The department is responsible for assuring each client is placed in a facility certified as capable of meeting the needs of the client. The division's regional services section shall be responsible for authorizing changes in residential services.

(2) A client admitted to a facility may be transferred or discharged only for medical reasons, for the client's welfare, or for the welfare of other residents of the facility. This determination shall be made by the department based on an assessment of the resident, consultation with the service provider, the parent or guardian, and a review of the relevant records.

(3) If the department services provided to a resident are not commensurate with the resident's needs, the department

is responsible for initiating and facilitating the resident's relocation. The department shall consider a resident in a state facility eligible for community residential services when such services appropriately meet the person's individual needs.

A circumstance where the department may enforce immediate movement of a resident from an ICF/MR facility is the revocation or suspension of the ICF/MR certification or license.

(4) The department shall notify, in writing, the resident and resident's guardian, next of kin, or responsible party of the facility's certification or contract status when the:

(a) Department or health care financing administration (HCFA) determines a facility no longer meets certification requirements as an ICF/MR; or

(b) Department determines the facility does not meet contract requirements; or

(c) Facility voluntarily terminates the facility's contract or participation in the ICF/MR program.

(5) When the department determines a resident's relocation is necessary, the department shall give the resident and resident's guardian, next of kin, or responsible party twenty-eight days notice, in writing, of the department's intent to relocate the resident as required under WAC 275-38-060.

(6) When the department determines there is a serious and immediate threat to the resident's health or safety, the department shall not be required to give the resident and resident's guardian, next of kin, or responsible party twenty-eight days notice of the resident's relocation.

(7) Decertification, termination, or nonrenewal of contract actions require a stop payment of Title XIX funds. Such actions do not affect the facility's right to operate as a nursing home or boarding home, but does disqualify the facility from operating as an ICF/MR facility and receiving federal funds.

(8) Grounds for the request by a facility to have a resident relocated or discharged are limited to the following:

(a) Medical reasons;

(b) Resident's welfare;

(c) The welfare of the other residents; or

(d) Nonpayment of services provided to the resident during the resident's stay at the facility.

The facility shall follow the following procedure for resident relocation or discharge:

(i) The facility shall send a request in writing to the department, for relocation or discharge of a resident. The facility's request shall include the grounds for the request and substantiation of concurrence by the interdisciplinary team in the development of an appropriate individual habilitation plan;

(ii) The department shall approve or deny the request for relocation or discharge based on an on-site visit with the resident and a review of the resident's records, within fifteen working days following the receipt of the request;

(iii) The facility administrator shall be informed of the department's approval or denial of the request;

(iv) If the facility's request is approved, the department shall notify, in writing, the resident and the resident's guardian, or next-of-kin, or responsible party, of the decision as described under WAC 275-38-060; and

(v) The resident and the department shall be allowed thirty days from the date the resident is notified of relocation or discharge by the department in order to facilitate relocation.

(e) The resident has a right to request relocation and to select the ICF/MR the resident desires for placement. If this selection is available and appropriate to the habilitation and health care needs of the resident, the department shall make all reasonable attempts to accomplish relocation. If the relocation or ICF/MR selection is not appropriate or available, the resident may make another selection.

(i) The resident or the resident's guardian shall request such a move in writing.

(ii) The division of developmental disabilities shall be responsible for arranging the resident's relocation.

[99-19-104, recodified as § 388-835-060, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-055, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-055, filed 8/3/82.]

WAC 388-835-065 Resident rights—Relocation redetermination of eligibility. (1) Except in the cases specified in WAC 275-38-060 [(2)][(3)], the resident, and the resident's guardian, next-of-kin, or responsible party of the resident shall be informed in writing twenty-eight days before any relocation or redetermination of eligibility for ICF/MR services to ensure orderly transfer or discharge. Such resident's notice shall include:

(a) The grounds for the proposed eligibility change and/or transfer;

(b) A statement that the resident or any other individual designated by the resident has a right to a conference with a division of developmental disabilities representative within twenty-eight days of receipt of the notice;

(c) The right to request a fair hearing within twenty-eight days of the notice to contest the department's decision;

(d) The method by which a fair hearing may be obtained;

(e) The right to be represented at the fair hearing by an authorized representative;

(f) The existence and locations of available legal services in the community.

(2) The department shall send a fair hearing request form with the notice of relocation and/or redetermination of eligibility for ICF/MR services.

(a) If the resident requests a fair hearing within the twenty-eight day time period, the department shall not redetermine eligibility or transfer the resident pending fair hearing decision or appeal rights, unless such action is warranted by the health or safety needs of the resident.

(b) If the secretary or the secretary's designee finds the redetermination of eligibility is not appropriate, further action shall not be taken to redetermine eligibility or transfer the resident, unless there is a change in the situation or circumstances at which time the request may be resubmitted.

(c) If the secretary or the secretary's designee affirms the determination to change the resident's eligibility for services and/or transfer, and no judicial review is filed within twenty-eight days of the receipt of notice of determination, the department shall proceed with the planned action.

(d) If the secretary or secretary's designee affirms the determination to change the resident's eligibility for ICF/MR services or transfer and a request for judicial review has been

filed, any proposed redetermination of eligibility or transfer shall be delayed pending the outcome of the process, unless such action is warranted by the health or safety needs of the resident.

(3) Advance notice is not required:

(a) If the resident or the resident's guardian requests a transfer in writing and waives the right to a period notice; or

(b) In the event of an immediate threat to the resident's life or health, or life or health of others.

(4) Advance notice and planning shall not include a right to a fair hearing for a resident when the department judges the facility where the resident resides is not able to provide Title XIX services due to:

(a) Termination of the facility's contract;

(b) Decertification of the facility;

(c) Nonrenewal of the facility's contract;

(d) Revocation of the facility's license; or

(e) Emergency license suspension.

[99-19-104, recodified as § 388-835-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-060, filed 8/3/82.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-835-070 Transfer or discharge planning. The division of developmental disabilities (DDD) shall prepare a suitable written discharge or transfer plan for each resident to be transferred or discharged. DDD's plan shall include the location of available settings providing the appropriate services consistent with the needs of the resident. The plan shall include:

(1) Coordination of communication between the staffs of the old and new facilities;

(2) Pretransfer visit, when the resident's condition permits, to the new facility, familiarizing the resident with the new surroundings, and other residents;

(3) Coordination of active participation by the resident's guardian or family in the transfer preparation;

(4) Coordination with staffs of the old and new facilities to discuss expectations and provide consultation on request; and

(5) Posttransfer follow-up by the division of developmental disabilities to monitor the effects of the change.

[99-19-104, recodified as § 388-835-070, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-065, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-065, filed 8/3/82.]

WAC 388-835-075 Discharge, readmission, and incident reporting. (1) A certified ICF/MR facility having an ICF/MR contract with the department shall contact the regional services office, division of developmental disabilities giving immediate notification of unauthorized leave, disappearance, serious accident, or other traumatic incident effecting a resident or the resident's health or welfare.

(2) The department shall require discharge and readmission for residents admitted as hospital inpatients.

[99-19-104, recodified as § 388-835-075, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-075, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-075, filed 8/3/82.]

WAC 388-835-080 Social leave for IMR residents. (1) Social leaves should be consistent with goals and objectives of the resident's individual habilitation plan.

(2) Facility vacancies due to social leave of a resident will be reimbursed if such social leave complies with the individual habilitation plan and the following conditions:

(a) The facility shall notify the director of the division of developmental disabilities or his or her designee, of social leaves exceeding fifty-three hours.

(b) Social leaves over seven consecutive days require prior written approval by the director, division of developmental disabilities or his or her designee.

(c) Social leave in excess of seventeen days per year requires prior written approval by the director, division of developmental disabilities or his or her designee.

[99-19-104, recodified as § 388-835-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-080, filed 8/3/82.]

WAC 388-835-085 Superintendent's limited authority to hold. (1) When a superintendent, acting on behalf of the secretary, receives information that a resident intends to voluntarily discharge himself or herself from the programs and services of the residential habilitation center (RHC), the superintendent shall determine if such a departure would be harmful to the resident.

(2) If, in the superintendent's judgment, the resident's departure is harmful to the resident, the superintendent may hold the resident until the danger passes, not to exceed forty-eight hours. The superintendent may refer the resident to a mental health professional as described under RCW 71.05.150.

(3) When the superintendent detains an RHC resident as required under this section, the superintendent or the superintendent's designee shall give notification of such hold to the resident and the legal representative of the resident as provided under RCW 71A.10.070. If the legal representative is not available, the superintendent shall also notify one or more persons in the following order of priority:

(a) A parent of a person with a developmental disability eighteen years of age or older;

(b) Other kin of the person with a developmental disability with a preference to persons with closest kinship;

(c) The Washington protection and advocacy agency for the rights of a person with a developmental disability, appointed in compliance with 42 USC section 6042; or

(d) A person who is not an employee of the department nor a contractor under this title nor an employee of such contractor who, in the opinion of the superintendent is concerned with the person's welfare.

(4) This section shall not prohibit the superintendent of an RHC from notifying:

(a) A mental health professional;

(b) Local law enforcement;

(c) Adult protective services;

(d) Child protective services; or

(e) Other agencies as appropriate.

(5) At the end of the forty-eight-hour hold, the superintendent shall not continue to detain a resident.

(6) If the provisions of the section are invoked a second time within six months, the superintendent or superintendent's designee shall make a referral to a mental health professional within eight hours. In this situation, the resident may only be held until the mental health professional:

(a) Investigates and evaluates the specific facts surrounding the situation; and

(b) Determines the further detention of the resident in accord with RCW 71.05.150.

(7) This section shall not prohibit the superintendent of an RHC or designee from allowing a resident to leave the center for prescribed periods under such conditions as may be appropriate for the resident's habilitation or care.

(8) When a resident has voluntarily left the programs and services of the RHC, under the provision of this section, except as provided in subsection (7), the superintendent shall initiate discharge proceeding.

[99-19-104, recodified as § 388-835-085, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-090, filed 8/9/91, effective 9/9/91.]

WAC 388-835-090 Prospective cost-related reimbursement. The prospective cost-related reimbursement system is the system used by the department to pay for IMR services provided to IMR residents. Reimbursement rates for such services will be determined in accordance with the principles, methods, and standards contained in this chapter.

[99-19-104, recodified as § 388-835-090, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-510, filed 8/3/82.]

WAC 388-835-095 Conditions of participation. In order to participate in the prospective cost-related reimbursement system, the person or legal organization responsible for operation of an IMR facility shall:

(1) Obtain a state certificate of need as required, pursuant to chapter 70.38 RCW;

(2) Hold the appropriate current license (e.g., nursing home, boarding home);

(3) Hold current Title XIX certification to provide IMR services;

(4) Hold a current contract to provide IMR services; and

(5) Comply with all provisions of the contract and all applicable regulations, including but not limited to the provisions of chapter 275-38 WAC.

[99-19-104, recodified as § 388-835-095, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-515, filed 8/3/82.]

WAC 388-835-100 Projected budget for new contractors. (1) Unless a shorter period is approved by the division director, each new contractor shall submit a one-year projected budget to the department at least sixty days before the contract will become effective. For purposes of this section, a "new contractor" is one:

(a) Operating a new facility;

(b) Acquiring or assuming responsibility for operating an existing facility;

(c) Obtaining a certificate of need approval due to an addition to or renovation of a facility.

(2) The projected budget shall cover the twelve months immediately following the date the contractor will enter the program. The projected budget shall be prepared on forms and in accordance with instructions provided by the department, and shall include all earnest money, purchase, and lease agreements involved in the transaction.

[99-19-104, recodified as § 388-835-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-520, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-520, filed 8/3/82.]

WAC 388-835-105 Change of ownership. (1) On the effective date of a change of ownership, as defined in WAC 275-38-001, the department's contract with the former owner shall be terminated. The former owner shall give the department sixty days written notice of such termination in accordance with the terms of the contract. When certificate of need is required for the new owner to acquire the facility, and the new owner wishes to continue to provide service to recipients without interruption, certificate of need shall be obtained before the former owner submits a notice of termination.

(2) If the new contractor desires to participate in the cost-related reimbursement system, the contractor shall meet the conditions specified in WAC 275-38-515, and shall submit a projected budget in accordance with WAC 275-38-520. The IMR contract with the new owner shall be effective as of the date of the change of ownership.

(3) A new contractor shall submit the following as a part of the projected budget:

(a) A statement disclosing the identity of all individuals and organizations having beneficial ownership interest in the current operating entity or in the land, building, or equipment of the facility; and

(b) The identity of individuals or organizations having beneficial ownership in the purchasing or leasing entity.

[99-19-104, recodified as § 388-835-105, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-525, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-525, filed 8/3/82.]

WAC 388-835-110 Termination of contract. (1) When a contract is terminated for any reason, the former contractor shall give the department sixty days written notice of such termination in accordance with the terms of the contract.

(2) When a contractor terminates for any reason, the former contractor shall submit final reports in accordance with WAC 275-38-546.

(3) Upon notification of a contract termination, the department shall determine by preliminary or final settlement calculations the amount of any overpayments made to the contractor, including overpayments disputed by the contractor. If preliminary or final settlements are unavailable for any period up to the date of contract termination, the department shall make a reasonable estimate of any overpayment or underpayments for such periods. The department shall base a reasonable estimate upon prior period settlements, available audit findings, the projected impact of prospective rates, and other information available to the department.

(4) Payments for one or more months for care provided under a contract will be held until the former contractor has filed a properly completed final annual cost report, and the final settlement has been determined. In lieu of the withheld payments, the former contractor may provide security, in a form acceptable to the department, in the amount of determined and estimated overpayments, whether or not the overpayments are the subject of good-faith dispute. Security shall consist of:

(a) A surety bond issued by a bonding company acceptable to the department; or

(b) An assignment of funds to the department; or

(c) Collateral acceptable to the department; or

(d) A purchaser's assumption of liability for the prior contractor's overpayment; or

(e) Any combination of (4)(a), (b), (c), or (d) of this subsection.

(5) A surety bond or assignment of funds shall:

(a) Be at least equal in amount to determined or estimated overpayments, whether or not the subject of good-faith dispute, minus withheld payments;

(b) Be issued or accepted by a bonding company or financial institution licensed to transact business in Washington state;

(c) Be for a term sufficient to ensure effectiveness after final settlement and the exhaustion of administrative and judicial remedies: Provided, That the bond or assignment shall initially be for a term of five years, and shall be forfeited if not renewed thereafter in an amount equal to any remaining overpayment in dispute;

(d) Provide the full amount of the bond or assignment, or both, shall be paid to the department if a properly completed final cost report is not filed in accordance with this chapter, or if financial records supporting this report are not preserved and made available to the auditor; and

(e) Provide an amount equal to any recovery the department determines is due from the contractor at settlement, but not exceeding the amount of the bond and assignment. The bond or assignment or both shall be paid to the department if the contractor does not pay the refund within sixty days following receipt of written demand or the conclusion of administrative or judicial proceedings to contest settlement issues.

(6) The department shall release any payment withheld as security if alternate security, acceptable to the department, is provided under subsection (4) of this section in an amount equivalent to determined and estimated overpayments.

(7) If the total of withheld payments, bonds, and assignments is less than the total of determined and estimated overpayments, the unsecured amount of such overpayments shall be a debt due the state. The debt shall become a lien against the real and personal property of the contractor from the time of filing by the department with the county auditor of the county where the contractor resides or owns property. Such a lien claim has preference over the claims of all unsecured creditors.

(8) The contractor shall file a properly completed final cost report in accordance with the requirements of chapter 275-38 WAC, which may be audited by the department. A final settlement shall be determined within ninety days following completion of the audit process (including any administrative review of the audit requested by the contractor) or within twelve months if audit is not performed.

(9) Following determination of settlement for all periods, security held pursuant to this section shall be released to the contractor after overpayments determined in connection with final settlement have been paid by the contractor. If the contractor contests the settlement determination in accordance with WAC 275-38-886, the department shall hold the security, not to exceed the amount of estimated unrecovered overpayments being contested, pending completion of the administrative appeal process.

(10) If, after calculation of settlements for any periods, it is determined that overpayments exist in excess of the value of security held by the state, the department may seek recovery of these additional overpayments as provided by law.

(11) The department may accept an assignment of funds if the assignment meets the requirements of subsection (4) of this section.

(12) When a contract is terminated, any accumulated liabilities assumed by a new owner shall be reversed against the appropriate accounts by the contractor.

[99-19-104, recodified as § 388-835-110, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-530, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-530, filed 8/3/82.]

WAC 388-835-115 Due dates for reports. (1) Nonstate facilities' annual cost reports for a calendar year shall be submitted by March 31 of the following year.

(2) State facilities' annual cost reports for a fiscal year shall be submitted by December 31 of that year.

(3) If a contract is terminated for any reason, the former owner shall submit a final cost report, in addition to any reports due under subsection (1) of this section, within one hundred twenty days after the effective date of termination for the period January 1 of the year of termination through the effective date of termination.

(4) A new contractor shall submit, by March 31 of the following year, a cost report for the period from the effective date of the contract through December 31 of the year the contract was made effective, unless an exception is granted by the division director.

[99-19-104, recodified as § 388-835-115, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-535, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-535, filed 9/17/84; 82-16-080 (Order 1853), § 275-38-535, filed 8/3/82.]

WAC 388-835-120 Requests for extensions. (1) The department, upon a written request setting forth reasons for the necessity of an extension, may grant two extensions of up to thirty days each for filing any required report, if the written request is received at least ten days prior to the due dates of the reports.

(2) Extensions shall be granted only if the circumstances stated clearly indicate the due date cannot be met and the circumstances were not foreseeable by the contractor.

[99-19-104, recodified as § 388-835-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-540, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-540, filed 8/3/82.]

WAC 388-835-125 Reports. (1) Each nonstate contractor shall submit to the department an annual cost report for the period from January 1 through December 31 of the preceding year.

(2) Each state facility shall submit to the department an annual cost report for the period from July 1 of the preceding year through June 30 of the current year, i.e., state fiscal year.

[99-19-104, recodified as § 388-835-125, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-545, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-545, filed 8/3/82.]

WAC 388-835-130 Failure to submit final reports. (1) If a contract is terminated, the former contractor shall submit a final report as required by WAC 275-38-530(2) and 275-38-535(3). The former contractor shall submit final reports to the department within one hundred twenty days after the contract is terminated or prior to the expiration of any department-approved extension granted pursuant to WAC 388-96-107. When the contractor fails to submit a final report, all payments made to the contractor relating to the period for which a report has not been received shall be a debt owed to the department. The contractor shall refund the amount due to the department within thirty days after receiving written demand from the department.

(2) Effective thirty days after written demand for the payment is received by the contractor, interest will begin to accrue on any unpaid balance at the rate of one percent per month.

[99-19-104, recodified as § 388-835-130, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-546, filed 6/1/88.]

WAC 388-835-135 Improperly completed or late reports. (1) For 1981 and subsequent annual cost reporting periods, contractors shall submit an annual report, including the proposed settlement computed by cost center pursuant to WAC 275-38-886, in accordance with chapter 275-38 WAC, departmental regulations and instructions. The department may return an annual cost report deficient in any of these respects in whole or in part to the contractor for proper completion. Submit annual reports by the due date determined in accordance with WAC 275-38-535.

(2) If a the department does not receive properly completed report on or before the due date of the report, including any approved extensions, all or a part of any payments due under the contract may be held by the department until the improperly completed or delinquent report is properly completed and received by the department.

[99-19-104, recodified as § 388-835-135, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-550, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-550, filed 8/3/82.]

WAC 388-835-140 Completing reports and maintaining records. (1) All reports shall be legible and reproducible. All entries shall be in black or dark blue ink or provided in an acceptable, indelible copy.

(2) Contractors shall complete reports in accordance with instructions provided by the department. If no specific instruction covers a situation, follow generally accepted accounting principles.

(3) Contractors shall use the accrual method of accounting, except for governmental institutions operated on a modified accrual method of accounting. Reverse all revenue and expense accruals against the appropriate accounts if not received or paid within one hundred twenty days after the accrual is made, unless special circumstances are documented justifying continuing to carry all or part of the accrual (e.g., contested billings). Accruals for vacation, holiday, sick pay, and taxes may be carried for longer periods, provided the contractor's usual policy and generally accepted accounting principles are followed.

(4) Contractor shall consistently apply methods of allocating costs [shall be consistently applied], including indirect or overhead costs. Contractors operating multiservice facilities or facilities incurring joint facility costs shall allocate costs in accordance with benefits received from the resources represented by those costs.

(5) The contractor shall maintain records relating to an IMR so reported data can be audited for compliance with generally accepted accounting principles and the department's reimbursement principles and reporting instructions. If a contractor maintains records utilizing a chart of accounts other than that established by the department, the contractor shall provide to the department a written schedule specifying the way in which the contractor's individual account numbers correspond to the department's chart of accounts. Contractors shall make records available for review by authorized personnel of the department and of the United States Department of Health and Human Services during normal business hours at a location in the state of Washington specified by the contractor.

(6) If a contractor fails to maintain records adequate for audit purposes or fails to allow inspection of such records by authorized personnel as provided in the contractor's IMR contract, the department may suspend all or part of subsequent reimbursement payments due under the contract until compliance is forthcoming. Upon compliance, the department shall resume current contract payments and shall release payments suspended pursuant to the contractor's IMR contract.

[99-19-104, recodified as § 388-835-140, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-555, filed 6/1/88; 86-18-002 (Order 2412), § 275-38-555, filed 8/21/86; 82-16-080 (Order 1853), § 275-38-555, filed 8/3/82.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-835-145 Certification requirement. Each required report shall be accompanied by a certification signed on behalf of the contractor responsible to the department during the report period. If the contractor files a federal income tax return, the certification shall be executed by the person normally signing this return. The certification shall also be signed by the administrator of the IMR facility. If the report is prepared by someone other than an employee of the contractor, include a separate statement with the certification signed by the individual preparing the report and indicating his or her status with the contractor. Submit only the original signature of the certification of the cost report.

[99-19-104, recodified as § 388-835-145, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-560, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-560, filed 8/3/82.]

WAC 388-835-150 Reports—False information. (1) If a contractor knowingly or with reason to know files a report containing false information, such action constitutes cause for termination of the contractor's contract with the department.

(2) Adjustments to reimbursement rates required because a false report was filed will be made in accordance with WAC 275-38-900.

(3) Contractors filing false reports may be referred for prosecution under applicable statutes.

[99-19-104, recodified as § 388-835-150, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-565, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-565, filed 8/3/82.]

WAC 388-835-155 Amendments to reports. (1) For purposes of determining allowable costs for computing a final settlement, the department shall consider an amendment to an annual report only if filed by the contractor before receipt of notification scheduling the department's field audit. If no audit is conducted by the department and the preliminary settlement report becomes the final settlement report, the department shall consider an amendment to an annual report only if filed within thirty days after the contractor receives the final settlement report for which no audit has been conducted. For only the purpose of adjusting reimbursement rates for errors or omissions, the contractor may file an amendment subsequent to notification scheduling the department's field audit pursuant to the provision of WAC 275-38-900. A contractor may file an amendment and the department can consider it only if the errors or omissions are significant. Errors or omissions shall be deemed "significant" if errors or omissions would mean a net difference of two cents or more per resident day or one thousand dollars or more in reported costs, whichever is higher, in any cost area. To file an amendment, only pages where changes are required need to be filed, together with the certification required by WAC 275-38-560. Adjustments to reimbursement rates resulting from an amended report will be made in accordance with WAC 275-38-885.

(2) If an amendment is filed, a contractor shall also submit with the amendment an account of the circumstances relating to and the reasons for the amendment, along with supporting documentation. The department may refuse to consider an amendment resulting in a more favorable settlement or rate to a contractor if the amendment is:

(a) Not the result of circumstances beyond the control of the contractor; or

(b) The result of good-faith error under the system of cost allocation and accounting in effect during the reporting period in question.

(3) Acceptance or use by the department of an amendment to a cost report shall in no way be construed as a release of applicable civil or criminal liability.

[99-19-104, recodified as § 388-835-155, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-570, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-570, filed 8/3/82.]

WAC 388-835-160 Requirement for retention of reports by the department. The department shall retain each required report for a period of five years following the date the report was submitted. If at the end of five years there are unresolved audit questions, the department shall retain the report until such questions are resolved.

[99-19-104, recodified as § 388-835-160, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-585, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-585, filed 8/3/82.]

WAC 388-835-165 Requirements for retention of records by the contractor. The contractor shall retain all records supporting the required reports for a period of five years subsequent to filing at a location in the state of Washington specified by the contractor. If at the end of five years there are unresolved audit questions, the records shall be retained until these questions are resolved. All such data shall be made available upon demand to authorized representatives of the department and of the United States Department of Health and Human Services. When a contract is terminated, final settlement shall not be made until accessibility to and preservation of the records within the state of Washington are assured.

[99-19-104, recodified as § 388-835-165, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-586, filed 6/1/88.]

WAC 388-835-170 Disclosure of IMR facility reports. Pursuant to chapter 388-320 WAC, all required financial and statistical reports submitted by IMR facilities to the department will be available for public disclosure.

[99-19-104, recodified as § 388-835-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-590, filed 8/3/82.]

WAC 388-835-175 Desk review. (1) The department will analyze each annual cost report within six months after the annual cost is properly completed and filed.

(2) If it appears from the analysis a contractor has not correctly determined or reported costs, the department may request additional information from the contractor. If the department deems it necessary in order to ensure correct reporting, the department may schedule a special field audit of the contractor.

[99-19-104, recodified as § 388-835-175, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-595, filed 8/3/82.]

WAC 388-835-180 Field audits. (1) The department shall field audit all cost reports for calendar year 1983.

(2) The department may field audit cost reports for years subsequent to 1983 by auditors employed by or under contract with the department. The department shall notify facilities selected for audit within one hundred twenty days after submission of a complete and correct cost report of the department's intent to audit. The department shall complete such audits within one year after notification of the department's intent to audit unless the contractor fails to allow access to records and documentation or otherwise prevents the audit from being completed in a timely manner.

[99-19-104, recodified as § 388-835-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-600, filed 6/1/88; 84-09-018 (Order 2091), § 275-38-600, filed 4/10/84; 82-16-080 (Order 1853), § 275-38-600, filed 8/3/82.]

WAC 388-835-185 Preparation for audit by the contractor. (1) The department shall normally notify the contractor at least ten working days in advance of a field audit.

(2) The contractor shall provide the auditors with access to the IMR and to all financial and statistical records. These financial and statistical records shall include income tax returns relating to the cost report directly or indirectly, and work papers supporting the data in the cost report or relating to resident trust funds. Such records shall be made available at a location in the state of Washington specified by the contractor.

(3) The contractor shall reconcile reported data with applicable federal income and payroll tax returns and with the financial statement as of the end of the period covered by the report. Such reconciliation shall be in suitable form for verification by the auditors.

(4) The contractor shall designate and make available one or more individuals familiar with the internal operations of a facility being audited in order to respond to questions and requests for information and documentation from the auditors. If the individual or individuals designated cannot answer all questions and respond to all requests, an alternative individual with sufficient knowledge and access to records and information must be provided by the contractor.

[99-19-104, recodified as § 388-835-185, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-605, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-605, filed 8/3/82.]

WAC 388-835-190 Scope of field audits. (1) Auditors shall review the contractor's recordkeeping and accounting practices and, where appropriate, make written recommendations for improvements.

(2) Auditors shall examine the contractor's financial and statistical records to verify:

(a) Supporting records are in agreement with reported data; and

(b) Only assets, liabilities, and revenue and expense items the department has specified as allowable costs have been included by the contractor in computing the costs of services provided under the contract; and

(c) Allowable costs have been accurately determined and are necessary, ordinary, and related to resident care; and

(d) Related organizations and beneficial ownerships or interests have been correctly disclosed; and

(e) Resident trust funds have been properly maintained.

(3) Auditors shall prepare and provide draft audit narratives and summaries to the contractor before final narratives and summaries are prepared.

[99-19-104, recodified as § 388-835-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-610, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-610, filed 8/3/82.]

WAC 388-835-195 Inadequate documentation. The auditors shall disallow any assets, liabilities, revenues, or expenses reported as allowable which are not supported by adequate documentation in the contractor's financial records. Documentation must show:

(1) The costs were incurred during the period covered by the report and were related to resident care and training; and

(2) Assets reported were used in the provision of resident care and training.

[99-19-104, recodified as § 388-835-195, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-615, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-615, filed 8/3/82.]

WAC 388-835-200 Deadline for completion of audits. (1) The department shall complete field audits within one year after a properly completed annual cost report is received or within one year after an IMR facility is notified it has been selected for audit, provided field auditors are given timely access to the IMR facility and to all records necessary to audit the report.

(2) For state IMRs, the department shall complete field audits within three years after a properly completed cost report is received by the department, provided field auditors are given timely access to the facility and all records necessary to audit the report.

(3) The department shall give priority to any field audits of final annual reports and whenever possible shall begin such field audits within ninety days after a properly completed final annual report is received.

[99-19-104, recodified as § 388-835-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-620, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-620, filed 8/3/82.]

WAC 388-835-205 Disclosure of audit narratives and summaries. Final audit narratives and summaries prepared by the auditor will be available for public disclosure.

[99-19-104, recodified as § 388-835-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-625, filed 8/3/82.]

WAC 388-835-210 Resident trust accounts. (1) The provider shall establish and maintain, as a service to the recipient, a bookkeeping system, incorporated in the business records, adequate for audit, for all resident moneys entrusted to and received by the facility for the resident.

(2) The system will apply to the resident:

(a) Incapable of handling his or her own money and whose guardian, relative, developmental disabilities regional service office administrator, or physician makes written request of the facility to accept this responsibility; if the Social Security Form SSA-780, "certificate of applicant for benefits on behalf of another," is utilized as documentation, the form must be signed by one of the persons designated in this subsection.

(b) Capable of handling his or her own money, but requests the facility in writing to accept this responsibility.

(3) It shall be the responsibility of the provider to maintain such written authorization in the resident's file.

(4) The resident must be given at least a quarterly reporting of all financial transactions in his or her trust account. The representative payee, the guardian and/or other designated agents of the recipient must be sent a copy of the quarterly accounting report.

[99-19-104, recodified as § 388-835-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-645, filed 8/3/82.]

WAC 388-835-215 Accounting procedures for resident trust accounts. (1) The provider shall maintain a subsidiary ledger with an account for each resident for whom the provider holds money in trust. Each account and related supporting information shall:

(a) Be maintained at the facility;

(b) Be kept current;

(c) Be balanced each month, and;

(d) Show in detail, with supporting verification, all moneys received on behalf of the individual resident and the disposition of all moneys so received.

(2) The contractor shall make each account available for audit and inspection by a department representative and be maintain such accounts for a minimum of five years. The provider further agrees to notify the division of developmental disabilities, regional services office of the department when:

(a) The account of any individual certified on or before December 31, 1973, having an award letter limit of two hundred dollars cash, reaches the sum of one hundred seventy-five dollars.

The regional services office shall reevaluate the status of each recipient certified under the eligibility criteria prior to January 1, 1974, having an award letter specifying a two hundred dollar cash limit.

(b) The account of any individual certified on or after January 1, 1974, whose resources are within one hundred dollars of the amount listed on the award letter.

(c) The accumulation toward the limit under subsection (2)(a) or (b) of this section, after admission to the facility, is permitted only from savings from the clothing and personal incidentals allowance and other income the department specifically designates as exempt income from time to time.

(d) No resident may overdraw his or her account (show a debit balance). If a resident wants to spend an amount greater than in his or her trust account, the IMR may provide money from its own funds. The IMR can collect the debt by installments from that portion of the resident's allowance remaining at the end of each month. No interest may be charged to residents for such loans.

(3) Resident trust accounts may not be charged for services provided under the Title XIX program. Any charge for medical services otherwise properly made to a resident's trust account must be supported by a written denial from the department.

(a) A request for additional equipment such as a walker, wheelchair or crutches must have a written denial from the department of social and health services before a resident's trust account can be charged.

(b) Except as otherwise provided below, a request for physical therapy, drugs, or other medical services must have a written denial from the department before a resident trust account can be charged.

A written denial from the department is not required when the pharmacist verifies a drug is not covered by the program (e.g., items on the FDA list of ineffective or possible effective drugs, nonformulary over-the-counter (OTC) medications such as vitamins, nose drops, etc.). The pharmacist's notation to this effect is sufficient.

[99-19-104, recodified as § 388-835-215, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-650, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-650, filed 8/3/82.]

WAC 388-835-220 Trust moneys—Imprest fund. (1) The provider may maintain a petty cash fund originating from trust moneys of an amount reasonable and necessary for the size of the facility and the needs of the residents, not to exceed five hundred dollars. This petty cash fund shall be an imprest fund. The contractor shall deposit all moneys over and above the trust fund petty cash amount intact in a trust fund checking account, separate and apart from any other bank account(s) of the facility or other facilities.

(2) Cash deposits of resident allowances shall be made intact to the trust account within one week from the time payment is received from the department, social security administration, or other payor.

(3) The contractor shall make any related bankbooks, bank statements, checkbook, check register, and all voided and cancelled checks, available for audit and inspection by a department representative, and shall be maintained by the IMR for not less than five years.

(4) No service charges for such checking account shall be paid by resident trust moneys.

(5) The trust account per bank shall be reconciled monthly to the trust account per resident ledgers.

[99-19-104, recodified as § 388-835-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-655, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-655, filed 8/3/82.]

WAC 388-835-225 Trust moneys control or disbursement. The contractor shall hold trust moneys and not to be turned over to anyone other than:

(a) The resident or his or her guardian without the written consent of the resident,

(b) His or her designated agent as appointed by power of attorney, or

(c) Appropriate department of social and health services personnel as designated by the DDD regional services administrator.

(1) Complete a receipt in duplicate when moneys are received; give one copy to the person making payment or deposit, and retain the other copy in the receipt book for easy reference.

(2) Residents shall endorse any checks received. Each resident receiving a check or state warrant is responsible for endorsement by his or her own signature. Only when the resident is incapable of signing his or her name may the provider assume the responsibility of securing the resident's mark "X" followed by the name of the resident and the signature of two witnesses.

(3) If both the general fund account and the trust fund account are at the same bank, deposit the trust portion of checks including care payments can be deposited directly to trust by including a trust account deposit slip for the correct amount with the checks and the general account deposit slip.

(4) The contractor shall credit the resident's trust account ledger sheet with the allowance received. This should be ref-

erenced with the receipt number and must be supported by a copy of the deposit slip (one copy for all deposits made).

[99-19-104, recodified as § 388-835-225, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-660, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-660, filed 8/3/82.]

WAC 388-835-230 Trust moneys availability. Moneys so held in trust for any resident shall be available for his or her personal and incidental needs when requested by the resident or one of the individuals designated in WAC 275-38-660.

[99-19-104, recodified as § 388-835-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-665, filed 8/3/82.]

WAC 388-835-235 Accounting upon change of ownership. (1) Upon sale of the facility or other transfer of ownership, the former contractor shall provide the new contractor with a written accounting, in accordance with generally accepted auditing standards, of all resident funds being transferred, and obtain a written receipt for the funds from the new contractor.

(2) The facility shall give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.

(3) In the event of a disagreement with the accounting provided by the former contractor, the resident retains all rights and remedies provided under state law.

[99-19-104, recodified as § 388-835-235, filed 9/20/99, effective 9/20/99. Statutory Authority: 74.09.120. 88-12-087 (Order 2629), § 275-38-667, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-667, filed 8/3/82.]

WAC 388-835-240 Procedure for refunding trust money. When a recipient is discharged and/or transferred, the balance of the resident's trust account will be returned to the individual designated in WAC 275-38-660, within thirty days, and a receipt obtained. In certain cases it may be advisable to mail the refund to the resident's new residence.

[99-19-104, recodified as § 388-835-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-670, filed 8/3/82.]

WAC 388-835-245 Liquidation of trust fund. (1) Expired resident. The provider will obtain a receipt from next-of-kin, guardian, or duly qualified agent when releasing the balance of money held in trust. If there is no identified next-of-kin, guardian, or duly qualified agent, the DDD regional service office is to be contacted in writing within seven days for assistance in the release of the money held in trust. A check or other document showing payment to such next-of-kin, guardian, or duly qualified agent will serve as a receipt.

(2) Resident, unable to locate. In situations where the resident leaves the IMR facility without authorization and his or her whereabouts are unknown:

(a) The IMR will make a reasonable attempt to locate the missing resident. This includes: Contacting friends, relatives, police, the guardian, and the DDD in the area.

(b) If the resident cannot be located after ninety days, the IMR must notify the department of revenue of the existence of "abandoned property," outlined in chapter 63.28 RCW. The IMR will be required to deliver to the department of revenue the balance of the resident's trust fund account within twenty days following such notification.

[99-19-104, recodified as § 388-835-245, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-675, filed 8/3/82.]

WAC 388-835-250 Resident property records. (1) The facility must maintain a current, written record for each resident including written receipts for all personal possessions deposited with the facility by the resident.

(2) The property record must be available to the resident and resident representative as designated in WAC 275-38-645 (2)(a).

[99-19-104, recodified as § 388-835-250, filed 9/20/99, effective 9/20/99. Statutory Authority: 74.09.120. 82-16-080 (Order 1853), § 275-38-678, filed 8/3/82.]

WAC 388-835-255 Allowable costs. (1) Allowable costs are documented costs which are necessary, ordinary, and related to the provision of IMR services to IMR residents, and are not expressly declared nonallowable by applicable statutes or regulations. Costs are ordinary if costs are of the nature and magnitude which prudent and cost-conscious management would pay.

(2) Upon a request for a rate adjustment pursuant to WAC 275-38-900 or 275-38-906, costs previously audited and not disallowed are subject to review by the department pursuant to subsection (1) of this section.

[99-19-104, recodified as § 388-835-255, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-680, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-680, filed 8/3/82.]

WAC 388-835-260 Substance prevails over form. (1) In determining allowable costs, the substance of a transaction shall prevail over the transaction's form. Accordingly, allowable costs shall not include increased costs resulting from transactions or the application of accounting methods which circumvent the principles of the prospective cost-related reimbursement system.

(2) The department shall not allow increased costs resulting from a series of transactions between the same parties and involving the same assets (e.g., sale and leaseback, successive sales or leases of a single facility or piece of equipment).

[99-19-104, recodified as § 388-835-260, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-685, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-685, filed 8/3/82.]

WAC 388-835-265 Offset of miscellaneous revenues. (1) The contractor shall reduce allowable costs whenever the item, service, or activity covered by such costs generates revenue or financial benefits (e.g., purchase discounts or rebates) other than through the contractor's normal billing for IMR services. The contractor shall not deduct unrestricted grants, gifts, endowments, and interest therefrom, from the allowable costs of a nonprofit facility.

(2) Where goods or services are sold, the amount of the reduction shall be the actual cost relating to the item, service, or activity. In the absence of adequate documentation of cost,

the amount of the reduction shall be the full amount of the revenue received. Where financial benefits such as purchase discounts or rebates are received, the amount of the reduction shall be the amount of the discount or rebate.

(3) The department shall recover only allowable costs under this section. Costs allocable to activities or services not included in IMR services (e.g., costs of vending machines and services specified in chapter 388-86 WAC which are not included in IMR services) are nonallowable costs.

[99-19-104, recodified as § 388-835-265, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-690, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-690, filed 8/3/82.]

WAC 388-835-270 Costs of meeting standards. All necessary and ordinary expenses a contractor incurs in providing IMR services meeting all applicable standards will be allowable costs. The expenses include necessary and ordinary costs of:

(1) Meeting licensing and certification standards;

(2) Fulfilling accounting and reporting requirements imposed by chapter 275-38 WAC; and

(3) Performing any resident assessment activity required by the department.

[99-19-104, recodified as § 388-835-270, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-695, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-695, filed 8/3/82.]

WAC 388-835-275 Limit on costs to related organizations. (1) The department shall allow costs applicable to services, facilities, and supplies furnished by organizations related to the contractor only to the extent:

(a) The costs do not exceed the lower of the cost to the related organization; or

(b) The price of comparable services, facilities, or supplies are purchased elsewhere. The term "related organization" is defined in WAC 275-38-001.

(2) Nonstate facilities shall make documentation of costs to related organizations available to the auditors at the time and place the financial records relating to the entity are audited. State facilities shall make documentation of costs to related organizations available to the auditors at the time the facility is audited at the department's offices of accounting services, financial recovery, or budget. The department shall disallow payments to or for the benefit of the related organization where the cost to the related organization cannot be documented.

[99-19-104, recodified as § 388-835-275, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-700, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-700, filed 8/3/82.]

WAC 388-835-280 Start-up costs. The department shall allow necessary and ordinary start-up costs, as defined in WAC 275-38-001, in the administration and operations rate component. Start-up costs shall be amortized over not less than sixty consecutive months beginning with the month the first resident is admitted for care.

[99-19-104, recodified as § 388-835-280, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-705, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-705, filed 8/3/82.]

WAC 388-835-285 Organization costs. (1) The department shall allow necessary and ordinary costs directly incident to the creation of a corporation or other form of business of the contractor and that are incurred prior to the admission of the first resident. The department will allow these costs in the administration and operations cost area if they are amortized over not less than sixty consecutive months beginning with the month in which the first resident is admitted for care.

(2) Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization and fees paid to states for incorporation. Organization costs do not include costs relating to the issuance and sale of shares of stock or other securities.

[99-19-104, recodified as § 388-835-285, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-706, filed 6/1/88.]

WAC 388-835-290 Education and training. (1) The department shall allow ordinary expenses of on-the-job training and in-service training required for employee orientation and certification training when directly related to the performance of duties assigned.

(2) Ordinary expenses of resident life staff training pursuant to chapter 18.52A RCW shall be allowable costs.

(3) Necessary and ordinary expenses of recreational and social activity training conducted by the contractor for volunteers shall be allowable costs. Expenses of training programs for other nonemployees shall not be allowable costs, except training provided to employees of a county-contracted training program which is provided by an IMR as a condition of their agreement with the county-contracted training program.

(4) The department shall allow expenses for travel in the states of Idaho, Oregon, and Washington and the Province of British Columbia associated with education and training if the expenses meet the requirements of chapter 275-38 WAC.

[99-19-104, recodified as § 388-835-290, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-715, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-715, filed 8/3/82.]

WAC 388-835-295 Total compensation—Owners, relatives, and certain administrative personnel. For purposes of the tests in WAC 275-38-725 and 275-38-730, total compensation shall be as provided in the employment contract, including benefits, whether such contract is written, verbal, or inferred from the acts of the parties. In the absence of a contract, total compensation shall include gross salary or wages and fringe benefits (e.g., health insurance) made available to all employees but excludes payroll taxes paid by the contractor.

[99-19-104, recodified as § 388-835-295, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-720, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-720, filed 8/3/82.]

WAC 388-835-300 Owner or relative—Compensation. (1) The department shall limit total compensation of an owner or relative of an owner to the ordinary compensation for necessary services actually performed.

(a) Compensation is ordinary if it is the amount usually paid for comparable services in a comparable facility to an

unrelated employee, and does not exceed limits set out in this chapter.

(b) A service is necessary if the service is related to resident care and training and would have had to be performed by another person if the owner or relative had not performed the service.

(2) The contractor, in maintaining customary time records adequate for audit, shall include such records for owners and relatives receiving compensation. Such records shall document compensated time was spent in provision of necessary services actually performed.

(3) For purposes of this section, if the contractor with the department is a corporation, "owner" includes all corporate officers and directors.

[99-19-104, recodified as § 388-835-300, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-725, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-725, filed 8/3/82.]

WAC 388-835-305 Allowable interest. (1) The department shall allow the contractor's necessary and ordinary interest for working capital and capital indebtedness.

(a) To be necessary, interest must be incurred in connection with a loan satisfying a financial need of the contractor and be for a purpose related to resident care and training. Interest expense relating to business opportunity or goodwill will not be allowed.

(b) To be ordinary, interest must be at a rate not in excess of what a prudent borrower would have to pay at the time of the loan in an arm's-length transaction in the money market.

(c) Interest expense shall include amortization of bond discounts and expenses related to the bond issue. Amortization shall be over the period from the date of sale to the date of maturity or, if earlier, the date of extinguishment of the bonds.

(d) Interest expense for assets acquired in a change of ownership entered into after September 30, 1984, shall be disallowed in proportion to the amount by which the loan principal for the acquired assets exceeds the original depreciation base of the owner of the assets as of July 18, 1984.

(2) Interest paid to or for the benefit of a related organization shall be allowed only to the extent the actual interest does not exceed the cost to the related organization of obtaining the use of the funds.

(3) The contractor shall capitalize interest expense and loan origination fees relating to construction incurred during the period of construction. Such costs shall be amortized over the life of the asset from the date the first resident is admitted or the asset is put into service for resident care and training.

[99-19-104, recodified as § 388-835-305, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-745, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-745, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-745, filed 8/3/82.]

WAC 388-835-310 Offset of interest income. (1) In computing allowable costs, the contractor shall deduct interest income from the investment or lending of nonrestricted funds from allowable interest expense, except for a nonprofit facility.

(2) Interest income from the investment or lending of restricted funds shall not be deducted from allowable interest expense.

[99-19-104, recodified as § 388-835-310, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-750, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-750, filed 8/3/82.]

WAC 388-835-315 Operating leases of facilities and equipment. Rental or lease costs under arm's-length operating leases of facilities and/or equipment shall be allowable to the extent the cost is not in excess of arm's-length rental or lease costs of comparable facilities or equipment.

[99-19-104, recodified as § 388-835-315, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-760, filed 8/3/82.]

WAC 388-835-320 Rental expense paid to related organizations. The expense of renting facilities or equipment from a related organization shall be allowable to the extent the rental does not exceed the related organization's costs of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with this chapter.

[99-19-104, recodified as § 388-835-320, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-765, filed 8/3/82.]

WAC 388-835-325 Capitalization. The contractor shall capitalize the following costs:

(1) Expenditures and costs for equipment including furniture and furnishings, with historical cost in excess of one hundred fifty dollars per unit and a useful life of more than one year from the date of purchase.

(2) Expenditures and costs for equipment including furniture and furnishings, with historical cost of one hundred fifty dollars or less per unit if either:

(a) The item was acquired in a group purchase where the total cost exceeded one hundred fifty dollars; or

(b) The item was part of the initial equipment or stock of the IMR facility.

(3) Effective January 1, 1981, for settlement purposes for periods subsequent to that date, and for purposes of setting rates for periods beginning July 1, 1982, and subsequently, subsection (1) of this section shall be applied with the sum five hundred dollars replacing the sum one hundred fifty dollars.

(4) Effective January 1, 1990, for settlement purposes for periods subsequent to that date, and for purposes of setting rates for periods beginning July 1, 1990, and subsequently, subsection (1) of this section shall be applied with the sum one thousand dollars replacing the sum five hundred dollars.

(5) Expenditures for and costs of building, and other real property items, components, and improvements and leasehold improvements, if required or authorized by the lease agreement, in excess of one thousand dollars and involving one or more of the following:

(a) Increase the interior floor space of the structure;

(b) Increase or renewal of paved areas outside the structure adjacent to or providing access to the structure;

(c) Modification of the exterior or interior walls of the structure;

(d) Installation of additional heating, cooling, electrical water-related, or similar fixed equipment;

(e) Landscaping or redecorating;

(f) Increase the useful life of the structure by two years or more;

(g) For a leasehold improvement, the asset shall be amortized over the asset's useful life in accordance with American hospital association guidelines.

[99-19-104, recodified as § 388-835-325, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 90-15-017 (Order 3037), § 275-38-770, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-770, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-770, filed 8/3/82.]

WAC 388-835-330 Depreciation expense. Depreciation expense on depreciable assets required in the regular course of providing resident care and training shall be an allowable cost. The depreciation expense shall be:

(1) Identifiable and recorded in the contractor's accounting records, and

(2) Computed using the depreciation base, lives and methods specified in chapter 275-38 WAC.

[99-19-104, recodified as § 388-835-330, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-775, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-775, filed 8/3/82.]

WAC 388-835-335 Depreciable assets. (1) Tangible assets of the following types where a contractor has an economic interest through ownership are subject to depreciation:

(a) Building - The basic structure or shell and additions thereto.

(b) Building fixed equipment - Attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, and air conditioning system. The general characteristics of this equipment are:

(i) Affixed to the building and not subject to transfer; and

(ii) A fairly long life, but shorter than the life of the building where affixed.

(c) Major movable equipment - Such items as beds, wheelchairs, desks, and x-ray machines. The general characteristics of this equipment are:

(i) A relatively fixed location in the building;

(ii) Capable of being moved as distinguished from building equipment;

(iii) A unit cost sufficient to justify ledger control;

(iv) Sufficient size and identity to make control feasible by means of identification tags; and

(v) A minimum life of approximately three years. Effective January 1, 1981, for settlement purposes for periods subsequent to that date, and for purposes of setting rates for periods beginning July 1, 1982, and subsequently, this equipment shall be characterized by a minimum life of greater than one year.

(d) Minor equipment - Such items as waste baskets, bed pans, syringes, catheters, silverware, mops, and buckets properly capitalized. No depreciation shall be taken on items not properly capitalized (see WAC 275-38-770). The general characteristics of minor equipment are:

(i) In general, no fixed location and subject to use by various departments;

(ii) Small in size and unit cost;

(iii) Subject to inventory control;

(iv) Fairly large number in use; and

(v) Generally, a useful life of one to three years.

(e) Land improvements - Such items as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc., where replacement is the responsibility of the contractor.

(f) Leasehold improvements - Betterments and additions made by the lessee to the leased property, which become the property of the lessor after the expiration of the lease.

(2) Land is not depreciable. The cost of land includes the cost of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a nondepreciable nature, and the cost of curbs and sidewalks, replacement of which is not the responsibility of the contractor.

[99-19-104, recodified as § 388-835-335, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-780, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-780, filed 8/3/82.]

WAC 388-835-340 Depreciation base. (1) The depreciation base shall be the historical cost of the contractor in acquiring the asset from an unrelated organization and preparing depreciation base for use, less goodwill and less accumulated depreciation incurred during periods the assets have been used in or as a facility by the contractor, such accumulated depreciation to be measured in accordance with subsection (4) of this section and WAC 275-38-790, 275-38-795, and 275-38-800. If the department challenges the historical cost of an asset or a contractor is not able to provide adequate documentation of the historical cost of an asset, the department may have the fair market value of the asset at the time of purchase established by appraisal. The fair market value of items of equipment will be established by appraisals performed by vendors of the particular type of equipment. When these appraisals are conducted, the depreciation base of the asset will not exceed fair market value. Estimated salvage value, if any, shall be deducted from historical cost where the straight-line or sum-of-the-years digits method of depreciation is used.

(2) Effective January 1, 1981, for purposes of setting rates for rate periods beginning July 1, 1982, and subsequently, subsection (1) of this section shall be applied with the phrase "in an arm's-length transaction" replacing the phrase "from an unrelated organization."

(3) Effective July 1, 1982, in all cases subsection (1) of this section shall be applied with the phrase "in an arm's-length transaction" replacing the phrase "from an unrelated organization."

(4) Where depreciable assets are acquired from a related organization, the contractor's depreciation base shall not exceed the base the related organization had or would have had under a contract with the department.

(5) Effective October 1, 1984, the depreciation base for assets acquired in a change of ownership entered into on or after July 18, 1984, shall not exceed the lower of the purchase price of the new owner or the acquisition cost base of the owner of the assets on or after July 18, 1984. Costs (including legal fees, accounting and administrative costs, travel costs,

and the cost of feasibility studies) attributable to the negotiation or settlement of the assets acquired in the change of ownership, where any payment has previously been made by Title XIX, shall not be allowed.

[99-19-104, recodified as § 388-835-340, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-785, filed 6/1/88; 86-01-008 (Order 2312), § 275-38-785, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-785, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-785, filed 8/3/82.]

WAC 388-835-345 Depreciation base—Donated or inherited assets. (1) The depreciation base of donated assets, as defined in WAC 275-38-001, or of assets received through testate or intestate distribution, shall be the lesser of:

(a) Fair market value at the date of donation or death, less goodwill. Estimated salvage value, if any, shall be deducted from fair market value where the straight-line or sum-of-the-years digits method of depreciation is used; or

(b) The historical cost of the owner last contracting with the department, if any.

(2) If the donation or distribution is between related organizations, the base shall be the lesser of:

(a) Fair market value, less goodwill and, where appropriate, salvage value, or

(b) The depreciation base the related organization had or would have had for the asset under a contract with the department.

[99-19-104, recodified as § 388-835-345, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-790, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-790, filed 8/3/82.]

WAC 388-835-350 Lives. (1) The contractor shall use lives no shorter than guideline lives contained in the Internal Revenue Service class life ADR system or published by the American Hospital Association in computing allowable depreciation except the building. The shortest life which may be used for buildings is thirty years.

(2) Lives shall be measured from the date of the most recent arm's-length acquisition of the asset.

(3) Building improvements shall be depreciated over the remaining useful life of the building, as modified by the improvement, but not less than fifteen years, except as follows: For boarding home licensed facility building improvements required by the Fire Safety Evaluation System (FSES) of the Life Safety Code of 1984, the improvements shall be depreciated over a period of not less than five years. This exception shall require prior approval by the department.

(4) Improvements to leased property which are the responsibility of the contractor under the terms of the lease shall be depreciated over the useful life of the improvement, except as follows: For boarding home licensed facility building improvements required by the Fire Safety Evaluation System (FSES) of the Life Safety Code of 1984, the improvements shall be depreciated over a period of not less than five years. This exception shall require prior approval by the department.

(5) A contractor may change the estimate of an asset's useful life to a longer life for purposes of depreciation.

[99-19-104, recodified as § 388-835-350, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-795, filed 12/5/85; 82-16-080 (Order 1853), § 275-38-795, filed 8/3/82.]

WAC 388-835-355 Methods of depreciation. (1) Buildings, building improvements, land improvements, leasehold improvements, and fixed equipment shall be depreciated using the straight-line method. Major-minor equipment shall be depreciated using either the straight-line method, the sum-of-the-years digits method, or declining balance method not to exceed one hundred fifty percent of the straight-line rate. Contractors electing to take either the sum-of-the-years digits method or the declining balance method of depreciation on major-minor equipment may change to the straight-line method without permission of the department.

(2) The annual provision for depreciation shall be reduced by the portion allocable to use of the asset for purposes not both necessary and related to resident care and training.

(3) No further depreciation shall be claimed after an asset has been fully depreciated unless a new depreciation base is established pursuant to WAC 275-38-785.

[99-19-104, recodified as § 388-835-355, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-800, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-800, filed 8/3/82.]

WAC 388-835-360 Retirement of depreciable assets. (1) Where depreciable assets are disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, or fire or other casualty, depreciation shall no longer be taken on the assets. No further depreciation shall be taken on permanently abandoned assets.

(2) Where an asset has been retired from active use but is being held for stand-by or emergency service, and the department has determined that the asset is needed and can be effectively used in the future, depreciation may be taken, as prescribed in WAC 275-38-775 through 275-38-800.

[99-19-104, recodified as § 388-835-360, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-805, filed 8/3/82.]

WAC 388-835-365 Handling of gains and losses upon retirement of depreciable assets. Settlement periods prior to January 1, 1981, and rate periods prior to July 1, 1982.

(1) For settlement purposes for periods prior to January 1, 1981, and for rate-setting purposes for periods prior to July 1, 1982, gains and losses on the retirement of depreciable assets either during the period of participation in the program or within twelve months following termination, shall be treated in accordance with this section.

(2) A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for loss of, the asset. For purposes of subsections (3) and (4) of this section, the total gain shall be reduced by one percent for each month of ownership of an asset with an expected useful life of one hundred months or longer. For an asset with an expected useful life of less than one hundred months, total gain shall be reduced by the portion thereof equal to the ratio of the actual life of the asset from the most recent arm's-length acquisition up to the date of retirement to the assets expected useful life.

(3) If the retired asset is replaced, the gain or loss shall be applied against or added to the cost of the replacement asset, provided a loss will only be so applied if the contractor has

made a reasonable effort to recover at least the outstanding book value of the asset.

(4) If the retired asset is not replaced, or if the contractor is terminating the contract, the gain or loss shall be spread over the actual life of the asset up to the date of retirement, provided a loss will only be so spread if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset. The difference between reimbursement actually paid for depreciation in any period beginning on or after January 1, 1978, and the reimbursement for depreciation having been paid with the base adjusted to reflect the gain or loss, will be computed. Where the difference results from a gain, the difference shall be recovered by the department. Where the difference results from a loss, the difference will be added to allowable costs for purposes of determining settlement.

[99-19-104, recodified as § 388-835-365, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-810, filed 8/3/82.]

WAC 388-835-370 Handling of gains and losses upon retirement of depreciable assets—Other periods. (1) This section shall apply in the place of WAC 275-38-810 effective January 1, 1981, for purposes of settlement for settlement periods subsequent to that date, and for purposes of setting rates for rate periods beginning July 1, 1982, and subsequently.

(2) A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for loss of, the asset.

(3) If the retired asset is replaced, the gain or loss shall be applied against or added to the cost of the replacement asset, provided a loss will only be so applied if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset.

[99-19-104, recodified as § 388-835-370, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-812, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-812, filed 8/3/82.]

WAC 388-835-375 Handling of gains and losses upon retirement of depreciable assets. This section shall apply in the place of WAC 275-38-812 effective October 1, 1984. Effective October 1, 1984, assets acquired in a change of ownership entered into on or after July 18, 1984, shall be subject to the following depreciation recapture provisions.

(1) A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for loss of, the asset.

(2) If the retired asset is replaced, the gain or loss shall be applied against or added to the cost of the replacement asset, provided a loss will only be so applied if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset.

(3) If the retired asset is not replaced, or if the contractor is terminating the contract, the gain or loss shall be spread over the actual life of the asset up to the date of retirement, provided a loss will only be so spread if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset. The difference between reimbursement actually paid for depreciation and the reimbursement for depreciation having been paid with the base adjusted to reflect the gain or loss, will be computed. Where the difference results from a gain, the difference shall be recovered by the department.

[99-19-104, recodified as § 388-835-375, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-813, filed 12/5/85.]

WAC 388-835-380 Recovery of excess over straight-line depreciation. If a contractor terminates the contract without selling or otherwise retiring equipment which was depreciated using an accelerated method, depreciation schedules relating to these assets for periods the contractor participated in the IMR program shall be adjusted. The difference between reimbursement actually paid for depreciation in any period beginning on or after January 1, 1978, and the reimbursement which would have been paid for depreciation if the straight-line method had been used, shall be recovered by the department.

[99-19-104, recodified as § 388-835-380, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-815, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-815, filed 8/3/82.]

WAC 388-835-385 Unallowable costs. (1) Costs shall be unallowable if not documented, necessary, ordinary, and related to the provision of services to IMR residents.

(2) Unallowable costs include, but are not limited to, the following:

(a) Costs of items or services not covered by the Medicaid program. Costs of nonprogram items or services will be unallowable even if indirectly reimbursed by the department as the result of an authorized reduction in resident contribution.

(b) Costs of services and items provided to IMR residents covered by the department's medical care program but not included in IMR services respectively. Items and services covered by the medical care program are listed in chapter 388-86 WAC.

(c) Costs associated with a capital expenditure subject to Section 1122 approval (part 100, Title 42 CFR) if the department found the capital expenditure was not consistent with applicable standards, criteria or plans. If the department was not given timely notice of a proposed capital expenditure, all associated costs will be nonallowable as of the date the costs are determined not to be reimbursable under applicable federal regulations.

(d) Costs associated with a construction or acquisition project requiring certificate of need approval pursuant to chapter 70.38 RCW if such approval was not obtained.

(e) Costs of outside activities (e.g., costs allocable to the use of a vehicle for personal purposes, or related to the part of a facility leased out for office space).

(f) Salaries or other compensation of officers, directors, stockholders, and others associated with the contractor or home office, except compensation paid for service related to resident care and training.

(g) Costs in excess of limits or violating principles set forth in this chapter.

(h) Costs resulting from transactions or the application of accounting methods circumventing the principles of the prospective cost-related reimbursement system.

(i) Costs applicable to services, facilities, and supplies furnished by a related organization in excess of the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere.

(j) Bad debts.

(k) Charity and courtesy allowances.

(l) Cash, assessments, or other contributions, excluding dues, to charitable organizations, professional organizations, trade associations, or political parties, and cost incurred to improve community or public relations.

(i) Any portion of trade association dues attributable to legal and consultant fees and costs in connection with lawsuits, or other legal action against the department.

(ii) Travel expenses for members of trade association boards of directors, otherwise meeting the requirements of chapter 275-38 WAC, for more than twelve meetings per year.

(m) Vending machine expenses.

(n) Expenses for barber or beautician services not included in routine care.

(o) Funeral and burial expenses.

(p) Costs of gift shop operations and inventory.

(q) Personal items such as cosmetics, smoking materials, newspapers and magazines, and clothing, except items used in resident activity programs or in IMR programs where clothing is a part of routine care.

(r) Fund-raising expenses, except those directly related to the resident activity program.

(s) Penalties and fines.

(t) Expenses related to telephones, televisions, radios, and similar appliances in residents' private accommodations.

(u) Federal, state, and other income taxes.

(v) Costs of special care services, except where authorized by the department.

(w) Expenses of key-man insurance and other insurance or retirement plans not in fact made available to all employees.

(x) Expenses of profit-sharing plans.

(y) Expenses related to the purchase and/or use of private or commercial airplanes in excess of what a prudent contractor would expend for the ordinary and economic provision of such a transportation need related to resident care.

(z) Personal expenses and allowances of owners or relatives.

(aa) All expenses of maintaining professional licenses or membership in professional organizations.

(bb) Costs related to agreements not to compete.

(cc) Goodwill and amortization of goodwill.

(dd) Expenses related to vehicles in excess of what a prudent contractor would expend for the ordinary and economic provision of transportation needs related to resident care.

(ee) Legal and consultant fees in connection with a fair hearing against the department, including but not limited to accounting services in preparation of administrative or judicial review, where the final administrative decision is rendered in favor of the department or where otherwise the determination of the department stands at the termination of administrative review.

(ff) Legal and consultant fees in connection with a lawsuit against the department, including appeals of administrative decision suits.

(gg) Lease acquisition costs and other intangibles not related to resident care and training.

(hh) Interest charges assessed by the state of Washington for failure to make timely refund of overpayments and interest expenses incurred for loans obtained to make such refunds.

(ii) Travel expenses outside the states of Idaho, Oregon, and Washington and the Province of British Columbia. However, travel to and from the home and central office of a chain organization operation will be allowed outside those areas if such travel is necessary, ordinary, and related to resident care and training.

(jj) Moving expenses of employees in the absence of a demonstrated, good-faith effort to recruit within the states of Idaho, Oregon, and Washington and the Province of British Columbia.

(3) If a contractor provides goods or services not reimbursable under chapter 275-38 WAC, any material indirect or overhead costs must be allocated to such goods or services and not be reported as an allowable cost.

[99-19-104, recodified as § 388-835-385, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-820, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-820, filed 8/3/82.]

WAC 388-835-390 Reimbursement principles. (1) Medicaid program reimbursement rates established under the provisions of this chapter shall be only for facilities holding appropriate state licenses and certified to provide IMR services in accordance with applicable state and federal laws and regulations.

(2) Rates established shall be reasonable and adequate to meet the costs that must be incurred by economically and efficiently operated facilities to provide services in conformity with applicable state and federal laws and regulations.

(3) For nonstate facilities, final payment shall be the lower of their prospective rate or allowable costs.

(a) Prospective rates for nonstate facilities shall be determined in accordance with WAC 275-38-845, 275-38-846, 275-38-850, 275-38-860, 275-38-863, 275-38-865, 275-38-868, 275-38-869, 275-38-870, 275-38-875, and 275-38-880.

(b) Final payments for nonstate facilities shall be determined in accordance with WAC 275-38-886.

(4) For state facilities, final payment shall be their allowable costs.

(a) Interim rates for state facilities shall be determined in accordance with WAC 275-38-846 and 275-38-890.

(b) Final payments for state facilities shall be determined in accordance with WAC 275-38-892.

[99-19-104, recodified as § 388-835-390, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-831, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-831, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-831, filed 8/19/83.]

WAC 388-835-395 Program services not covered by the reimbursement rate. Medical services which are part of

the department's medical care program but not included in IMR services are not covered by the prospective reimbursement rate. Payment is made directly to the provider of service in accordance with chapter 388-87 WAC. Items and services covered by the medical care program are listed in chapter 388-86 WAC.

[99-19-104, recodified as § 388-835-395, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-835, filed 8/3/82.]

WAC 388-835-400 Prospective reimbursement rate for new contractors. (1) A prospective reimbursement rate for a new contractor shall be established within sixty days following receipt by the department of a properly completed projected budget (see WAC 275-38-520). The reimbursement rate shall be effective as of the effective date of the contract.

(2) The prospective reimbursement rate shall be based on the contractor's projected cost of operations, and on costs and payment rates of the prior contractor, if any, and/or of other contractors in comparable circumstances taking into account applicable lids or maximums.

(3) If a properly completed projected budget is not received at least sixty days prior to the effective date of the contract, the department shall establish a preliminary rate based on the other factors specified in subsection (2) of this section. The preliminary prospective rate shall remain in effect until an initial prospective rate can be set.

(4) Where a change of ownership is involved which is not an arm's-length transaction as defined in WAC 275-38-001, the new contractor's prospective rates in the administration and operation and property cost areas shall be no higher than the rates of the old contractor, adjusted if necessary to take into account economic trends.

[99-19-104, recodified as § 388-835-400, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-840, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-840, filed 8/3/82.]

WAC 388-835-405 Rate determination. (1) Each contractor's reimbursement rate shall be determined prospectively once each calendar year to be effective July 1. Rates may be adjusted to take into consideration legislative inflation adjustments or pursuant to WAC 275-38-900 or 275-38-906.

(2) If the contractor participated in the program for at least six months of the prior calendar year, its rates shall be based on the contractor's allowable costs in the prior period. If the contractor participated in the program for less than six months of the prior calendar year, its rates shall be based on its rate determined per WAC 275-38-840.

(3) Contractors submitting correct and complete cost reports by March 31, shall be notified of their rates by July 1, unless circumstances beyond the control of the department interfere.

(4) The department shall take data used in determining rates from the most recent, complete, desk-reviewed cost report submitted by the contractor.

(5) Data containing obvious errors shall be excluded from the determination of predicted costs, cost averages, and rate upper limits for WAC 275-38-870.

(6) Inflation factor adjustments shall be specified in division policy Directive 406.

[99-19-104, recodified as § 388-835-405, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-845, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-845, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-845, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-845, filed 8/3/82.]

WAC 388-835-410 Desk review for rate determination. (1) The department shall analyze each cost report to determine if the information is correct, complete, and reported in conformity with generally accepted accounting principles, the requirements of chapter 275-38 WAC, and such rules and instructions issued by the department. An analysis by the department to determine whether reported information is correct and complete may include, but is not limited to:

(a) An examination of reported costs for prior years;

(b) An examination of desk review adjustments made in prior years and their final disposition; and

(c) An examination of findings, if any, from field audits of cost reports from prior years and findings, if any, from the field audit of the cost report under analysis.

(2) If it appears from the analysis a contractor has not correctly determined or reported its costs, the department may make adjustments to the reported information for purposes of establishing reimbursement rates. The department shall provide a schedule of such adjustments to contractors and shall include an explanation for the adjustment and the dollar amount for each adjustment made. Adjustments shall be subject to review and appeal as provided in subsection (2)(a) or (b) below.

(a) If a contractor believes an adjustment is in error, the adjustment shall be subject to review pursuant to WAC 275-38-900; and

(b) If a satisfactory resolution of issues is not reached between the contractor and the department, the adjustment shall be subject to further review pursuant to WAC 275-38-950 and 275-38-960.

(3) The department may accumulate data from properly completed cost reports for use in exception profiling and establishing rates.

(4) The department may further utilize such accumulated data for analytical, statistical, or informational purposes as deemed necessary by the department.

[99-19-104, recodified as § 388-835-410, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-846, filed 6/1/88; 83-17-074 (Order 2012), § 275-38-846, filed 8/19/83.]

WAC 388-835-415 Cost centers. (1) A contractor's overall reimbursement rate for IMR residents consists of the total of three component rates, each covering one cost center. The five cost centers are: Resident care and habilitative services; food; administration and operations; property; and return on equity;

(2) Effective January 1, 1985, a contractor's reimbursement rate for IMR residents consists of the total of three component rates, each covering one cost center. The three cost centers are: Resident care and habilitation; administration, operations, and property; and return on equity.

[99-19-104, recodified as § 388-835-415, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-850, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-850, filed 8/3/82.]

WAC 388-835-420 Resident care and habilitation cost center rate. (1) For C and D level facilities, the resident care and habilitation cost center shall reimburse for resident living services, habilitative and training services, recreation services, and nursing services in accordance with applicable federal and state regulation.

(2) For E level facilities, the resident care and habilitation cost center shall reimburse for resident living services, habilitative and training services, recreation services, and nursing services in accordance with applicable federal and state regulation. The cost center shall reimburse for resident care and training staff performing administration and operations functions specified in WAC 275-38-870.

(3) A facility's resident care and habilitation cost center rate shall be the facility's most recent desk-reviewed costs per resident day adjusted for inflation.

[99-19-104, recodified as § 388-835-420, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 93-17-034 (Order 3616), § 275-38-860, filed 8/11/93, effective 9/11/93; 90-15-017 (Order 3037), § 275-38-860, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-860, filed 6/1/88; 86-18-002 (Order 2412), § 275-38-860, filed 8/21/86; 86-01-008 (Order 2312), § 275-38-860, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-860, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-860, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-860, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-860, filed 8/3/82.]

WAC 388-835-425 Administration, operations, and property cost center rate. Effective October 1, 1985, the administration, operations, and property cost center rate shall consist of the sum of three rate components: Food, administration and operations, and property. The food rate component shall be established pursuant to WAC 275-38-865. The administration and operations rate component shall be established pursuant to WAC 275-38-870. The property rate component shall be established pursuant to WAC 275-38-875.

[99-19-104, recodified as § 388-835-425, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-863, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-863, filed 3/6/85.]

WAC 388-835-430 Food rate component. (1) The food rate component will reimburse for the necessary and ordinary costs of bulk and raw food, dietary supplements, and beverages for meals and between-meal nourishment for residents.

(2) A facility's food rate component shall be set at the July 1, 1983, IMR food rate component, adjusted for inflation.

[99-19-104, recodified as § 388-835-430, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-865, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-865, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-865, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-865, filed 8/3/82.]

WAC 388-835-435 Maximum allowable compensation of certain administrative personnel. (1) Compensation for administrative personnel shall be an allowable cost, subject to the limits contained in this section.

(2) Total compensation of the licensed administrator for services actually rendered to an IMR facility on a full-time basis (at least forty hours per week, including reasonable vacation, holiday, and sick time) will be allowable at the lower of:

(a) Actual compensation received; or

(b) The amount specified in division policy Directive 403 corresponding to the number of set-up beds in the IMR facility. Compensation of the licensed administrator will only be allowable if the department is given written notice of his or her employment within ten days after the employment begins.

(3) Total compensation of not more than one full-time licensed assistant administrator will be allowable if there are at least eighty set-up beds in the IMR, at the lower of:

(a) Actual compensation received; or

(b) Seventy-five percent of the amount specified in division policy Directive 403.

(4) Total compensation of not more than one full-time registered administrator-in-training will be allowable at the lower of:

(a) Actual compensation received; or

(b) Sixty percent of the amount specified in division policy Directive 403.

(5) The cost of a licensed administrator, assistant administrator, or administrator-in-training is not an allowable expense in IMR facilities of fifteen beds or less. Administrative services will be provided by the QMRP in these facilities. Total compensation of wages and salaries for the QMRP will be allowable at the lower of:

(a) Actual compensation received; or

(b) The amount specified in division policy Directive 403.

(6) If the licensed administrator, licensed assistant administrator, registered administrator-in-training, or QMRP regularly works fewer than forty hours per week, allowable compensation shall be the lower of:

(a) Actual compensation received, or

(b) The maximum amount allowed multiplied by the percentage derived by dividing actual hours worked by forty hours. Further discounting is required if the person was licensed or registered and/or worked for less than the entire report period.

(7) The contractor shall maintain time records for the licensed administrator and for an assistant administrator, administrator-in-training, or QMRP, if any.

[99-19-104, recodified as § 388-835-435, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 84-19-042 (Order 2150), § 275-38-868, filed 9/17/84. Formerly WAC 275-38-730.]

WAC 388-835-440 Management agreements, management fees, central office services, and board of directors. (1) If a contractor intends to enter into a management agreement with an individual or firm which will manage the IMR facility as agent of the contractor, a copy of the agreement must be submitted by the contractor at least sixty days before the agreement is to become effective. A copy of any amendment to a management agreement must also be received by the department at least thirty days in advance of the date the amendment is to become effective. No manage-

ment fees for periods prior to the time the department receives a copy of the applicable agreement shall be allowable. When necessary for the health and safety of facility residents, the sixty-day notice requirement may be waived, in writing, by the department.

(2) Management fees shall be allowed only if:

(a) A written management agreement both creates a principal and/or agent relationship between the contractor and the manager, and sets forth the items, services, and activities to be provided by the manager; and

(b) Documentation demonstrates the services contracted for were actually delivered.

(c) To be allowable, fees must be for necessary, nonduplicative services.

(3) The contractor shall limit allowable fees for general management services, including corporate or business entity management and board of director's fees and including the overhead and indirect costs associated with providing general management services to:

(a) The maximum allowable compensation under WAC 275-38-868 of the licensed administrator and, if the facility has at least eighty set-up beds, of an assistant administrator; less

(b) Actual compensation received by the licensed administrator and by the assistant administrator, if any. In computing maximum allowable compensation under WAC 275-38-868 for a facility with at least eighty set-up beds, include the maximum compensation of an assistant administrator even if no assistant administrator is employed;

(c) For IMR facilities of fifteen or fewer beds, the maximum allowable compensation under WAC 275-38-868, less the actual compensation received by the QMRP.

(4) A management fee paid to or for the benefit of a related organization shall be allowable to the extent the fee does not exceed the lesser of:

(a) The limits set out in subsection (3) of this section; or

(b) The lower of the actual cost to the related organization of providing necessary services related to resident care and training under the agreement, or the cost of comparable services purchased elsewhere.

Where costs to the related organization represents joint facility costs, the measurement of such costs shall comply with WAC 275-38-868.

(5) Central office costs, owner's compensation, and other fees or compensation, including joint facility costs, for general administrative and management services, shall include the overhead and indirect costs associated with providing general management expense not allocated to specific services. Such costs shall be subject to the management fee limits determined in subsections (3) and (4) of this section.

(6) Necessary travel and housing expenses of nonresident staff working at a contractor's IMR facility are allowable costs if the visit does not exceed three weeks. Such costs in excess of three weeks shall be subject to the management fee limits determined in subsections (3) and (4) of this section.

(7) Bonuses paid to employees at a contractor's IMR facility are compensation. Bonuses paid to employees at a contractor's central office or otherwise not employed at the IMR facility, who are not engaged in nonmanagerial services such as accounting, are management costs and shall be subject to the management fee limits determined in subsections (3) and (4) of this section.

(8) Fees paid to members of the board of directors of corporations operating IMR facilities shall be subject to the management fee limits determined in subsection (3) and (4) of this section.

[99-19-104, recodified as § 388-835-440, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-869, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-869, filed 9/17/84. Formerly WAC 275-38-740.]

WAC 388-835-445 Administration and operations rate component. (1) The administration and operations rate component will include reimbursement for the necessary and ordinary costs of overall administration and management of the facility, operation and maintenance of the physical plant, resident transportation, dietary service (other than the cost of food and beverages), laundry service, medical and habilitative supplies, taxes, and insurance.

(2) A facility's administration and operations rate component shall be the lesser of:

(a) The facility's most recent desk-reviewed cost per resident day, adjusted for inflation; or

(b) The eighty-fifth percentile ranking of state and nonstate facilities' most recent desk-reviewed cost per resident day, adjusted for inflation. The ranking shall be based on cost reports used for rate determination for facilities having an occupancy level of at least eighty-five percent for the cost report period.

[99-19-104, recodified as § 388-835-445, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-870, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-870, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-870, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-870, filed 8/3/82.]

WAC 388-835-450 Property rate component. The property rate component will reimburse for the necessary and ordinary costs of leases, depreciation, and interest. A facility's property rate component shall be the facility's most recent desk-reviewed cost per resident day.

[99-19-104, recodified as § 388-835-450, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-875, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-875, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-875, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-875, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-875, filed 8/3/82.]

WAC 388-835-455 Return on equity. (1) The department will pay a return on equity to proprietary contractors.

(2) A contractor's net equity will be calculated using the appropriate items from the contractor's most recent desk-reviewed cost report utilizing the definition of equity capital in WAC 275-38-001 and applying relevant Medicare rules and regulations, except that goodwill is not includable in the determination of net equity and monthly equity calculations will not be used.

(3) The contractor's net equity will be multiplied by the prior calendar year's December 31 Medicare rate of return for the twelve-month period ending on the date of the closing date of the contractor's cost report. The amount will be divided by the contractor's annual resident days for the cost

report period to determine a rate per resident day. Where a contractor's cost report covers less than a twelve-month period, annual resident days will be estimated using the contractor's reported resident days. The contractor shall be paid a prospective rate which is the lesser of the amount calculated pursuant to this section or two dollars per resident day.

(4) The information on which the return on equity is calculated is subject to field audit. Field audit shall determine whether the desk-reviewed reported equity exceeds the equity documented and calculated in conformance with Medicare rules and regulations as modified by this section. Using the determinations of field audit, the department shall recalculate the contractor's return on equity rate for the rate period using the report. Any payments in excess of the rate shall be refunded to the department as part of the settlement procedure established by WAC 275-38-886.

[99-19-104, recodified as § 388-835-455, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-880, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-880, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-880, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-880, filed 8/3/82.]

WAC 388-835-460 Upper limits to reimbursement rate. The reimbursement rate shall not exceed the contractor's customary charges to the general public for the services covered by the rate, except that public facilities rendering such services free of charge or at a nominal charge will be reimbursed according to the methods and standards set out in this chapter. The contractor shall immediately inform the department if the department's reimbursement rate does exceed customary charges for comparable services. If necessary, the rate will be adjusted in accordance with WAC 275-38-900. Rates will not exceed the limits set in 42 CFR 447.316.

[99-19-104, recodified as § 388-835-460, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-885, filed 8/3/82.]

WAC 388-835-465 Principles of settlement. (1) Settlement shall be calculated at the lower of prospective reimbursement rate or audited allowable costs, except as otherwise provided in this chapter.

(2) Each contractor shall complete a proposed preliminary settlement as part of the annual cost report and submit it by the due date of the annual cost report. After review of the proposed preliminary settlement, the department shall issue a preliminary settlement report to the contractor.

(3) If a field audit is conducted, the department shall evaluate the audit findings after completion of the audit and shall issue a final settlement which takes account of such findings and evaluations.

(4) Pursuant to preliminary or final settlement and the procedures set forth in chapter 275-38 WAC[, the contractor shall refund overpayments to the department and the department shall pay underpayments to the contractor].

(5) When payment for services is first made following preliminary or final settlement for the period during which the services were provided, payment shall be at the most recent available settlement rate.

[99-19-104, recodified as § 388-835-465, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-886, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-886, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-886, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-886, filed 8/19/83.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-835-470 Procedures for overpayments and underpayments. (1) The department shall make payment of underpayments determined by preliminary or final settlement within thirty days after the preliminary or final settlement report is submitted to the contractor.

(2) A contractor found to have received overpayments or payments in error as determined by preliminary or final settlement shall refund such payments to the department within thirty days after receipt of the preliminary or final settlement report as applicable.

(3) If a contractor fails to comply with subsection (2) of this section, the department shall:

(a) Deduct from current monthly amounts due the contractor the refund due the department and interest on the unpaid balance at the rate of one percent per month; or

(b) If the contract has been terminated:

(i) Deduct from any amounts due the contractor the refund due the department and interest on the unpaid balance at the rate of one percent per month; or

(ii) Pursue, as authorized by law and regulation, recovery of the refund due and interest on the unpaid balance at the rate of one percent per month.

(4) If a facility is pursuing timely filed administrative or judicial remedies in good faith regarding settlement report, the contractor need not refund. The department shall not withhold any refund or interest from current amounts due the facility if the refund is specifically disputed by the contractor on review or appeal. The department may recover portions of refunds not specifically disputed by the contractor on review or appeal and assess interest as provided in subsection (3) of this section. If the administrative or judicial remedy sought by the facility is not granted or is granted only in part after exhaustion or mutual termination of all appeals, the facility shall refund all amounts due the department within sixty days after the date of decision or termination plus interest as payable on judgments from the date the review was requested pursuant to WAC 275-38-950 and 275-38-960 to the date the repayment is made.

[99-19-104, recodified as § 388-835-470, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-887, filed 6/1/88.]

WAC 388-835-475 Preliminary settlement. (1) Effective January 1, 1985, the proposed preliminary settlement submitted by a contractor pursuant to WAC 275-38-886 shall use the prospective rate for the resident care and habilitation cost center at which the contractor was paid during the report period, including any client specific payment adjustments made for the resident care and habilitation cost center. Such payments shall be weighted by the number of paid resident days reported for the period each rate was in effect. These

payments shall be compared to the contractor's allowable costs for the resident care and habilitation cost center divided by total resident days.

(2) A contractor's administration, operations, and property cost center settlement rate shall be its prospective rate for the report period weighted by the number of paid resident days reported for the period each rate was in effect.

(3) A contractor's return on equity settlement rate shall be its prospective rate for the report period weighted by the number of paid resident days reported for the period each rate was in effect.

(4) Within one hundred twenty days after a proposed preliminary settlement is received, the department shall review it for accuracy and either accept or reject the proposal of the contractor. If accepted, the proposed preliminary settlement shall become the preliminary settlement report. If rejected, the department shall issue a preliminary settlement report by cost center which shall fully substantiate disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

(5) A contractor shall have thirty days after receipt of a preliminary settlement report to contest such report pursuant to WAC 275-38-950 and 275-38-960. Upon expiration of the thirty-day period, a preliminary settlement report shall not be subject to review.

[99-19-104, recodified as § 388-835-475, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-888, filed 6/1/88.]

WAC 388-835-480 Final settlement. (1) If an audit is conducted, the department shall issue a final settlement report to the contractor after completion of the audit process, including exhaustion or mutual termination of reviews and appeals of audit findings or determinations.

(2) The final settlement shall be by cost center and shall fully substantiate disallowed costs, refunds, underpayments, or adjustments to the cost reports and financial statements, reports, and schedules submitted by the contractor.

(a) The final settlement report shall use the prospective rate at which the contractor was paid during the report period, including any client specific payment adjustments made for resident care and training cost center. Such payments shall be weighted by the number of paid resident days reported for the period each rate was in effect. The department shall compare these payments to the contractor's audited allowable costs for the period.

(b) A contractor's administration operations and property cost center settlement rate shall be its prospective rate for the period weighted by the number of paid resident days reported for the period each rate was in effect.

(c) A contractor's return on equity rate shall be its prospective rate for the report period weighted by the number of paid resident days reported for the period each rate was in effect.

(3) If the contractor is pursuing an administrative or judicial review or appeal in good faith regarding audit findings or determinations, the department may issue a partial final settlement report in order to recover overpayments based on audit findings or determinations not in dispute on review or appeal.

(4) A contractor shall have thirty days after receipt of a final settlement report to contest such report pursuant to WAC 275-38-950 and 275-38-960. Upon expiration of the thirty-day period, a final settlement report shall not be subject to review.

[99-19-104, recodified as § 388-835-480, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-889, filed 6/1/88.]

WAC 388-835-485 Interim rate. (1) A state facility's interim rate shall be determined utilizing the most recent desk-reviewed costs per resident day. These costs may be adjusted to incorporate federal, state, or department changes in program standards or services.

(2) A facility's interim rate may be adjusted for federal, state, or department changes in program standards or services.

[99-19-104, recodified as § 388-835-485, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-890, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-890, filed 9/17/84.]

WAC 388-835-490 Final payment. (1) A settlement shall be determined to establish a state facility's final payment. A settlement shall be calculated as follows:

(a) If the state facility's allowable costs for the report period are greater than their interim payment, the amount owed to the facility shall be the difference of cost minus interim payment.

(b) If the state facility's allowable costs for the report period are less than their interim payments, the amount owed by the department shall be the difference of interim payment minus cost.

(2) The settlement process shall consist of a preliminary settlement and a final settlement.

(3) The preliminary settlement process shall be as follows:

(a) State facilities shall submit a proposed settlement report with their cost report.

(b) Within one hundred twenty days after receipt of the proposed settlement, the department shall verify the accuracy of the proposal and shall issue a preliminary settlement substantiating the settlement amount.

(4) The final settlement process shall be as follows:

(a) After completion of the audit process, the department shall submit a final settlement report to the state facility substantiating disallowed costs, refunds, underpayments, or adjustments to the contractor's financial statements, cost report, and final settlement.

(b) A preliminary settlement as issued by the department shall become the final settlement if an audit is not to be conducted pursuant to WAC 275-38-620.

[99-19-104, recodified as § 388-835-490, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-892, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-892, filed 9/17/84.]

WAC 388-835-495 Notification of rates. The department will notify each contractor in writing of the department's prospective reimbursement rate. Unless otherwise specified at the time the reimbursement rate is issued, the rate will be effective from the first day of the month the rate is

issued until a new rate becomes effective. If a rate is changed as the result of an appeal in accordance with WAC 275-38-960, the rate will be effective as of the date the rate appealed from became effective.

[99-19-104, recodified as § 388-835-495, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-895, filed 8/3/82.]

WAC 388-835-500 Adjustments required due to errors or omissions. (1) The department may adjust prospective rates in accordance with subsection (1) of this section and WAC 275-38-570, as a result of cost report or computational errors or omissions by the department or by the contractor. The department shall notify the contractor in writing of each adjustment and of the effective date, and of any amount due to the department or to the contractor as a result of the rate adjustment. Rates adjusted in accordance with this section shall be effective as of the effective date of the original rate, whether the adjustment is solely for computing a preliminary or final settlement or for the purpose of modifying past or future rate payments as well.

(2) If a contractor claims an error or omission based upon incorrect cost reporting, the contractor shall submit amended cost report pages. Amended pages shall be accompanied by the certification required by WAC 275-38-560 and a written justification explaining why the amendment is necessary. Such amendments shall not be accepted unless the amendments meet the requirements of WAC 275-38-570. If the department determines the changes made by such amendments are material, the amended pages shall be subject to field audit. If the department determines the amendments are incorrect or otherwise unacceptable from a field audit, or other information available to the department, any rate adjustment based on the amendment shall be null and void. Future rate payment increases, if any, scheduled as a result of such an amendment shall be cancelled immediately. Payments based upon the rate adjustment shall be subject to repayment as provided in subsection (3) of this section.

(3) The contractor shall pay or commence repayment for an amount he or she owes the department resulting from an error or omission within sixty days after receipt of notification of the rate adjustment or in accordance with a schedule determined by the department. If the determination is contested in accordance with WAC 275-38-950 and 275-38-960, the contractor shall pay or commence repayment within sixty days after completion of these proceedings. If a refund is not paid when due, the amount thereof may be deducted from current payments by the department.

(4) The department shall pay any amount owed the contractor as a result of a rate adjustment within thirty days after the department notifies the contractor of the rate adjustment.

(5) No adjustments for any purpose shall be made to a rate more than one hundred twenty days after the final audit narrative and summary is sent to the contractor or more than one hundred twenty days after the preliminary settlement becomes the final settlement.

(a) A final settlement within this one hundred twenty day time limit may be reopened for the sole purpose of making an adjustment to a prospective rate in accordance with WAC 275-38-900.

(b) Only such an adjustment to a prospective rate and its related computation shall be subject to review if timely contested pursuant to WAC 275-38-950 and 275-38-960. Other actions relating to settlement reopened shall not be subject to review unless previously contested in a timely manner.

[99-19-104, recodified as § 388-835-500, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-900, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-900, filed 8/3/82.]

WAC 388-835-505 Receivership. (1) If the IMR facility is providing care to recipients of state medical assistance is placed under receivership pursuant to chapter 388-98 WAC, the receiver shall:

(a) Become the Medicaid contractor for the duration of the receivership period;

(b) Assume all reporting responsibilities for new contractors;

(c) Assume all other responsibilities for new contractors set forth in chapter 275-38 WAC; and

(d) Be responsible for the refund of Medicaid rate payments pursuant to chapter 275-38 WAC in excess of costs during the period of receivership.

(2) In establishing the prospective rate during receivership, the department shall consider:

(a) Compensation, if any, ordered by the court for the receiver. Such compensation may already be available to the receiver through the rate as follows:

(i) The return on equity cost center rate, or

(ii) The administrator's salary in the case of facilities where the receiver is also the administrator.

If these existing sources of compensation are less than what was ordered by the court, additional costs may be allowed in the rate up to the compensation amount ordered by the court;

(b) Start-up costs and costs of repairs, replacements, and additional staff needed for resident health, training, security, and welfare. To the extent such costs can be covered through the return on equity cost center rate, if any, no additional money will be added to the rate; and

(c) Any other allowable costs as set forth in chapter 275-38 WAC.

(3)(a) Upon order of the court, the department shall provide emergency or transitional financial assistance to a receiver not to exceed thirty thousand dollars.

(b) The department shall recover any emergency or transitional expenditure from revenue generated by the facility which is not obligated to the operation of the facility.

(c) If the department has not fully recovered any emergency or transitional expenditure at the termination of receivership, the department may:

(i) File an action against the former licensee or owner to recover such expenditure; or

(ii) File a lien on the facility or on the proceeds of the sale of the facility.

(4) If recommendations on receiver's compensation are solicited from the department by the court, the department shall consider the following:

(a) The range of compensation for nonstate IMR facility managers;

(b) Experience and training of the receiver;

(c) The size, location, and current condition of the facility;

(d) Any additional factors deemed appropriate by the department.

(5) When the receivership terminates, the department may revise the facility's Medicaid reimbursement as follows:

(a) The Medicaid reimbursement rate for the former owner or licensee shall be what it was prior to receivership. Unless the former owner or licensee may request prospective rate revisions from the department as set forth in chapter 275-38 WAC;

(b) The Medicaid reimbursement rate for licensed replacement operators shall be determined consistent with rules governing prospective reimbursement rates for new contractors as set forth in chapter 275-38 WAC.

[99-19-104, recodified as § 388-835-505, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-903, filed 6/1/88.]

WAC 388-835-510 Adjustments to prospective rates. (1) Prospective rates shall be maximum payment rates for contractors for the periods to which they apply, except as otherwise provided in WAC 275-38-906. The department shall not grant rate adjustments for cost increases which are or were subject to management control or negotiation including, but not limited to, all lease cost increases, or for cost increases not expressly authorized in subsections (2) and (3) of this section.

(2) The department shall adjust rates for any capitalized additions or replacements made as a condition for licensure or certification.

(3) The department shall adjust rates for increased costs that must be incurred and which cannot be otherwise met through the contractor's prospective rate, for the following:

(a) Program changes required by the department;

(b) Changes in staffing levels or consultants at a facility required by the department; and

(c) Changes required by survey; and

(d) Changes in assessments related to revenue as required by the state legislature.

(4) Contractors requesting an adjustment shall submit:

(a) A financial analysis showing the increased cost and an estimate of the rate increase, computed according to allowable methods, necessary to fund the cost;

(b) A written justification for granting the rate increase; and

(c) A certification and supporting documentation which shows the changes in staffing, or other improvements, have been commenced or completed.

(5) Contractors receiving prospective rate increases under WAC 275-38-906 shall submit quarterly reports, beginning the first day of the month following the date the increase is granted, showing how the additional rate funds were spent. If the funds were not spent for change or improvements approved by the department in granting the adjustment, they may be subject to immediate recovery by the department unless the department finds the facility gave written notice of its intent to close by a date certain and recovery jeopardizes the facility's ability to provide for resident health, safety, and welfare.

(6) A contractor requesting an adjustment under subsection (3)(c) of this section shall submit a written plan specifying additional staff to be added and the resident needs the facility has been unable to meet due to lack of sufficient staff.

(7) In reviewing a request made under subsection (3) of this section, the department shall consider:

(a) Whether additional staff requested by a contractor is appropriate in meeting resident needs;

(b) Comparisons of staffing levels of facilities having similar characteristics;

(c) The physical layout of the facility;

(d) Supervision and management of current staff;

(e) Historic trends in under-spending of a facility's resident care and habilitation;

(f) Numbers and positions of existing staff; and

(g) Other resources available to the contractor under subsection (3) of this section.

[99-19-104, recodified as § 388-835-510, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 93-17-034 (Order 3616), § 275-38-906, filed 8/11/93, effective 9/11/93; 90-15-017 (Order 3037), § 275-38-906, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-906, filed 6/1/88.]

WAC 388-835-515 Public review of rate-setting methods and standards. The department will provide all interested members of the public with an opportunity to review and comment on proposed rate-setting methods and standards each year before setting rates.

[99-19-104, recodified as § 388-835-515, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-910, filed 8/3/82.]

WAC 388-835-520 Public disclosure of rate-setting methodology. Without identifying individual IMR facilities, the department will make available to the public full information regarding the department's rate-setting methodology.

[99-19-104, recodified as § 388-835-520, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-915, filed 8/3/82.]

WAC 388-835-525 Billing period. A contractor shall bill the department for care provided to medical care recipients from the first through the last day of each calendar month.

[99-19-104, recodified as § 388-835-525, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-920, filed 8/3/82.]

WAC 388-835-530 Billing procedures. (1) A contractor shall bill the department each month by completing and returning the IMR statement provided by the department. The IMR statement shall be completed and filed in accordance with instructions issued by the department.

(2) A contractor shall not bill the department for service provided to a resident until a department award letter relating to the resident has been received. At that time the contractor may bill for service provided back through the date the resident was admitted or became eligible.

(3) Billing shall not cover the day of a resident's death, discharge, or transfer from the IMR facility.

[99-19-104, recodified as § 388-835-530, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-925, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-925, filed 8/3/82.]

WAC 388-835-535 Charges to residents. (1) The department will notify a contractor of the amount each resident is required to pay for care provided under the contract and the effective date of such required contribution. It is the contractor's responsibility to collect that portion of the cost of care from the resident, and to account for any authorized reduction from his or her contribution in accordance with procedures established by the department.

(2) If a contractor receives documentation showing a change in the income or resources of a resident which will mean a change in his or her contribution toward the cost of care, this shall be reported in writing to the regional services office, DDD, within seventy-two hours. If necessary, appropriate corrections shall be made in the next IMR statement, and a copy of documentation supporting the change shall be attached. If increased funds for a resident are received by a contractor, the normal amount shall be allowed for clothing, personal, and incidental expense, and the balance applied to the cost of care.

(3) The contractor shall accept the reimbursement rate established by the department as full compensation for all services the contractor is obligated to provide under the contract. The contractor shall not seek or accept additional compensation from or on behalf of a resident for any or all such services.

[99-19-104, recodified as § 388-835-535, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-930, filed 8/3/82.]

WAC 388-835-540 Payment. (1) The department will reimburse a contractor for service rendered under the IMR contract and billed for in accordance with WAC 275-38-925.

(2) The amount paid will be computed using the appropriate rate assigned to the contractor.

(3) For each resident, the department will pay an amount equal to the appropriate rate or rates, multiplied by the number of resident days each rate was in effect, less the amount the resident is required to pay for his or her care (see WAC 275-38-930).

[99-19-104, recodified as § 388-835-540, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-935, filed 8/3/82.]

WAC 388-835-545 Suspension of payment. (1) Payments to a contractor may be withheld by the department in each of the following circumstances:

(a) A required report is not properly completed and filed by the contractor within the appropriate time period, including any approved extensions. Payments shall be released as soon as a properly completed report is received.

(b) Auditors or other authorized department personnel in the course of his or her duties are refused access to an IMR or are not provided with existing appropriate records. Payments shall be released as soon as such access or records are provided.

(c) A refund in connection with a settlement or rate adjustment is not paid by the contractor when due. The amount withheld shall be limited to the unpaid amount of the refund.

(d) Payments for the final service under a contract, pursuant to WAC 275-38-530, shall be held pending final settlement when the contract is terminated.

(2) No payment shall be withheld until written notification of the suspension is given to the contractor, stating the reason therefor.

[99-19-104, recodified as § 388-835-545, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-940, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-940, filed 8/3/82.]

WAC 388-835-550 Termination of payments. All Medicaid Title XIX payments to a contractor shall end no later than sixty days after any of the following occurs:

(1) A contract expires, is terminated or is not renewed;

(2) A facility license is revoked; or

(3) A facility is decertified as a Title XIX facility.

[99-19-104, recodified as § 388-835-550, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-945, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-945, filed 8/3/82.]

WAC 388-835-555 Disputes. (1) If a contractor wishes to contest the way a rule, contract provision, or policy statement relating to the prospective cost-related reimbursement system was applied to the contractor by the department, (e.g., in setting a reimbursement rate or determining a disallowance at audit), the contractor shall first pursue the administrative review process set out in WAC 275-38-960.

(2) The administrative review process in WAC 275-38-960 need not be exhausted if a contractor wishes to challenge the legal validity of a statute, rule, contract provision or policy statement.

[99-19-104, recodified as § 388-835-555, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-950, filed 8/3/82.]

WAC 388-835-560 Recoupment of undisputed overpayments. The department is authorized to withhold from the IMR current payment all amounts found by preliminary or final settlement to be overpayments not identified by the IMR and challenged as overpayments as part of a good-faith administrative or judicial review. Contested amounts retained by the IMR pursuant to this section may be subject to recoupment by the department from the IMR current payment upon completion of judicial and administrative review procedures to the extent the department's position or claims are upheld.

[99-19-104, recodified as § 388-835-560, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-955, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-955, filed 8/3/82.]

WAC 388-835-565 Administrative review—Adjudicative proceeding. (1) A contractor has the right to an administrative review to challenge an audit finding (adjusting journal entries or AJEs) or other audit determination, or a rate, desk review, or other settlement determination. A contractor challenging an audit or settlement determination shall within twenty-eight days of receipt of the determination:

(i) File a written request for an administrative review with the:

(A) Office of vendor services when the challenge pertains to an audit finding (adjusting journal entries or AJEs) or other audit determination; or

(B) Director, division of developmental disabilities, for a rate, desk review, or other settlement determination.

(ii) Sign the request or have the facility administrator sign the request;

(iii) Identify the challenged determination and the date thereof;

(iv) State as specifically as practicable the issues and regulations involved and the grounds for contending the determination was erroneous;

(v) Attach to the request copies of any documentation the contractor intends to rely on to support the contractor's position.

(2) After receiving a timely request meeting the criteria of this section, the department shall:

(a) Contact the contractor to schedule a conference for the earliest mutually convenient time; and

(b) Schedule the conference for no earlier than fourteen days after the contractor was notified of the conference and no later than ninety days after a properly completed request is received, unless both parties agree, in writing, to a specific later date.

The department may conduct the conference by telephone unless either the department or the contractor requests, in writing, the conference be held in person.

(3) The contractor and appropriate representatives of the department shall participate in the conference. The contractor shall bring to the conference, or provide to the department in advance of the conference:

(a) Any documentation requested by the department which the contractor is required to maintain for audit purposes under WAC 275-38-555; and

(b) Any documentation the contractor intends to rely on to support the contractor's contentions. The parties shall clarify and attempt to resolve the issues at the conference.

If additional documentation is needed to resolve the issues, a second session of the conference shall be scheduled for not later than thirty days after the initial session unless both parties agree, in writing, to a specific later date.

(4) Regardless of whether agreement is reached at the conference, the department shall furnish a written decision to the contractor within sixty days after the conclusion of the conference.

(5) A contractor shall have the right to an adjudicative proceeding to contest an administrative review decision.

(a) A contractor contesting an administrative review decision shall within twenty-eight days of receipt of the decision:

(i) File a written application for an adjudicative proceeding with the office of appeals;

(ii) Sign the application or have the administrator of the facility sign the application;

(iii) State as specifically as practicable the issues and regulations involved;

(iv) State the grounds for contesting the administrative review decision; and

(v) Attach to the application a copy of the administrative review decision being contested and copies of any documentation the contractor intends to rely on to support the contractor's position.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), this chapter, and chapter 388-08 WAC. If any provision in this chapter conflicts with chapter 388-08 WAC, the provision in this chapter governs.

[99-19-104, recodified as § 388-835-565, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-38-960, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-960, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-960, filed 8/3/82.]

Chapter 388-840 WAC

WORK PROGRAMS FOR RESIDENTS OF RESIDENTIAL HABILITATION CENTERS IN THE DIVISION OF DEVELOPMENTAL DISABILITIES

(Formerly chapter 275-41 WAC)

WAC

WAC 388-840-005 Purpose. The regulations provide guidelines for the operation of work programs at residential habilitation centers or for programs contracted on behalf of residents of residential habilitation centers within the division of developmental disabilities as required under RCW 43.20A.445.

[99-19-104, recodified as § 388-840-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-005, filed 8/9/91, effective 9/9/91.]

WAC 388-840-010 Definition. (1) "Compensate" means the resident's receipt of money for work done at a work program.

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

(3) "Division" means the developmental disabilities division of the department of social and health services.

(4) "Prevailing wage" means the amount paid to a nondisabled worker in a nearby industry or surrounding community for essentially the same type, quality, and quantity of work or work requiring comparable skills.

(5) "Residential habilitation center (RHC)" means a residential habilitation center operated by the developmental disabilities division.

(6) "Work program" means a directed vocational activity or series of related activities provided on a systematic, organized basis for developing and maintaining individual resident work skills, and providing remuneration to resident employees. Work programs must result in:

(a) Benefit to the economy of the facility; or

(b) A contribution to the facility's maintenance; or

(c) Produce articles or services for sale.

[99-19-104, recodified as § 388-840-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-010, filed 8/9/91, effective 9/9/91.]

WAC 388-840-015 Establishment of new work programs. The requirements of RCW 43.20A.445 shall be followed before the department establishes new residential habilitation center work programs.

[99-19-104, recodified as § 388-840-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-015, filed 8/9/91, effective 9/9/91.]

WAC 388-840-020 Protection of residents. (1) When a resident participates in a work program, the resident shall be employed in work and subjected to work conditions where reasonable precautions are taken to ensure the resident's health and safety.

(2) Resident work programs shall be consistent with the resident's individual habilitation plan objectives.

[99-19-104, recodified as § 388-840-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-020, filed 8/9/91, effective 9/9/91.]

WAC 388-840-025 Compensation for persons participating in work programs. (1) The department shall compensate a person participating in a work program at the prevailing minimum wage except when an appropriate certificate has been obtained by the RHC or contract program in accordance with current regulations and guidelines issued under the Fair Labor Standards Act (29 CFR Ch. V, 525 and 529) as amended.

(2) The department shall not be required to compensate a person participating in the shared domiciliary activities of maintaining the person's own immediate household or residence.

[99-19-104, recodified as § 388-840-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-025, filed 8/9/91, effective 9/9/91.]

Chapter 388-850 WAC

COUNTY PLAN FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES

(Formerly chapter 275-25 WAC)

WAC

WAC 388-850-010 Definitions. (1) All terms used in this chapter not defined herein shall have the same meaning as indicated in the act.

(2) "Act" means local funds for community services chapter 71.20 RCW, State services chapter 71A.12 RCW, and Local services chapter 71A.14 RCW as now existing or hereafter amended.

(3) "County" means each county or two or more counties acting jointly.

(4) "Department" means the department of social and health services.

(5) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

(6) "Indian" shall mean any:

(a) Person enrolled in or eligible for enrollment in a recognized Indian tribe; any person determined to be or eligible to be found to be an Indian by the secretary of the interior; and any Eskimo, Aleut or other Alaskan native;

(b) Canadian Indian person who is a member of a treaty tribe, Metis community, or other nonstatus Indian community from Canada;

(c) Unenrolled Indian person considered an Indian by a federally or nonfederally recognized Indian tribe or by an urban Indian/Alaska community organization.

(7) "Plan" means the application a county submits to the secretary for review and approval under the act(s); or revision of an existing plan.

(8) "Population" means the most recent estimate of the aggregate number of persons located in the designated county as computed by the office of financial management.

(9) "Secretary" means the secretary of the department or such employee or such unit of the department as the secretary may designate.

[99-19-104, recodified as § 388-850-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234. 93-15-013 (Order 3591), § 275-25-010, filed 7/8/93, effective 8/8/93. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-010, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-010, filed 1/12/83; Order 1142, § 275-25-010, filed 8/12/76. Formerly chapters 275-12, 275-13 and 275-29 WAC.]

WAC 388-850-015 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 275-25-010(5) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[99-19-104, recodified as § 388-850-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-015, filed 8/9/91, effective 9/9/91.]

WAC 388-850-020 Plan development and submission. (1) All dates in this section refer to the twenty-four-month period prior to the start of the state fiscal biennium.

(2) Before July 1, in the odd year of each biennium, the department shall negotiate with and submit to counties the biennial plan guidelines.

(3) Before July 1, the department shall submit to counties needs assessment data, and before December 31, updated needs assessment data in the odd year of each biennium.

(4) Before April 1, of the even year of each biennium, each county shall submit to the department a written plan for developmental disabilities services for the subsequent state fiscal biennium. The county's written plan shall be in the

form and manner prescribed by the department in the written guidelines.

(5) Within sixty days of receipt of the county's written plan, the department shall acknowledge receipt, review the plan, and notify the county of errors and omissions in meeting minimum plan requirements.

(6) Within thirty days after receipt, each county shall submit a response to the department's review when errors and omissions have been identified within the review.

(7) Before December 15 of the even year of each biennium, the department shall announce the amount of funds included in the department's biennial budget request to each county. The department shall announce the actual amount of funds appropriated and available to each county as soon as possible after final passage of the Biennial Appropriations Act.

(8) Each county shall submit to the department a contract proposal within sixty days of the announcement by the department of the actual amount of funds appropriated and available.

(9) The department may modify deadlines for submission of county plans and responses to reviews or contract proposals when, in the department's judgment, the modification enables the county to improve the program or planning process.

(10) The department may authorize the county to continue providing services in accordance with the previous plan and contract, and reimburse at the average level of the previous contract, in order to continue services until the new contract is executed.

[99-19-104, recodified as § 388-850-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-25-020, filed 4/21/92, effective 5/21/92. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-020, filed 1/12/83. Statutory Authority: RCW 69.54.040. 78-08-086 (Order 1322), § 275-25-020, filed 7/28/78; Order 1142, § 275-25-020, filed 8/12/76.]

WAC 388-850-025 Program operation—General provisions. (1) The provisions of this section shall apply to all programs operated under authority of the acts.

(2) The county and all contractors and subcontractors must comply with all applicable law or rule governing the department's approval of payment of funds for the programs. Verification may be in the manner and to the extent requested by the secretary.

(3) State funds shall not be paid to a county for costs of services provided by the county or other person or organization who or which was not licensed, certified, and approved as required by law or by rule whether or not the plan was approved by the secretary.

(4) The secretary may impose such reasonable fiscal and program reporting requirements as the secretary deems necessary for effective program management.

(5) **Funding.**

(a) The department and county shall negotiate and execute a contract before the department provides reimbursement for services under contract, except as provided under WAC 275-25-020(10).

(b) Payments to counties shall be made on the basis of vouchers submitted to the department for costs incurred under the contract. The department shall specify the form and content of the vouchers.

(c) The secretary may make advance payments to counties, where such payments would facilitate sound program management. The secretary shall withhold advance payments from counties failing to meet the requirements of WAC 275-25-020 until such requirements are met. Any county failing to meet the requirements of WAC 275-25-020 after advance payments have been made shall repay said advance payment within thirty days of notice by the department that the county is not in compliance.

(d) If the department receives evidence a county or subcontractor performing under the contract is:

(i) Not in compliance with applicable state law or rule; or

(ii) Not in substantial compliance with the contract; or

(iii) Unable or unwilling to provide such records or data as the secretary may require, then the secretary may withhold all or part of subsequent monthly disbursement to the county until such time as satisfactory evidence of corrective action is forthcoming. Such withholding or denial of funds shall be subject to appeal under the Administrative Procedure Act (chapter 34.05 RCW).

(6) **Subcontracting.** A county may subcontract for the performance of any of the services specified in the contract. The county's subcontracts shall include:

(a) A precise and definitive work statement including a description of the services provided;

(b) The subcontractor's specific agreement to abide by the acts and the rules;

(c) Specific authority for the secretary and the state auditor to inspect all records and other material the secretary deems pertinent to the subcontract; and agreements by the subcontractor that such records will be made available for inspection;

(d) Specific authority for the secretary to make periodic inspection of the subcontractor's program or premises in order to evaluate performance under the contract between the department and the county; and

(e) Specific agreement by the subcontractor to provide such program and fiscal data as the secretary may require.

(7) **Records: Maintenance.** Client records shall be maintained for every client for whom services are provided and shall document:

(a) Client demographic data;

(b) Diagnosis or problem statement;

(c) Treatment or service plan; and

(d) Treatment or services provided including medications prescribed.

(8) **Liability.**

(a) The promulgation of these rules or anything contained in these rules shall not be construed as affecting the relative status or civil rights or liabilities between:

(i) The county and community agency; or

(ii) Any other person, partnership, corporation, association, or other organization performing services under a contract or required herein and their employees, persons receiving services, or the public.

(b) The use or implied use herein of the word "duty" or "responsibility" or both shall not import or imply liability other than provided for by the statutes or general laws of the

state of Washington, to any person for injuries due to negligence predicated upon failure to perform on the part of an applicant, or a board established under the acts, or an agency, or said agency's employees, or persons performing services on said agency's behalf.

(c) Failure to comply with any compulsory rules shall be cause for the department to refuse to provide the county and community agency funds under the contract.

[99-19-104, recodified as § 388-850-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-030, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-030, filed 1/12/83; Order 1142, § 275-25-030, filed 8/12/76.]

WAC 388-850-030 Appeal procedure. (1) Any agency making application to participate in a county program operated under authority of the act(s), which is dissatisfied with the disposition of its application, or the community board(s) as defined in the act(s) or the community social services board, which is dissatisfied with any aspect of the plan, may appeal for a hearing before the county governing body. The county governing body shall review the appeal and notify the agency or board of its disposition within thirty days after the appeal has been received.

(2) A county which is dissatisfied with the department's disposition of its plan may request an administrative review.

(3) All requests for administrative reviews shall:

(a) Be made in writing to the appropriate program office within the department;

(b) Specify the date of the decision being appealed;

(c) Specify clearly the issue to be resolved by the review;

(d) Be signed by, and include the address of the county or its representative;

(e) Be made within thirty days of notification of the decision which is being appealed.

(4) An administrative review and redetermination shall be provided by the department within thirty days of the submission of the request for review, with written confirmation of the findings and the reasons for the findings to be forwarded to the county as soon as possible.

(5) Any county dissatisfied with the finding of an administrative review or who chooses not to request an administrative review may initiate proceedings pursuant to the Administrative Procedure Act (chapter 34.05 RCW).

[99-19-104, recodified as § 388-850-030, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234. 93-15-013 (Order 3591), § 275-25-040, filed 7/8/93, effective 8/8/93; Order 1142, § 275-25-040, filed 8/12/76.]

WAC 388-850-035 Services—Developmental disabilities. (1) A county may purchase and provide services listed under chapter 71A.14 RCW. The department shall pay a county for department authorized services provided to an eligible developmentally disabled person.

(2) A county may purchase or provide authorized services. Authorized services may include, but are not limited to:

(a) Early childhood intervention services;

(b) Employment services;

(c) Community access services;

(d) Residential services;

(e) Individual evaluation;

(f) Program evaluation;

(g) County planning and administration; and

(h) Consultation and staff development.

[99-19-104, recodified as § 388-850-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-520, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-25-520, filed 3/1/82. Statutory Authority: RCW 71.20.030, 71.20.050, and 71.20.070. 78-04-002 (Order 1278), § 275-25-520, filed 3/2/78; Order 1142, § 275-25-520, filed 8/12/76.]

WAC 388-850-040 Rights—Health and safety assured. A county, when contracting for specific services, must assure that client rights and client health and safety are protected.

[99-19-104, recodified as § 388-850-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-25-527, filed 3/1/82.]

WAC 388-850-045 Funding formula—Developmental disabilities. (1) For the purposes of this section, "county" shall mean the legal subdivision of the state, regardless of any agreement with another county to provide developmental disabilities services jointly.

(2) The allocation of funds to counties shall be based on the following criteria:

(a) Each county shall receive a base amount of funds. The amount shall be based on the prior biennial allocation, including any funds from budget provisos from the prior biennium, and subject to the availability of state and federal funds;

(b) The distribution of any additional funds provided by the legislature or other sources shall be based on a distribution formula which best meets the needs of the population to be served as follows:

(i) On a basis which takes into consideration minimum grant amounts, requirements of clients residing in an ICF/MR or clients on one of the division's Title XIX home and community-based waivers, and the general population of the county, and special education enrollment as well as the population eligible for county-funded developmental disabilities services;

(ii) On a basis that takes into consideration the population numbers of minority groups residing within the county;

(iii) A biennial adjustment shall be made after these factors are considered; and

(iv) Countries not receiving any portion of additional funds pursuant to this formula shall not have their base allocation reduced due to application of this formula.

(c) Funding appropriated through legislative proviso, including vendor rate increases, shall be distributed to the population directed by the legislature utilizing a formula as directed by the legislature or using a formula specific to that population or distributed to identified people;

(d) The ability of the community to provide funds for the developmental disability program provided in chapter 71A.14 RCW may be considered with any or all of the above.

(3) A county may utilize seven or less percent of the county's allocated funds for county administrative expenses. A county may utilize more than seven percent for county

administration with approval of the division director. A county electing to provide all services directly, in addition to county administration, is exempt from this requirement.

(4) The department may withhold five or less percent of allocated funds for new programs, for state-wide priority programs, and for emergency needs.

[99-19-104, recodified as § 388-850-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.040. 92-13-032 (Order 3404), § 275-25-530, filed 6/10/92, effective 7/11/92. Statutory Authority: RCW 71A.14.030. 91-17-005 and 91-17-025 (Orders 3230 and 3230A), § 275-25-530, filed 8/9/91 and 8/14/91, effective 9/9/91 and 9/14/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-530, filed 1/12/83; Order 1142, § 275-25-530, filed 8/12/76.]

WAC 388-850-050 Client rights—Notification of client. (1) All agencies providing services under the act shall post a statement of client rights. Such statement shall inform the client of the client's right to:

(a) Be treated with dignity;

(b) Be protected from invasion of privacy;

(c) Have information about him/her treated confidentially;

(d) Actively participate in the development or modification of his/her treatment program;

(e) Be provided treatment in accordance with accepted quality-of-care standards and which is responsive to his/her best interests and particular needs;

(f) Review his/her treatment records with the therapist at least bimonthly: Provided, That information confidential to other individuals shall not be reviewed by the client;

(g) Be fully informed regarding fees to be charged and methods for payment.

(2) Clients shall be informed of their rights pursuant to WAC 275-55-170 upon admission to inpatient service.

[99-19-104, recodified as § 388-850-050, filed 9/20/99, effective 9/20/99; Order 1142, § 275-25-755, filed 8/12/76.]

Chapter 388-853 WAC
COSTS OF CARE OF MENTALLY DEFICIENT PERSONS RESIDING IN STATE INSTITUTIONS
(Formerly chapter 275-20 WAC)

WAC

WAC 388-853-010 Authority. The following rules regarding costs of care of mentally/physically deficient persons are hereby adopted under the authority of chapter 72.33 RCW.

[00-17-151, recodified as § 388-853-010, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-20-010, filed 2/17/78; Order 2, § 275-20-010, filed 2/23/68.]

WAC 388-853-030 Schedule of per capita cost. Resident charges will be established in accordance with the methodology promulgated under chapter 275-38 WAC.

[00-17-151, recodified as § 388-853-030, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.33.660. 84-18-022 (Order 2144), § 275-20-030, filed 8/29/84. Statutory Authority: RCW 72.33.600. 83-18-028 (Order 2018), § 275-20-030, filed 8/31/83; 82-20-022 (Order 1885), § 275-20-030, filed 9/29/82; 81-17-025 (Order 1690), § 275-20-030, filed 8/12/81; 81-06-004 (Order 1611), § 275-20-030, filed 2/19/81; 80-12-011 (Order 1535), § 275-20-030, filed 8/25/80; 80-02-060 (Order 1480), § 275-20-030, filed 1/18/80; 79-08-044 (Order 1418), § 275-20-030, filed 7/19/79; 78-10-057 (Order 1341), § 275-20-030, filed 9/22/78. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-20-030, filed 2/17/78; Order 1191, § 275-20-030, filed 2/18/77; Order 1071, § 275-20-030, filed 12/2/75; Order 982, § 275-20-030, filed 11/14/74, effective 1/1/75; Order 903, § 275-20-030, filed 1/29/74; Order 808, § 275-20-030, filed 6/15/73, effective 8/1/73; Order 15, § 275-20-030, filed 5/11/71; Order 2, § 275-20-030, filed 2/23/68.]

WAC 388-853-035 Exempt income. Residents whose total resources are insufficient to pay the actual cost of care shall be entitled to a monthly exemption from income in the amount of $25 or such amount as specified in WAC 388-29-125.

[00-17-151, recodified as § 388-853-035, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-20-035, filed 2/17/78.]

WAC 388-853-080 Notice and finding of responsibility—Appeal procedure. (1) When the department determines that the estate of a resident of a state residential habilitation center is able to pay all or a portion of the monthly charges for care, support, and treatment, the department shall serve a notice and finding of responsibility (NFR) on the:

(a) Guardian of the resident's estate; or

(b) If a guardian has not been appointed, resident's spouse or parent or other person acting in a representative capacity and in possession of the resident's property, and the superintendent of the state school.

(2) When a resident is an adult and is not under a legal disability, the department shall personally serve the NFR on the resident.

(3) The NFR shall state the amount which the department determines the resident's estate is able to pay per month. The amount shall not exceed the monthly charges fixed under RCW 43.20B.420.

(4) The resident's or guardian's responsibility for payment to the department shall commence twenty-eight days after service of the NFR.

(5) The right to an adjudicative proceeding contesting the NFR is contained in RCW 43.20B.430.

(a) A financially responsible person wishing to contest the NFR shall, within twenty-eight days of receipt of the NFR:

(i) File a written application for an adjudicative proceeding showing proof of receipt with the Secretary, DSHS, Attn: Determination Officer, P.O. Box 9768, Olympia, WA 98504; and

(ii) Include in or with the application:

(A) A specific statement of the issues and law involved;

(B) The grounds for contesting the department decision; and

(C) A copy of the NFR being contested.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20B.430, this chapter, and chapter 388-08 WAC. If any provision in

this chapter conflicts with chapter 388-08 WAC, the provision in this chapter governs.

[00-17-151, recodified as § 388-853-080, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 71.05.560. 90-21-030 (Order 3083), § 275-20-080, filed 10/9/90, effective 11/9/90. Statutory Authority: RCW 34.05.220 (1)(a) and 43.20B.420. 90-04-074 (Order 2997), § 275-20-080, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 72.33.660. 79-08-044 (Order 1418), § 275-20-080, filed 7/19/79.]

Chapter 388-855 WAC

LIABILITY FOR COSTS OF CARE AND HOSPITALIZATION OF THE MENTALLY ILL

(Formerly chapter 275-16 WAC)

WAC

WAC 388-855-0010 Authority. The following rules regarding hospitalization charges are hereby adopted under the authority of Title 71 RCW.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0010, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-010, filed 3/25/81. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-16-010, filed 2/17/78; Order 1, § 275-16-010, filed 2/23/68; Emergency Rules (part), filed 1/26/68, 10/24/67, and 8/2/67.]

WAC 388-855-0015 Definitions. "Adjusted charges" are those [charges levied upon] [amounts charged to] a patient who is or has been confined to a state hospital for the mentally ill, either by voluntary or involuntary admission, and their estates and responsible relatives, which are less than the actual cost of hospitalization as reflected in the schedule of charges herein and which has been established by the issuance of a notice of finding of responsibility.

"Adjusted gross income" is that gross income of the estate of the patient and responsible relatives less any deductions, contributions or payments mandated by law including, but not necessarily limited to, income tax and social security.

"Dependent" means any spouse, minor son or daughter, or permanently disabled son or daughter, of the patient living in the patient's household. If the patient is a minor, then the same definitions shall apply in determining the dependency of members of the parent's household. If a minor son or daughter is not living in the patient's household, that son or daughter shall not be considered a dependent unless the patient is in fact contributing more than fifty percent of that child's support in accordance with a court order or court-recognized agreement.

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

"Determination officer" is that duly appointed and qualified claims investigator who is delegated authority by the secretary to conduct or cause to have conducted an investigation of the financial condition of the estate of the patient and responsible relatives; to evaluate the results of such investigations; to make determinations of the ability to pay hospitalization changes from such investigations and evaluations; and to issue notices of findings of responsibility to the responsible parties.

"Estate of patient and responsible relative" means the total assets available to the patient and his responsible relatives to reimburse the department for hospitalization charges incurred by the patient in a state hospital for the mentally ill in accordance with these regulations.

"Gross income" means the total assets available to the estate of the patient and responsible relatives expressed in terms of their cash equivalent on a monthly basis. The total assets available to the estate of the patient and responsible relatives are converted to a monthly cash equivalent figure by dividing those assets by twelve months. Gross income includes all of the following calculated prior to any mandatory deductions; gross wages for service; net earnings from self-employment; and all other assets divided by twelve months.

"Responsible relative" includes the spouse of a patient, or the parent of a patient who is under eighteen years of age.

"Secretary" means the secretary of the department of social and health services.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0015, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-015, filed 3/25/81.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-855-0030 Schedule of charges. Under RCW 43.20B.325, the department shall base hospitalization charges for patients in state hospitals on the actual operating costs of such hospitals. The department shall require patient's hospitalization charges due and payable on or before the tenth day of each calendar month for services rendered to department patients during the preceding month. A schedule of each hospital's charge rates will be computed under this section based on actual operating costs of the hospital for the previous year. The schedule will be prepared by the secretary's designee, from financial and statistical information contained in hospital records. The schedule will be updated at least annually. All changes under this section shall be prepared in advance of the effective date. Each hospital will make available the schedule of current charge rates upon request.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0030, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.325. 94-16-048 (Order 3764), § 275-16-030, filed 7/27/94, effective 8/27/94; 93-22-031 (Order 3659), § 275-16-030, filed 10/27/93, effective 11/27/93; 92-17-007 (Order 3434), § 275-16-030, filed 8/6/92, effective 9/6/92; 92-09-118 (Order 3376), § 275-16-030, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 43.20B.335. 91-21-122 (Order 3267), § 275-16-030, filed 10/23/91, effective 11/23/91; 91-17-

064 (Order 3235), § 275-16-030, filed 8/20/91, effective 9/20/91; 91-08-014 (Order 3155), § 275-16-030, filed 3/26/91, effective 4/26/91. Statutory Authority: RCW 43.20B.335 and 71.05.560. 90-18-004 (Order 3061), § 275-16-030, filed 8/23/90, effective 9/23/90. Statutory Authority: RCW 71.02.412. 89-22-128 (Order 2890), § 275-16-030, filed 11/1/89, effective 12/2/89. Statutory Authority: RCW 43.20B.335. 88-21-095 (Order 2715), § 275-16-030, filed 10/19/88. Statutory Authority: RCW 71.02.412. 87-19-026 (Order 2531), § 275-16-030, filed 9/10/87; 86-17-075 (Order 2414), § 275-16-030, filed 8/19/86; 85-17-038 (Order 2273), § 275-16-030, filed 8/15/85; 84-17-011 (Order 2131), § 275-16-030, filed 8/3/84; 83-18-029 (Order 2019), § 275-16-030, filed 8/31/83; 82-17-070 (Order 1866), § 275-16-030, filed 8/18/82; 80-06-087 (Order 1508), § 275-16-030, filed 5/28/80. Statutory Authority: RCW 72.01.090. 79-03-019 (Order 1372), § 275-16-030, filed 2/21/79; 78-03-029 (Order 1270), § 275-16-030, filed 2/17/78; Order 1190, § 275-16-030, filed 2/18/77; Order 1086, § 275-16-030, filed 1/15/76; Order 1002, § 275-16-030, filed 1/14/75; Order 947, § 275-16-030, filed 6/26/74; Order 812, § 275-16-030, filed 6/28/73; Order 14, § 275-16-030, filed 5/11/71; Order 6, § 275-16-030, filed 1/10/69; Order 1, § 275-16-030, filed 2/23/68; Emergency Rules (part), filed 1/26/68, 10/24/67, 8/2/67, and 7/28/67.]

WAC 388-855-0035 Available assets of estate of patients and responsible relatives. (1) The department will include, but not necessarily be limited to, in their determination of the assets of the estates of present and former patients of state hospitals for the mentally ill and their responsible relatives, cash, stocks, bonds, savings, security interests, insurance benefits, guardianship funds, trust funds, governmental benefits, pension benefits and personal property.

(2) Real property shall also be an available asset to the estate: Provided, That the patient's home shall not be considered an available asset if that property is owned by the estate and serves as the principal dwelling and actual residence of the patient, the patient's spouse, and/or minor children and disabled sons or daughters: Provided further, That if the home is not being used for residential purposes by the patient, the patient's spouse, and/or minor children and disabled sons or daughters, and in the opinion of two physicians, there is no reasonable expectancy that the patient will be able to return to the home during the remainder of his life, the home shall be considered an asset available to the estate.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0035, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-035, filed 3/25/81.]

WAC 388-855-0045 Exempt income. Patients whose total resources are insufficient to pay for the actual cost of care shall be entitled to a monthly exemption from income in the amount of forty-one dollars and sixty-two cents or such amount as specified in WAC 388-478-0040.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0045, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 388-16-045 (codified as WAC 275-16-045), filed 2/17/78.]

WAC 388-855-0055 Notice and finding of responsibility (NFR)—Appeal procedure. (1) The determination officer's assessment of the ability and liability of a person or of the person's estate to pay hospitalization charges shall be issued in the form of a notice and finding of responsibility (NFR) as prescribed by RCW 43.20B.340.

(2) When the NFR is for full hospitalization charges as specified under WAC 388-855-0030, the department shall:

(a) Inform the financially responsible person of the current charges; and

(b) Periodically recompute the financially responsible person's charges.

(3) When the NFR is for adjusted charges, the department shall:

(a) Express the charges in a daily or monthly rate; and

(b) Set aside charges for ancillary services.

(4) The right to an adjudicative proceeding to contest the NFR is contained in RCW 43.20B.340.

(a) A financially responsible person wishing to contest the NFR shall, within twenty-eight days of receipt of the NFR:

(i) File a written application for an adjudicative proceeding showing proof of receipt with the Secretary, DSHS, Attn: Determination Officer, P.O. Box 9768, Olympia, WA 98504; and

(ii) Include in or with the application:

(A) A specific statement of the issues and law involved;

(B) The grounds for contesting the department decision; and

(C) A copy of the contested NFR.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20B.340, this chapter, and chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0055, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 71.05.560. 90-21-030 (Order 3083), § 275-16-055, filed 10/9/90, effective 11/9/90. Statutory Authority: RCW 34.05.220 (1)(a) and 43.20B.335. 90-04-075 (Order 3001), § 275-16-055, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-055, filed 3/25/81.]

WAC 388-855-0065 Determination of liability. (1) In determining the ability of the estate of the patient and responsible relative to pay hospitalization charges, first priority shall be given to any third party benefits which might be available. The availability of third party benefits, such as medical insurance, health insurance, Medicare, Medicaid, CHAMPUS, CHAMPVA, shall be considered as an available asset of the estate and shall justify a finding for actual costs of hospitalization during such period as the coverage is in effect.

(2) In the absence of third party benefits, charges shall be based upon the available assets of the estate giving consideration to any unusual and exceptional circumstances and other pertinent factors. No financial determination of the ability of the estate to pay hospitalization charges shall conflict with the eligibility requirements for Medicaid for those patients who are eligible or potentially eligible for such benefits.

(3) The ability of the estate to pay adjusted charges will be determined by applying the following formula:

$$X = (Z\text{-}E)F$$

Where $Z = (A\text{-}Y\text{-}N\text{-}R) \div D$

Z = available income per family member

X = adjusted charges (daily)

A = gross income

Y = mandatory deductions

N = allowance for unusual and exceptional circumstances
R = allowance for other pertinent factors
D = number of dependents
E = exempt income
F = a factor which converts the monthly figures to a daily rate (.0328767).

All calculations are expressed in monthly terms except the final adjusted charge which is converted to a daily rate. All final figures are rounded out to the nearest cent.

(4) The adjusted gross income (A-Y) is determined by first developing the gross income of the estate of the patient and the responsible relative. Gross income (A) includes not only gross wages for services rendered, and/or net earnings from self-employment, but all other available assets which have been divided by twelve months to convert them to a monthly cash equivalent figure. All mandatory deductions (Y), such as income tax and social security, are deducted from the gross income to arrive at the adjusted gross income.

(5) Approved allowances for unusual and exceptional circumstances (N) and for other pertinent factors (R) are then subtracted from the adjusted gross income.

(6) The available income (A-Y-N-R) is then divided by the number of dependents in the household of the patient (D) to determine the available income per family member.

(7) Exempt income (E) as defined in WAC 388-855-0045 is then subtracted from the available income per family member to arrive at the monthly adjusted charges.

(8) The monthly adjusted charges are multiplied by the factor of .0328767 which converts the monthly figure to a daily rate.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0065, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-065, filed 3/25/81.]

WAC 388-855-0075 Unusual and exceptional circumstances. Unusual and exceptional circumstances for these purposes will cover those expenses other than usual or common; rare and extraordinary; that are of a medical nature and *must* be supplied to the patient for his health, medical or physical well being. Such expenses do not include those expenses that are reimbursable from insurance benefits or can be reasonably obtained from welfare agencies, health maintenance organizations, free clinics, or other free private or governmental sources. The existence and necessity of such unusual and exceptional circumstances must be attested to in writing, by the institution superintendent, that those expenses resulting therefrom are an integral part of the patient's treatment plan and that allowance for such circumstances is necessary for the medical and/or mental well-being of the patient. Upon such written certification, the resources necessary to meet the unusual and exceptional circumstances will not be considered as an asset available to the estate of the patient and responsible relatives for these purposes: Provided, That any such attestation by the institution superintendent must conform with the eligibility criteria of Medicaid if the patient is eligible or potentially eligible for such benefits.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0075, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-075, filed 3/25/81.]

WAC 388-855-0085 Other pertinent factors. The determination officer may consider the following other pertinent factors in determining the ability of the estate of the patient and responsible relatives to pay.

(1) The determination officer may consider those factors related to the well-being, education and training, child support obligations set by court order or by administrative finding under chapter 74.20A RCW, and/or rehabilitation of the patient and the patient's immediate family, to whom the patient owes a duty of support. The patient and/or responsible relatives shall show the existence and the necessity for the pertinent factors as defined. Upon such a showing, the determination officer may consider such resources necessary to reasonably provide for such pertinent factors as assets not available to the estate of the patient and responsible relatives.

(2) Consistent with RCW 43.20B.335, the determination officer shall consider a judgment owed by the patient to any victim of an act that would have resulted in criminal conviction of the patient but for a finding of the patient's criminal insanity. A victim shall include an estate's personal representative who has obtained judgment for wrongful death against the criminally insane patient.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0085, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.335. 96-18-090, § 275-16-085, filed 9/4/96, effective 10/5/96. 81.02.412 [71.02.412]. Statutory Authority: RCW 81-08-020 (Order 1627), § 275-16-085, filed 3/25/81.]

WAC 388-855-0095 Failure to cooperate with department. Any patient, former patient, guardian, or other responsible party or parties who, after diligent effort by the department, has been shown to have failed to cooperate with the financial investigation by the department; or fails to comply with, or ignores, departmental correspondence; or supplies false or misleading information; or willfully conceals assets or potential assets; will be subject to a determination by the department that the estate of the patient and responsible relatives has the ability to pay full hospitalization charges: Provided, That no person adjudged incompetent by a court of this state at the time of said investigation shall be penalized by his or her actions: Provided further, That such a finding of liability to pay full hospitalization charges shall in no way diminish the responsible party's right to appeal such a finding of responsibility.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0095, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-095, filed 3/25/81.]

WAC 388-855-0105 Petition for review. (1) After a finding of responsibility becomes final in accordance with RCW 43.20B.340, the responsible party may petition for a review of such findings to the secretary. The petitioner must show a substantial change in the financial ability of the estate to pay the charges in a petition for review. The burden of proof of a change in financial ability rests with the petitioner.

(2) A petition for review shall be in writing and to the following address:

Secretary, DSHS
Attn: Determination Officer
P.O. Box 9768 MS HJ-21
Olympia, WA 98504

(3) The determination officer, upon receipt of the petition for review, may conduct or cause to have conducted such investigation as may be necessary to verify the alleged changes in financial status or to determine any other facts which would bear upon the financial ability of the estate to pay.

(4) Based upon the review of the facts, the determination officer may modify or vacate the NFR under the provisions of RCW 43.20B.350.

(5) The NFR will not be modified or vacated, if such modification or vacation inflicts or causes the loss of Medicaid eligibility; jeopardizes the eligibility for other third-party benefits; or has the potential end result of diminishing or jeopardizing the recovery of hospitalization cost by the department without a clear showing of real benefit, financial or otherwise, to the patient and/or responsible relatives.

(6) Nothing herein is intended to preclude the reinvestigation and/or review of the finding of responsibility by the department of its own volition.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0105, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.335. 90-23-071 (Order 3096), § 275-16-105, filed 11/20/90, effective 12/21/90. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-105, filed 3/25/81.]

Chapter 388-860 WAC
JUVENILE INVOLUNTARY TREATMENT
(Formerly chapter 275-54 WAC)

WAC

WAC 388-860-010 Purpose. Adopted pursuant to and in accordance with chapter 354, Laws of 1985. These regulations are adopted to provide operational procedures to ensure minors in need of mental health care receive appropriate care and treatment, and to enable treatment decisions to be made in response to clinical needs and in accordance with sound professional judgment while also recognizing parents' rights to participate in treatment decisions for their minor children, and to protect minors against needless hospitalization and deprivations of liberty.

[00-23-089, recodified as § 388-860-010, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-010, filed 12/23/85.]

WAC 388-860-020 Definitions. (1) "Child psychiatrist" means a person having a license as a physician and surgeon in this state, having had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

(2) "Children's mental health specialist" means a mental health professional who has completed a minimum of one hundred actual hours, not quarter or semester hours, of specialized training devoted to the study of child development and the treatment of children and who has the equivalent of one year of full-time experience in the treatment of children under the supervision of a children's mental health specialist.

(3) "Commitment" means a determination by a judge or court commissioner, made after a commitment hearing, that the minor is in need of inpatient diagnosis, evaluation, or treatment or the minor is in need of less restrictive alternative treatment.

(4) "County-designated mental health professional" means a mental health professional designated by one or more counties to perform the functions of a county-designated mental health professional described in this chapter.

(5) "Department" means the department of social and health services.

(6) "Evaluation and treatment facility" means a public or private facility or unit certified by the department to provide emergency, inpatient, residential, or outpatient mental health evaluation and treatment services for minors. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility for minors. A facility which is part of or operated by the department or federal agency does not require certification. No correctional institution or facility, juvenile court detention facility, or jail may be an evaluation and treatment facility within the meaning of this chapter.

(7) "Evaluation and treatment program" means the total system of services and facilities coordinated and approved by

a county or combination of counties for the evaluation and treatment of minors under this chapter.

(8) "Gravely disabled minor" means a minor who, as a result of a mental disorder, is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

(9) "Inpatient treatment" means twenty-four-hour-per-day mental health care provided within a general hospital, psychiatric hospital, or residential treatment facility certified by the department as an evaluation and treatment facility for minors.

(10) "Involuntary patient" means a person presenting, as a result of a mental disorder, a likelihood of serious harm or is gravely disabled, and is initially detained and/or court-committed for evaluation and treatment.

(11) "Less restrictive alternative" or "less restrictive setting" means outpatient treatment provided to a minor not residing in a facility providing inpatient treatment as defined in this chapter.

(12) "Likelihood of serious harm" means either:

(a) A substantial risk physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;

(b) A substantial risk physical harm will be inflicted by an individual upon another, as evidenced by behavior having caused such harm or placing another person or persons in reasonable fear of sustaining such harm; or

(c) A substantial risk physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior having caused substantial loss or damage to the property of others.

(13) "Mental disorder" means any organic, mental, or emotional impairment having substantial adverse effects on an individual's cognitive or volitional functions. The presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or mental retardation alone is insufficient to justify a finding of "mental disorder" within the meaning of this section.

(14) "Mental health professional" means a person regularly involved in mental health evaluation and treatment, and qualifying as one of the following:

(a) A psychiatrist, psychologist, psychiatric nurse, or social worker.

(b) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional.

(c) A licensed physician permitted to practice medicine or osteopathy in the state of Washington.

(d) A person otherwise qualified to perform the duties of a mental health professional but does not meet the requirements listed in subsection (14)(a), (b), or (c) of this section, where an exception to such requirements has been granted by the director upon submission of a written request by the county involved, such request to document the following:

(i) The extent to which the county has made an effort to provide and has the capability of providing a mental health professional;

(ii) The amount and type of employment experience the applicant possesses. Such an applicant shall have had at least three years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional, as defined under subsection (14)(a), (b), or (c) of this section;

(iii) The overall needs of the mental health program in the particular county involved; and

(iv) Such factors as shall be brought to the attention of the director by the county involved.

(15) "Minor" means any person under the age of eighteen years.

(16) "Outpatient treatment" means any of the nonresidential services mandated under chapter 71.24 RCW and provided by licensed services providers as identified by RCW 71.24.025(3).

(17) "Parent" means:

(a) A biological or adoptive parent having legal custody of the child, including either parent if custody is shared under a joint custody agreement; or

(b) A person or agency judicially appointed as legal guardian or custodian of the child.

(18) "Professional person in charge" means a physician or other mental health professional empowered by an evaluation and treatment facility with authority to make admission and discharge decisions on behalf of that facility.

(19) "Psychiatric nurse" means a registered nurse having a bachelor's degree from an accredited college or university, and having had, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse having three years of such experience.

(20) "Psychiatrist" means a person having a license as a physician in this state having completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

(21) "Psychologist" means a person licensed as a psychologist under chapter 18.83 RCW.

(22) "Responsible other" means the minor, the minor's parent or estate, or any other person legally responsible for support of the minor.

(23) "Secretary" means the secretary of the department or secretary's designee.

(24) "Social worker" means a person with a masters or further advanced degree from an accredited school of social work or a degree from a graduate school deemed equivalent under rules and regulations adopted by the secretary.

(25) "Start of initial detention" means the time of arrival of the minor at the first evaluation and treatment facility offering inpatient treatment if the minor is being involuntarily detained at the time. With regard to voluntary patients,

"start of initial detention" means the time at which the minor gives notice of intent to leave under the provisions of this chapter.

(26) "State-funded facility" means those long-term inpatient hospital or residential facilities receiving state funds to pay part or all of the cost of care for juveniles under one hundred eighty-day commitment and placed in these facilities by the placement committee.

[00-23-089, recodified as § 388-860-020, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-020, filed 12/23/85.]

WAC 388-860-030 Application for admission—Voluntary minor. (1) Outpatient - Any minor thirteen years or older may request and receive outpatient treatment without the consent of the minor's parents. Parental authorization is required for outpatient treatment of a minor under the age of thirteen.

(2) Inpatient - When in the judgment of the professional person in charge of an evaluation and treatment facility it is not feasible to treat a minor in a less restrictive setting and the minor is in need of inpatient treatment because of a mental disorder, and the facility provides the type of evaluation and treatment services needed by the minor, the minor may be voluntarily admitted to an evaluation and treatment facility in accordance with the following requirements:

(a) A minor under thirteen years of age may only be admitted on the application of the minor's parents.

(b) A minor thirteen years or older may be voluntarily admitted by application of the parent. Such application must be accompanied by the written consent, knowingly and voluntarily given, of the minor.

(c) A minor thirteen years or older may, with concurrence of the professional person in charge of the evaluation and treatment facility, admit himself or herself without parental consent to the evaluation and treatment facility. Notice must be given by the facility to the minor's parents in accordance with the following requirements:

(i) Notice shall be in the form most likely to reach the parent within twenty-four hours of the minor's voluntary admission for inpatient treatment.

(ii) The notice must contain the location and telephone number of the facility providing such treatment and the name of the professional person on the staff of the facility providing that treatment who is designated to discuss the minor's need for inpatient treatment with the parent.

(iii) The minor shall be released to the parent, at the parent's request, unless the facility files a petition with the court requesting authorization to provide voluntary treatment to the minor, and setting forth the basis for the facility's belief that the minor is in need of inpatient treatment and that release would constitute a threat to the minor's health or safety.

(iv) The petition shall be signed by the professional person in charge and shall contain the following:

(A) The name and address of the petitioner.

(B) The name of the minor whose release is alleged to constitute a threat to the minor's health or safety.

(C) The name, telephone number, and address if known of every person believed by the petitioner to be legally responsible for the minor.

(D) A statement and the supporting facts for this statement that the petitioner has examined the minor and finds the minor in need of inpatient treatment and that release would constitute a threat to the minor's health or safety.

(E) A statement that the minor has been advised of the need for inpatient treatment and knowingly and voluntarily consented to such treatment.

(F) A statement concerning whether a less-restrictive alternative is available or is in the best interest of the minor.

(v) A copy of the petition shall be personally delivered to the minor and a copy shall be sent to the minor's attorney and the minor's parents.

(vi) The hearing shall be heard within three judicial days from the filing of the petition, and shall be conducted by a judge, court commissioner, or licensed attorney designated by the superior court as a hearing officer for such hearing. The hearing may be held at the treatment facility. The petition shall be presented by the prosecuting attorney.

(vii) The facility must demonstrate at the hearing by a preponderance of the evidence presented that the minor is in need of inpatient treatment and that release would constitute a threat to the minor's health or safety, and that the minor has knowingly and voluntarily consented to treatment.

(viii) The hearing shall not be conducted using rules of evidence. The admission or exclusion of evidence sought to be presented shall be within the exercise of sound discretion by the judicial officer conducting the hearing.

(ix) The parent and child may apply to the court for separate counsel to represent the parent if the parent cannot afford counsel.

(x) If by the preponderance of evidence the minor is found to be in need of inpatient treatment and that release would constitute a threat to the minor's health or safety, and that the minor's parent refuses to give parental consent for such treatment, and that the minor has knowingly and voluntarily consented to treatment, the petition shall be approved. The parent, then, will not have the right to demand immediate release until the next renewal of voluntary admission.

(d) The minor's need for continued inpatient treatment shall be reviewed and documented at least each one hundred eighty days.

(e) Written renewal of voluntary consent must be obtained from the applicant and the minor thirteen years or older no less than once every twelve months.

(f) A notice by a voluntary minor of intent to leave shall result in the following:

(i) Any minor under the age of thirteen must be discharged immediately upon written request of the parent.

(ii) Any minor thirteen years or older may give notice of intent to leave at any time. The notice need not follow any specific form so long as it is written and the intent of the minor can be discerned.

(iii) The staff member receiving notice shall date it immediately, record its existence in the minor's clinical record, and send copies of it to the minor's attorney, if any, the county-designated mental health professional, and the parent.

(iv) In the case of a minor thirteen years or older, the professional person in charge of the evaluation and treatment facility shall discharge that minor from the facility within

twenty-four hours upon receipt of the minor's notice of intent to leave, unless the county-designated mental health professional serves on the minor a copy of a petition for initial detention, a notice of initial detention, and a statement of rights. The county-designated mental health professional shall file the original petition for initial detention with the court on the next judicial day following the minor's notice of intent to leave.

[00-23-089, recodified as § 388-860-030, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-030, filed 12/23/85.]

WAC 388-860-040 Emergency detention. (1) When a minor, thirteen years of age or older, is brought to an evaluation and treatment facility or emergency room for immediate mental health services, the professional person in charge of the facility shall:

(a) Evaluate the minor's mental condition to determine whether the minor suffers from a mental disorder and is in immediate need of inpatient treatment.

(b) Determine if the minor is willing to consent to voluntary admission.

(2) If the minor is unwilling to consent to voluntary admission and the professional person in charge believes the minor meets the criteria for initial detention, the facility may detain or arrange for the detention of the minor for up to twelve hours in order to enable the county-designated mental health professional to evaluate the minor and commence initial detention proceedings.

[00-23-089, recodified as § 388-860-040, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-040, filed 12/23/85.]

WAC 388-860-050 Investigation and involuntary detention. (1) When a county-designated mental health professional receives information that a minor thirteen years or older, as a result of mental disorder, presents a likelihood of serious harm or is gravely disabled, and has investigated the specific facts and the credibility of the person or persons providing the information, and has determined voluntary admission for inpatient treatment is not possible, the county-designated mental health professional may take or cause the minor to be taken into custody and transported to an evaluation and treatment facility providing inpatient treatment.

(2) Within twelve hours of the minor's arrival at that facility, the minor shall be served with a copy of the petition for initial detention, notice of initial detention, and a statement of rights.

(3) On the next judicial day following the initial detention, the county-designated mental health professional shall file with the court the original petition for initial detention, the notice of initial detention, and the statement or rights along with an affidavit of service, and shall commence service of the petition for initial detention on the minor's parents and minor's attorney.

(4) At the time of initial detention, the county-designated mental health professional shall advise the minor both orally and in writing that a commitment hearing shall be held within seventy-two hours of the minor's provisional acceptance to the facility. Within twelve hours of the admission, the facility shall advise the minor of his or her rights, including the fact the minor has the right to communicate immediately with an attorney and the minor has a right to have an attorney appointed to represent him or her before and at the hearing if the minor is indigent.

(5) The evaluation and treatment facility must immediately accept on a provisional basis the petition and the minor and within twenty-four hours must conduct an initial evaluation of the minor's condition and either admit or release the minor. If the minor is not approved for admission, the facility shall make such recommendations and referrals for further care and treatment of the minor as necessary.

(6) If the minor is approved for inpatient admission, the minor shall be examined and evaluated by a children's mental health specialist or other mental health professional, identified in WAC 275-54-170 (2)(e), within twenty-four hours of admission to determine the child's mental condition and by a physician to determine the child's physical condition. Reasonable measures shall be taken to ensure medical treatment is provided for any condition requiring immediate medical attention.

(7) The admitting facility shall take reasonable steps to notify immediately the minor's parents of the admission. The minor has the right to associate or receive communications from parents or others unless the professional person in charge determines such communication would be seriously detrimental to the minor's condition or treatment and so indicates in the minor's clinical records and notifies the minor's parents of this determination. In no event may the minor be denied the opportunity to consult an attorney.

(8) The minor's property shall be protected in accordance with the following:

(a) Articles brought to the facility shall be inventoried and articles not kept by the patient shall be housed by the facility giving due regard to reasonable precautions necessary to safeguard such property.

(b) The peace officer or mental health professional escorting the patient to the facility shall take reasonable precautions to safeguard the property of the patient in the immediate vicinity of the point of apprehension.

(c) Reasonable precautions shall be taken to safeguard belongings not in the immediate vicinity of the patient by the escorting officer or mental health professional, and/or facility when notice of possible danger thereto is received. Further, reasonable precautions shall be taken to lock and otherwise secure the domicile of the patient as soon as possible after the patient's initial detention.

(9) The facility may detain the minor for evaluation and treatment for a period not to exceed seventy-two hours from the time of provisional acceptance. The seventy-two-hour period shall exclude Saturdays, Sundays, or holidays. At the expiration of this time period the minor must be released unless a fourteen-day petition has been filed or the minor's good-faith application for voluntary treatment is accepted.

[00-23-089, recodified as § 388-860-050, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-050, filed 12/23/85.]

WAC 388-860-060 Fourteen-day commitment petition. (1) The professional person in charge of an evaluation

and treatment facility may petition to have a minor committed for fourteen days of diagnosis, evaluation, and treatment. The petition must be filed within the seventy-two-hour initial detention period with the superior court in the county where the minor is residing or being detained.

(2) This petition shall be signed either by two physicians or by one physician and a mental health professional examining the minor, and it shall contain the following:

(a) The name and address of the petitioner.

(b) The name of the minor alleged to meet the criteria for fourteen-day commitment.

(c) The name, telephone number, and address if known of every person believed by the petitioner to be legally responsible for the minor.

(d) A statement and the supporting facts for this statement that the petitioner has examined the minor and finds the minor's condition meeting required criteria for fourteen-day commitment.

(e) A statement the minor has been advised of the need for but has been unwilling or unable to consent to voluntary treatment.

(f) A statement recommending the appropriate facility or facilities for this commitment.

(g) A statement concerning whether a less-restrictive alternative is available or is in the best interest of the minor.

(3) A copy of the petition shall be personally delivered to the minor and a copy shall be sent to the minor's attorney and the minor's parents.

[00-23-089, recodified as § 388-860-060, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-060, filed 12/23/85.]

WAC 388-860-070 Fourteen-day commitment—Hearing. (1) A fourteen-day commitment hearing shall be held within seventy-two hours from the minor's provisional acceptance. Seventy-two hours does not include Saturdays, Sundays, or legal holidays. The hearing shall be conducted at the superior court, or an appropriate place at the facility, in the county where the minor is being detained.

(a) At such hearing the court must find by preponderance of the evidence the minor has a mental disorder, presents a likelihood of serious harm or is gravely disabled, is in need of inpatient treatment of the type provided by the recommended facility, or is in need of less-restrictive alternative treatment found to be in the best interests of the minor, and the minor is unwilling or unable in good faith to consent to voluntary treatment.

(b) Rules of evidence shall not apply in fourteen-day commitment hearings.

(c) The judicial officer may exercise discretion regarding the admission or exclusion of evidence.

(d) This hearing shall be held within seventy-two hours unless a continuance is requested by the minor or the minor's attorney. The court may, for good cause, transfer the proceeding to the county of the minor's residence, or to the county in which the alleged conduct evidencing need for commitment occurred. If the county of detention is changed, subsequent petitions may be filed in the county in which the minor is detained without the necessity of a change of venue.

(e) Evidence in support of the petition shall be presented by the county prosecutor.

(f) The minor shall be present at the hearing unless the minor, with the assistance of the minor's attorney, waives the right to be present.

(g) If the parents are opposed to the petition, they may be represented at the hearing and shall be entitled to a court-appointed counsel if they are indigent.

(2) At the commitment hearing, the minor shall have the following rights:

(a) To be represented by an attorney.

(b) Present evidence on his or her behalf.

(c) To question persons testifying in support of the petition.

(d) If the minor has received medication within twenty-four hours of the hearing, the court shall be informed of that fact and the probable effects of the medication.

(3) If the court finds a less-restrictive alternative is in the best interests of the minor, the court shall order less-restrictive alternative treatment upon conditions as necessary.

(4) If the court determines the minor does not meet the criteria for a fourteen-day commitment, the minor shall be released.

(5) A minor having been committed for fourteen days shall be released at the end of that period unless a petition for a one hundred eighty-day commitment is pending before the court.

[00-23-089, recodified as § 388-860-070, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-070, filed 12/23/85.]

WAC 388-860-080 One hundred eighty-day petition, hearing, and commitment. (1) At any time during the minor's fourteen-day commitment, the professional person in charge may petition the court for an additional one hundred eighty-day period of treatment. If this professional person is in charge of a facility other than a state-operated facility, then the evidence in support of the petition shall be presented by the county prosecutor. If the professional person in charge is employed by the state-operated facility, the evidence shall be presented by the attorney general.

(2) The petition for one hundred eighty-day commitment shall contain the following:

(a) The name and address of the petitioner or petitioners.

(b) The name of the minor alleged to meet the criteria for one hundred eighty-day commitment.

(c) A statement the petitioner is the professional person in charge of the facility responsible for the treatment of the minor.

(d) The date of the fourteen-day commitment order.

(e) A summary of the facts supporting the petition.

(f) Affidavits which describe in detail the behavior of the detained minor which supports the petition and shall state whether a less-restrictive alternative to inpatient treatment is in the best interest of the minor shall be signed by two examining physicians, one of whom shall be a child psychiatrist, or by one examining physician and one children's mental health specialist.

(3) The petition shall be filed with the clerk of the court at least three days before the expiration of the fourteen-day commitment period.

(4) The hearing shall be conducted at the superior court, or an appropriate place at the facility in the county where the minor is being detained. The court may, for good cause, transfer the proceeding to the county of the minor's residence or to the county where the alleged conduct evidencing need for commitment occurred. If the county of detention is changed, subsequent petition may be filed in the county where the minor is detained without the necessity of a change of venue.

(5) The petitioner shall serve a copy of the petition on the minor and notify the minor's attorney and the minor's parent within twenty-four hours of filing. A copy of the petition shall be provided to the minor's attorney and the minor's parent at least twenty-four hours prior to the hearing.

(6) At the time of the filing, the court shall set a hearing date which is to be within seven days of filing of the petition.

(7) The court may continue the hearing for not more than ten days upon the written request of the minor or the minor's attorney. The minor or the parents shall be afforded the same rights as in a fourteen-day commitment hearing. Treatment of the minor shall continue pending the proceeding.

(8) The court must find by clear, cogent, and convincing evidence the minor is suffering from a mental disorder and presents a likelihood of serious harm or is gravely disabled and is in need of further treatment that only can be provided in a one hundred eighty-day commitment.

(9) If the court finds the minor meets the criteria for continued commitment, and a less-restrictive alternative is not appropriate or available, the court may order the minor committed for further inpatient treatment to:

(a) A private evaluation and treatment facility if the minor's parents have assumed responsibility for payment of such treatment;

(b) The custody of the secretary if placement in a state-funded program is required.

(10) If the court finds a less-restrictive alternative is in the best interest of the minor, the court shall order less-restrictive alternative treatment upon conditions as necessary.

(11) If the minor does not meet the criteria for continued commitment, the minor shall be released.

(12) Successive one hundred eighty-day commitments are permissible on the same grounds under the same procedures as the original one hundred eighty-day commitment. Such petitions shall be filed at least five days prior to the expiration of the previous one hundred eighty-day commitment order.

[00-23-089, recodified as § 388-860-080, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-080, filed 12/23/85.]

WAC 388-860-090 Detention and commitment after eighteenth birthday. No minor may be detained or committed under chapter 354, Laws of 1985 after his or her eighteenth birthday unless commitment procedures under chapter 71.05 RCW have been initiated: Provided, That a minor may be detained after his or her eighteenth birthday for the purpose of completing the fourteen-day diagnosis, evaluation, and treatment.

[00-23-089, recodified as § 388-860-090, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-090, filed 12/23/85.]

WAC 388-860-100 Transfer from juvenile correctional institutions. (1) Any person committed to or confined in any juvenile correctional institution and determined to be in need of observation, diagnosis, or treatment in an inpatient evaluation and treatment facility may be transferred or moved to such facility by the secretary or the secretary's designee upon written authorization for a period of up to fourteen days, Provided, That:

(a) The secretary notifies the original committing court of the transfer.

(b) The inpatient evaluation and treatment facility is in agreement with the transfer.

(2) No minor transferred under the provisions of this section may be detained in an inpatient evaluation and treatment facility for more than fourteen days unless the minor is admitted as a voluntary patient or is committed for one hundred eighty-day treatment in accordance with provisions of WAC 275-54-030 and 275-54-080, or ninety-day treatment under chapter 71.05 RCW if eighteen years of age or older.

(3) Underlying jurisdiction of minors transferred, admitted, or committed under this section remains with the state correctional institutions.

(4) If a voluntarily admitted minor or minor committed under this section is no longer in need of the treatment provided by the facility or no longer meets the criteria for one hundred eighty-day commitment, the minor shall be returned to the state correctional institution to serve the remaining time of the underlying dispositional order or sentence.

(5) Time spent by the minor at the evaluation and treatment facility shall be credited toward the minor's juvenile court sentence.

[00-23-089, recodified as § 388-860-100, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-100, filed 12/23/85.]

WAC 388-860-110 Conditional release or early discharge. (1) The professional person in charge of the inpatient facility may authorize the minor's release under such conditions as appropriate. Conditional release may be revoked pursuant to WAC 275-54-150 if release conditions are not met or the minor's functioning substantially deteriorates.

(2) Minors may be discharged prior to the expiration of the commitment period if the treating physician or the professional person in charge concludes the minor no longer meets commitment criteria.

(3) Whenever the minor is conditionally released or discharged prior to the expiration of the commitment, the professional person in charge shall within three days of the conditional release or discharge notify the court and the placement committee, in the case of one hundred eighty-day commitment, in writing of the release.

[00-23-089, recodified as § 388-860-110, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-110, filed 12/23/85.]

WAC 388-860-120 Release of voluntary/involuntary minors to the custody of parents. (1) The facility shall release the minor to the custody of the minor's parent or other responsible person authorized by the parent to take custody of the minor. If the parent refuses to accept custody of the released minor, or to designate and authorize another responsible person to take custody of the minor on their behalf, the minor shall be referred and released to the appropriate juvenile authority for necessary dependency action. The facility shall furnish transportation for the minor to the minor's residence or other appropriate place.

(2) If the minor is released to someone other than the minor's parent, the facility shall make every effort to notify the minor's parents of the release as soon as possible.

(3) No indigent minor may be released to a less-restrictive alternative or discharged from inpatient treatment without suitable clothing. As funds are available from the department, these may be used to provide necessary funds for the immediate welfare of the indigent minor upon discharge. The superintendent of the state hospital in the releasing facility's catchment area should be contacted for prior approval of such funds for these needs.

[00-23-089, recodified as § 388-860-120, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-120, filed 12/23/85.]

WAC 388-860-130 Elopement of minors. In the event of a minor's elopement from an evaluation and treatment facility, the professional person in charge shall immediately notify parents and appropriate law enforcement agencies.

[00-23-089, recodified as § 388-860-130, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-130, filed 12/23/85.]

WAC 388-860-140 Long-term placement—Designated placement committee. (1) The secretary's placement authority shall be exercised through a designated placement committee composed of children's mental health specialists and established in accordance with chapter 354, Laws of 1985.

(2) The secretary shall appoint membership of the placement committee, at least one of whom shall be a child psychiatrist representing one of the state-funded, long-term evaluation and treatment facilities for minors.

(3) The committee's responsibilities shall include:

(a) The committee shall accept immediately, authorize, and effect placement of any minor committed to the secretary for one hundred eighty-day inpatient treatment in the most appropriate state-funded, long-term evaluation and treatment facility. Placement criteria shall include:

(i) The treatment needs of the minor;

(ii) The most appropriate facility able to respond to the minor's treatment needs;

(iii) The geographic proximity of the facility to the minor's family and home community;

(iv) The immediate availability of bed space;

(v) The probable impact of the minor's placement on other residents.

(b) The committee shall approve or deny requests from the state-funded facilities for transfer of a minor between facilities.

(c) Develop, maintain, and update policies and procedures to carry out the provisions of this section. Such policies and procedures shall be reviewed and approved by the mental health division.

(d) Receive and monitor reports and make such appropriate recommendations to the mental health division as may be necessary concerning needed individual patient or program corrective action. Such reports shall include:

(i) Individual patient status reports, at a minimum providing information concerning the minor's individual treatment plan and progress, recommendations for future treatment, anticipated discharge date, and possible less-restrictive treatment.

(ii) Incident reports covering such events as will be required by the placement committee's policies and procedures.

(iii) Individual patient discharge summaries.

(iv) Program utilization information as identified in the placement committee's policies and procedures.

(4) The responsibilities of the professional person in charge of the long-term state-funded inpatient evaluation and treatment facilities shall include:

(a) Establish policies, procedures, and practices assuring compliance with the provisions of this WAC.

(b) Provide the array and quality of evaluation and treatment services needed to respond to the needs of the minor in accordance with the provisions of WAC 275-54-200.

(c) Notify the court, the placement committee, and all responsible others of any major change in the minor's status and make such notification within three days of the date of any change in legal status, conditional release, or discharge.

(d) Provide the placement committee within ninety days of admission and at least one hundred eighty days thereafter with a report setting forth such facts as the committee requires, including the minor's individual treatment plan and progress, recommendations for future treatment, recommendations regarding less-restrictive treatment, and anticipated discharge date.

(e) Provide the placement committee with incident reports, discharges, program utilization information, and such other reports and information as may be specified in the placement committee policies and procedures.

(5) The placement committee shall provide the facility at the time of the minor's placement with formal written notification of placement. Such notification shall include authorization of the professional person in charge of the facility to carry out the secretary's responsibility for the care and custody of the minor and authorization to request the assistance of law enforcement agencies to return the minor in case of elopement.

(6) Any minor committed to the secretary shall remain at the treatment facility where the minor was held at the time of the commitment hearing, in accordance with the provisions of applicable mental health division issuance. The department's placement committee will be notified within twenty-four hours of the commitment to the secretary by the facility holding the minor.

(7) The committee will advise the treating facility as to the committee's requirements for information about the minor that will allow the committee to make a decision concerning placement of that minor.

[00-23-089, recodified as § 388-860-140, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-140, filed 12/23/85.]

WAC 388-860-150 Revocation of a less-restrictive alternative treatment or conditional release. (1) If a minor is failing to adhere to the conditions of the court-ordered less-restrictive alternative treatment or the stipulations of a conditional release or if substantial deterioration of a minor's functioning has occurred, the county-designated mental health professional or the secretary may order the minor be taken into custody and transported to an inpatient evaluation and treatment facility.

(2) An order of apprehension and detention shall be filed by the county-designated mental health professional or the secretary, and it shall be served upon the minor who shall, at the time of the service, be informed of the right to a hearing and to representation by an attorney. The minor's parent and attorney shall be notified of the detention within two days of return.

(3) The county-designated mental health professional or secretary may modify or rescind the order of apprehension and detention at any time prior to the hearing.

(4) A petition for revocation of a less-restrictive alternative treatment shall be filed by the county-designated mental health professional or the secretary with the same court that ordered such placement. A petition for revocation of a conditional release may be filed in either the county originally ordering inpatient treatment or in the county where the minor is presently residing.

(5) In either case, as identified in subsection (4) of this section, upon motion for good cause, the hearing may be transferred to the county where the minor resides or where the alleged violations occurred. The minor may waive the hearing and be returned to inpatient treatment or to less-restrictive alternative placement or conditional release on the same or modified grounds.

(6) The petition for revocation of less-restrictive alternative treatment or conditional release shall describe the behavior of the minor indicating violation of the conditions or deterioration of routine functioning and dispositional recommendations.

(7) The hearing shall be held within seven days of the minor's return and shall determine the following:

(a) Whether the minor adhered to the conditions of the less-restrictive placement or conditional release.

(b) Whether the minor's routine functioning has substantially deteriorated.

(c) Whether the conditions of less-restrictive placement or conditional release should be modified or if the minor should be returned to inpatient treatment.

(8) If the court decides the minor is to be returned to inpatient treatment, the secretary's placement responsibility as set forth in WAC 275-54-140 shall apply.

[00-23-089, recodified as § 388-860-150, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-150, filed 12/23/85.]

WAC 388-860-160 Requirements for certifying evaluation and treatment components for minors. (1) Each county or Regional Support Network shall develop and coordinate an evaluation and treatment program consistent with chapter 354, Laws of 1985 and chapter 71.24 RCW. Such program shall include, but is not limited to components of outpatient services, emergency services, and short-term inpatient services. The county or Regional Support Network may provide one or more of these components directly. The county or Regional Support Network may also contract or have a written agreement with one or more agencies to provide each component in its entirety. Component or components obtained on this basis from an agency or agencies shall be subject to all applicable provisions of these rules and of chapter 354, Laws of 1985. The county or Regional Support Network will maintain coordination responsibility over the program.

Any contract or agreement between county or Regional Support Network and agencies, or between two or more agencies, shall be required to comply with the standards for evaluation and treatment components. In addition, each contract or agreement shall indicate the department will consider those standards in the department's site visit and certification procedure as directed by WAC 275-54-210.

(2) In addition to the responsibilities specified, the following shall be required of the county or Regional Support Network or of such individual designated by the county as administrator of the evaluation and treatment program to:

(a) Identify, recommend to the department for certification, and coordinate the various facilities and components of the evaluation and treatment program;

(b) Assist the department in ensuring facilities and components are in compliance with all applicable rules and regulations set forth in chapter 354, Laws of 1985 and this chapter; and

(c) Make periodic reviews of a certified component consistent with county procedures.

(3) Any agency desiring certification of a component or components in order to become an evaluation and treatment facility shall make application for such to the county or Regional Support Network administrator of the evaluation and treatment program.

(4) The department is responsible for certifying each component of an agency desiring to become an evaluation and treatment facility. Upon formal request of the county-designated administrator of the evaluation and treatment program, the department may:

(a) Inspect and evaluate the applicant agency's component or components for certification in accordance with the provisions of WAC 275-54-210.

(b) Conduct on-site visits for the purposes of certification including, where possible, the county or Regional Support Network administrator of the evaluation and treatment program as part of the site visit team.

(5) All facilities shall be recognized elements of the county or Regional Support Network mental health plan. The

plan shall list the agencies for which certification is requested and the components to be provided by each. The plan shall also specify the method whereby components will be coordinated when more than one agency provides evaluation and treatment services, and the method whereby the services of the facility will be coordinated with other elements of the mental health program.

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WAC 388-860-170 Certification standards for evaluation and treatment program for minors. (1) The following general requirements shall apply to any agency desiring certification as a component or components of the evaluation and treatment program:

(a) The spectrum of evaluation and treatment services provided by the agency shall include at least one of the following:

(i) Outpatient.

(ii) Emergency.

(iii) Inpatient.

(b) The agency may directly provide one or more of the components specified in subsection (1)(a) of this section, or may indirectly provide one or more through contractual arrangement or agreements with other agencies. Such arrangements shall be set forth in WAC 275-54-160.

(c) The agency shall maintain a written statement describing the organizational structure and objectives. The statement shall include contractual affiliates (if any).

(d) The agency shall document and otherwise ensure:

(i) Care for patients is provided in a therapeutic environment.

(ii) Patient rights as described in WAC 275-54-290 is incorporated into this environment.

(iii) The use of a less restrictive treatment alternative is considered for each patient at the time of detention, admission, discharge, and development of fourteen- and one hundred eighty-day petitions.

(iv) Continuity of care, coordination, and integration of services is provided.

(v) Referral services and assistance in obtaining supportive services appropriate to treatment are provided to each patient.

(e) The agency desiring certification of the agency's component or components shall make application for such certification pursuant to WAC 275-54-160.

(2) In addition to the requirements specified for each in WAC 275-54-180, 275-54-190, and 275-54-200, the following general requirements shall apply to all facilities:

(a) In general, adults and minors shall be provided services separate from one another, wherever possible. Joint use by adults and minors of a facility's inpatient services is permitted only if the minor's clinical record contains documentation that:

(i) The anticipated effects of such joint use on the minor have been considered by the professional staff, and

(ii) A professional judgment has been made that such joint use will not be deleterious to the minor. No minor shall be placed on an adult inpatient unit unless no other alternative is available, or an emergency exists, and documentation has been made pursuant to subsection (2) of this section.

(b) Treatment plan and clinical record. All components shall:

(i) Maintain, for each patient, a plan of treatment, and a plan for discharge including a plan for follow-up where appropriate. The treatment plan shall address the needs identified in the admission evaluation of the minor. Such treatment and discharge plans shall be entered in the patient's clinical record as appropriate.

(ii) Maintain, for each patient, a clinical record containing sufficient information to justify the diagnosis, delineate the individual treatment plan, and document the course of treatment. The responsibility of the agency is to safeguard the record against loss, defacement, tampering, or use by unauthorized persons.

(c) Evaluation and treatment services provided to minors shall be provided by:

(i) A child mental health specialist, as defined by WAC 275-54-020(2), or

(ii) A mental health professional, as defined by WAC 275-54-020(14) directly supervised by a child mental health specialist, or

(iii) A mental health professional receiving at least one hour per week of clinical consultation from a child mental health specialist for each involuntarily detained minor provided direct client services during the week.

(d) Treatment. The evaluation and treatment program shall:

(i) Provide family therapy as needed.

(ii) Have available, as needed, professional personnel including, but not limited to, a licensed physician and a mental health professional.

(iii) Ensure each patient has access to necessary medical treatment emergency life-sustaining treatment, and medication.

(iv) Have psychiatric consultation available to other physicians or mental health professionals when treatment is not provided by or under the supervision of a psychiatrist.

(e) Use of restraints and seclusion. The use of medication, physical restraints, or locked seclusion rooms in response to assaultive, self-destructive, or unruly patient behavior shall occur only to the extent necessary to ensure the safety of patients and staff, and subject to the following conditions:

(i) In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour and shall authorize the restraints or seclusion.

(ii) No patient shall be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. Such patient must be directly observed every fifteen minutes and the observation recorded in the patient's clinical record.

(iii) If restraint or seclusion exceeds twenty-four hours, patient shall be examined by a licensed physician. The facts determined by his or her examination and any resultant decision to continue restraint or seclusion over twenty-four hours shall be recorded in the patient's clinical record over the signature of the authorizing physician. This procedure must be

repeated for each subsequent twenty-four hour period of restraint or seclusion.

(f) Periodic evaluation. Each involuntary patient shall be evaluated periodically for release from commitment. Such evaluation shall occur at least weekly for fourteen-day commitments, at least monthly for one hundred eighty-day commitments, and documented in each involuntary patient's clinical record.

(g) Training. All components shall develop an inservice training plan and provide regular training to all clinical personnel having responsibility for any aspect of patient care. Documentation of the type and amount of training received by staff members shall be maintained. Such training shall include information about:

(i) The availability and utilization of less restrictive alternatives.

(ii) Methods of patient care.

(iii) Managing assaultive and self-destructive behavior.

(iv) The provisions and requirements of this chapter and chapter 354, Laws of 1985 and standards and guidelines promulgated by the department.

(v) Other appropriate subject matter.

(h) Administration. All components shall:

(i) Maintain written procedures for managing assaultive and/or self-destructive patient behavior, and assure staff has access to and are familiar with these procedures.

(ii) Maintain adequate fiscal accounting records.

(iii) Prepare and submit such reports as are required by the secretary.

(iv) Maintain a procedure for collection of fees and third-party payments.

(3) Whenever a component is also subject to licensure under other federal or state statutes or regulations, the more restrictive standard shall apply.

[00-23-089, recodified as § 388-860-170, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 34.04.020. 87-19-070 (Order 2535), § 275-54-170, filed 9/16/87. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-170, filed 12/23/85.]

WAC 388-860-180 Outpatient component. (1) The outpatient component is defined as a setting where evaluation and treatment services are provided on a regular basis to patients. These services are intended to stabilize, sustain, and facilitate recovery of the individual within his or her living setting. Services shall be provided directly by a licensed physician licensed pursuant to chapter 18.57 or 18.71 RCW, a psychologist licensed pursuant to chapter 18.83 RCW, a psychiatric nurse licensed pursuant to chapter 18.88 RCW, or by an agency licensed pursuant to chapter 71.24 RCW and chapter 275-54 WAC.

(2) In addition to the general requirements stated in WAC 275-54-170, the following requirements shall apply to all outpatient components:

(a) Such component shall provide a therapeutic program including, but not limited to, at least one of the following:

(i) Individual therapy.

(ii) Group therapy.

(iii) Family/marital therapy.

(iv) Medication management.

(v) Case management.

(b) Such component shall provide treatment to each patient under the supervision of a mental health professional.

(c) Each patient should be seen at least weekly by assigned staff during the period of involuntary treatment. A mental health professional must review each outpatient case at least monthly to ensure updating of the treatment plan and such review must be recorded in the patient's clinical record. The frequency of patient contact and case review may be modified if in the opinion of a mental health professional such is warranted and the reasons for so doing are recorded in the patient's clinical record.

(d) Such component must have access to consultation by a psychiatrist or a physician with at least one year's experience in the direct treatment of mentally ill or emotionally disturbed persons.

(e) Such component shall include medical consultation with the involuntary patient to assess and prescribe psychotropic medication to meet the needs of the patient. Such consultation shall occur at least weekly during the fourteen-day period, and monthly during the one hundred eighty-day period of involuntary treatment unless determined otherwise by the attending physician and the reasons for so doing are recorded in the patient's clinical record.

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WAC 388-860-190 Emergency component. (1) The emergency component is defined as a public or private agency or hospital having the capacity to detain an individual posing an imminent threat to the safety and/or well-being of self, or others, or is gravely disabled.

(2) The department may upon the formal request of the county or Regional Support Network accept a hospital licensed under WAC 246-318-280 or 246-322 as a certified emergency component for an evaluation and treatment program, in lieu of requiring a hospital to meet the requirements set forth by WAC 275-54-170, 275-54-200, and 275-54-210.

(3) In addition to the general requirements stated in WAC 275-54-170, the following requirements shall apply to all emergency components. Such component shall:

(a) Be available twenty-four-hours-per-day, seven-days-per-week;

(b) Follow a written protocol for detaining an individual and contacting the county designated mental health professional;

(c) Provide or have access to medical services;

(d) Have a written agreement with a certified short-term inpatient component for admission on a seven-day-per-week, twenty-four-hour-per-day basis; and

(e) Follow a written protocol for transporting individuals to short-term inpatient components.

[00-23-089, recodified as § 388-860-190, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.34.800. 91-16-060 (Order 3221), § 275-54-190, filed 8/1/91, effective 9/1/91. Statutory Authority: RCW 34.04.020. 87-19-070 (Order 2535), § 275-54-190, filed 9/16/87. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-190, filed 12/23/85.]

WAC 388-860-200 Inpatient component. (1) The inpatient component is a hospital or residential setting where

treatment services are provided on a twenty-four-hour-per-day basis for individuals on seventy-two-hour detentions, or fourteen-day commitments, or one hundred eighty-day commitments.

(2) The department may accept a hospital licensed under WAC 246-318-280 or 246-322 as a certified short-term inpatient component for an evaluation and treatment program, in lieu of requiring a hospital to meet the requirements set forth by WAC 275-54-170, 275-54-200, and 275-54-210.

(3) In addition to the general requirements stated in WAC 275-54-170, the following requirements shall apply to all inpatient components:

(a) The inpatient component shall meet the standards required for state licensing as a skilled nursing facility, intermediate care facility, or residential treatment facility;

(b) Such component shall have the capability to admit the individual on a twenty-four-hour-per-day, seven-day-per-week basis;

(c) Such component shall not deny admission except under the following circumstances:

(i) After a psychosocial evaluation, there is a determination by a mental health professional that the individual does not present a likelihood of serious harm, or an imminent likelihood of serious harm, or the individual is not gravely disabled, and does not require inpatient care. Reference RCW 71.34.170 for necessary action in this case;

(ii) The individual requires specialized medical care and support services of a type not provided by the facility;

(iii) A greater degree of control is required than can be provided by the facility;

(iv) Treatment space is not available and is so documented;

(v) A less restrictive alternative provided by another facility is more appropriate and available; and

(vi) For situations arising under subsection (3)(c)(i) through (iv) of this section, the county or Regional Support Network-designated mental health professional shall make arrangements for the most appropriate placement available.

(d) Such component shall within twenty-four hours of initial detention, to include Saturday, Sunday, and holidays, conduct evaluations to determine the nature of the disorder, the treatment necessary, and whether or not detention is required. Such evaluations shall include at least a:

(i) Medical evaluation by a licensed physician; and

(ii) Psychosocial evaluation by a mental health professional.

(e) Such component shall have the capability to detain individuals dangerous to self, others, or gravely disabled, and shall provide or have access to at least one seclusion room meeting the requirements of WAC 248-18-001;

(f) Such component shall provide therapeutic services including generally accepted treatment modalities such as:

(i) Individual therapy;

(ii) Family therapy; and

(iii) Medication management.

(g) Such component shall provide treatment to each individual under the supervision of the professional person in charge;

(h) A mental health professional must have contact with each involuntary patient daily for the purpose of observation, evaluation, and the provision of continuity of treatment; and

(i) Such component shall have access to a mental health professional and a licensed physician for consultation and communication with the individual and the component staff on a twenty-four-hour-per-day, seven-day-per-week basis.

[00-23-089, recodified as § 388-860-200, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.34.800. 91-16-060 (Order 3221), § 275-54-200, filed 8/1/91, effective 9/1/91. Statutory Authority: RCW 34.04.020. 87-19-070 (Order 2535), § 275-54-200, filed 9/16/87. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-200, filed 12/23/85.]

WAC 388-860-210 Certification procedure—Waivers—Provisional certification—Renewal of certification. (1) In order to certify an agency's component or components, the department shall:

(a) Receive a formal request from the county-designated administrator of the evaluation and treatment program; and

(b) Conduct a site visit of the component or components including an inspection and examination of any records, procedures, materials, areas, programs, staff, and patients necessary to determine compliance with WAC 275-54-170, and the appropriate sections of WAC 275-54-180 through 275-54-220.

(2) The department shall issue full certification to a component only if the component is in full compliance with the applicable sections of this chapter.

(3) Variances from a rule may be granted by the department in the form of a waiver, pursuant to the provisions of WAC 275-55-371.

(4) Provisional certification may be granted by the director to a component or components which are in substantial compliance with the applicable sections of this chapter. Such provisional certification shall specify the number and type of deficiencies temporarily allowed and the length of provisional status.

(5) Renewal of certification is required at least every other year, and may require a complete site visit of the component or components as specified in subsection (1)(b) of this section.

[00-23-089, recodified as § 388-860-210, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-210, filed 12/23/85.]

WAC 388-860-220 Decertification. The department may decertify any component in accordance with the provisions of RCW 71.05.540 (4) and (5), guidelines promulgated and procedures for investigation of complaints set forth by the director.

[00-23-089, recodified as § 388-860-220, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-220, filed 12/23/85.]

WAC 388-860-230 Appeal procedure. (1) Any agency whose component or components have been denied certification or have been decertified by the department may appeal such a decision.

(2) Such appeal shall:

(a) Be made in writing;

(b) Specify the date of the decision being appealed;

(c) Specify clearly the issue to be reviewed;

(d) Be signed by and include the address of the agency;

(e) Be made within thirty days of notification of the decision being appealed.

(3) An appeal on decisions should be made in accordance with the Administrative Procedure Act, chapter 34.04 RCW.

[00-23-089, recodified as § 388-860-230, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-230, filed 12/23/85.]

WAC 388-860-240 Involuntary evaluation and treatment costs—Seventy-two hour detentions/fourteen-day commitments. (1) Responsibility of involuntary patient.

(a) Any person, or his or her estate, or his or her spouse, or the parents of a minor becoming an involuntary patient pursuant to chapter 354, Laws of 1985 shall be responsible for the cost of such evaluation and treatment. Payment of such costs by the involuntary patient, or on behalf of the involuntary patient by third-party payors, or other legally responsible persons or entities shall be made to:

(i) The state in instances where evaluation and treatment is provided in a facility maintained and operated by the department, pursuant to RCW 71.02.411.

(ii) The local agency in instances where evaluation and treatment is provided by the agency and the agency is not a facility maintained and operated by the department.

(b) In instances where inability to pay or substantial hardship is determined for an involuntary patient pursuant to this section, any unpaid costs for evaluation and treatment provided to such involuntary patient by a nondepartment agency shall be borne by the department, subject to the provisions of WAC 275-54-240 (2) and (3).

(2) Collection by agency.

(a) Definitions. For the purposes of this section:

(i) "Involuntary patient" is as defined by WAC 275-54-020.

(ii) "Title XIX" means Title XIX of the Social Security Act.

(iii) "CSO" means community services office of the department.

(b) Collection of costs for evaluation and treatment provided an involuntary patient by an agency not operated and maintained by the department shall be the responsibility of the agency. Such agency shall make reasonable efforts to make such collection pursuant to the agency's own regulations and policies. Such effort shall also include, but is not limited to, billing all appropriate resources of the involuntary patient and the patient's family, third-party payors, and other legally responsible persons and entities.

(c) Any involuntary patient not having private insurance to cover his or her costs, not already eligible for Title XIX or other state or federal assistance for his or her costs, or not otherwise paying for his or her evaluation and treatment costs, shall be referred by the agency providing the inpatient component to a local CSO for determination of eligibility for Title XIX or other state medical benefits in accordance with applicable mental health issuance benefits. If such patient is determined so eligible by the CSO, the agency shall bill according to the instructions set forth by the department.

(d) In the case of any involuntary patient not eligible for Title XIX benefits, the agency providing the inpatient component shall be responsible for collecting the amount the patient should participate in the treatment costs. As required by subsection (2)(c) of this section and applicable mental health issuance, the amount to be collected shall be determined by the local CSO.

(e) The agency may bill the department for the balance of costs in excess of the amount of required patient participation determined by the local CSO. Such billing shall be subject to the following:

(i) Reimbursement is sought through the appropriate county as defined by WAC 275-54-240(3). All bills shall be verified by the county or the county's designee before forwarding by the county to the department for payment.

(ii) Any collections made prior to such billing shall be shown and deducted from such billing. Any collections made subsequent to such billings shall be submitted to the department.

(f) In the event an involuntary patient is determined by the agency or by the local CSO (in instances where such patient had been referred for eligibility determination) to be fully capable of paying for his or her evaluation and treatment services, and such patient refuses to do so, the agency shall have primary responsibility for collection of costs and shall not expect the department to reimburse the agency for any uncollected balance, except as stated in the applicable mental health division issuance.

(g) The agency shall maintain appropriate records and other supporting material necessary to document billings and collection of costs for evaluation and treatment provided any involuntary patient, and shall permit authorized representatives of the county and/or the department to make such review of the records of the agency as may be deemed necessary to satisfy audit purposes. Such review shall be restricted to records for involuntary patients only.

(3) Responsibility of the county.

(a) All requests for reimbursement shall be made through the county of detention which shall review and approve requests pursuant to the following:

(i) The person being billed for was in fact an involuntary patient for the period of evaluation and treatment specified.

(ii) The date of initial detention is indicated.

(iii) Date of the seventy-two-hour (probable cause) hearing is indicated.

(iv) Date of conversion to voluntary patient status is shown (if appropriate).

(v) Date of release, transfer, or discharge is shown.

(vi) Days allowed by an approved extension request are shown (if appropriate).

(vii) The "patient participation" calculation is shown on inpatient facility invoices or the patient is shown to be eligible for Medicaid or LCP-MI.

(viii) If insurance coverage is indicated, such coverage collections have been deducted.

(b) All reimbursement payments for evaluation and treatment costs for involuntary patients shall be made directly to the service-providing agency.

(c) No payments will be made to agencies not certified pursuant to WAC 275-54-170, and not a part of a county's evaluation and treatment program pursuant to WAC 275-54-160, except in the case of licensed physicians.

(d) The counties shall maintain appropriate records and other supporting material necessary to document related administrative costs and shall submit such reports as the department shall request and shall permit authorized representatives of the department to make such review of records as may be deemed necessary to satisfy audit purposes.

(4) Responsibility of the department.

(a) In instances where an involuntary patient is unable to pay any or all of the costs of evaluation and treatment from all of the personal, family when legally responsible, or third-party payor resources available to him or her as required by WAC 275-54-240(1), or if payment would result in substantial hardship upon such patient or his or her family, the department shall be responsible for paying any uncollected balance of such costs, as set forth in the applicable mental health division issuance, except costs for which the CSO has determined the patient should continue to be liable.

(b) The department shall reimburse the counties for increased administrative costs, if any, resulting from implementation of the provisions of the Juvenile Involuntary Treatment Act. Additional costs to the counties shall be reimbursed in accordance with the following rules, subject to the availability of state and federal funds.

(c) For all increased involuntary commitment administrative costs, the department shall award an amount to the counties to pay such costs pursuant to RCW 71.05.550. "Increased costs" as used here shall mean costs exceeding the level financed by the county for calendar year 1984, resulting from implementation of the provisions of the Involuntary Treatment Act, and subsequent amendments.

(d) Involuntary commitment administrative costs are for services not listed under the Title XIX modality schedule. Such costs include:

(i) All travel and transportation expenses, whether for staff or involuntary patients;

(ii) All investigative costs not otherwise recoverable as a Title XIX listed service;

(iii) Expenses for hearings, testimony, legal services, courts, and prosecutors; and

(iv) The percentage of total staff time of the county mental health coordinator and agency administrative staff allocated to and expended in the involuntary commitment process.

(e) State funds shall in no case be used to replace local funds from any source used to finance administrative costs for involuntary commitment procedures conducted prior to January 1, 1985.

(f) For the evaluation and treatment provided each and every involuntary patient by a qualifying agency, the department shall reimburse the agencies in the amount of the actual expenditures incurred pursuant to this chapter and applicable departmental instructions. Such reimbursement by the department shall not exceed the Title XIX rate and shall not be allowed for any costs already reimbursed by other means. Such reimbursement by the department shall cover the following involuntary evaluation and treatment statuses only:

(i) Emergency component services for individuals where a petition for initial detention is filed under WAC 275-54-050 within twelve hours of admission to that component.

(ii) Initial detention period including Saturdays, Sundays, holidays, and up to three judicial days.

(iii) Fourteen-day period, including any involuntary outpatient treatment or less restrictive placement recommended by agency staff for the remainder of this period. Reimbursement beyond this fourteen-day period shall require approval from the department consistent with the applicable mental health division issuance.

(iv) Conditional release effected pursuant to the applicable provisions of this chapter and chapter 354, Laws of 1985. Reimbursement shall be restricted to the initial seventeen-day period.

(v) Conversion to voluntary status. Reimbursement shall be restricted to inpatient or outpatient services provided during the initial seventeen-day period, regardless of the day within that period the involuntary patient converts to voluntary status.

(g) The department may withhold department reimbursement in whole or in part from any county or agency in the event of a failure to comply with the provisions of this chapter.

[00-23-089, recodified as § 388-860-240, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-240, filed 12/23/85.]

WAC 388-860-250 Involuntary evaluation and treatment costs—One hundred eighty-day commitments. (1) Responsibility of involuntary patient.

(a) Payment for costs of care for an involuntary patient on a one hundred eighty-day commitment awaiting placement in a state-funded long-term inpatient facility shall be in accordance with the provisions of WAC 275-54-240.

(b) Any minor becoming an involuntary patient on a one hundred eighty-day commitment and placed in a state-funded long-term inpatient facility by the placement committee pursuant to chapter 354, Laws of 1985, or his or her estate, or his or her parents shall be responsible for the cost of such evaluation and treatment based upon a determination by the inpatient facility of ability to pay.

(c) Payment of such costs by the involuntary patient, or on behalf of the involuntary patient by third-party payors, or other legally responsible persons or entities shall be made to:

(i) The state in instances where evaluation and treatment is provided in a facility maintained and operated by the department, pursuant to RCW 71.02.411.

(ii) The local agency in instances where evaluation and treatment is provided by the agency and the agency is supported by, but not operated by the department.

(2) Collection by agency.

(a) Definitions.

(i) "Involuntary patient" is as defined by WAC 275-54-020(10).

(ii) "Title XIX" means Title XIX of the Social Security Act.

(iii) "CSO" means community services office of the department.

(b) Collection of costs for evaluation and treatment provided an involuntary patient by an agency not operated and maintained by the department shall be the responsibility of the agency. Such agencies shall make reasonable efforts to make such collection pursuant to the agency's own regulations and policies. Such efforts shall also include, but are not limited to, billing all appropriate resources of the involuntary patient, the patient's family, third-party payors, and other legally responsible persons and entities.

(c) Any involuntary patient who is a minor not having private insurance to cover his or her costs, not already eligible for Title XIX or other state or federal assistance for his or her costs, or not otherwise paying for their evaluation and treatment costs, shall be referred by the agency providing the inpatient component to a local CSO for determination of eligibility for Title XIX benefits. If such patient is determined so eligible by the CSO, the agency shall bill according to the instructions set forth by the department.

(d) The agency providing the long-term inpatient care shall determine the amount, if any, the patient, or his or her parents, or any responsible others should contribute to the cost of treatment. Such contributions shall be determined in accordance with the following:

(i) The agency shall have established financial screening criteria, policy, procedures, and format, and a sliding fee schedule or formula used to determine ability to contribute to the cost of inpatient care.

(ii) The financial screening criteria and the sliding fee schedule or formula shall take into consideration available income, family size, and allowable deductions.

(iii) Allowable deductions shall include unusual and exceptional circumstances and other pertinent factors as defined in WAC 275-16-075 and 275-16-085.

(iv) The agency shall establish a formal appeal policy and process allowing responsible others to appeal any financial contribution decision to the individual and agency administrative entity responsible for such decisions.

(3) Responsibility of department.

(a) The agency may bill the department for the balance of costs not collectible by actions taken in accordance with this subsection, for the care and treatment of minors on a one hundred eighty-day commitment and placed in the state-supported inpatient facility by the admissions committee.

(b) Such billing and reimbursement shall be in accordance with the instructions set forth in the department's contract for the provision of these services with the state-funded inpatient facility.

[00-23-089, recodified as § 388-860-250, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-250, filed 12/23/85.]

WAC 388-860-260 Involuntary treatment program administrative costs—Seventy-two hour/fourteen-day commitment. The mental health division will establish a maintenance of effort level for each county by January 1, 1986.

[00-23-089, recodified as § 388-860-260, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-260, filed 12/23/85.]

WAC 388-860-270 Involuntary treatment program transportation costs. (1) The minor or his or her parents shall be responsible for any transportation costs incurred in transporting a minor to an evaluation and treatment facility for seventy-two-hour detention, fourteen-day commitment, or initial one hundred eighty-day commitment to the custody of the secretary. Such responsibility shall be based upon a determination of ability to pay as prescribed in WAC 275-54-240.

(2) Where inability to pay has been determined by the local CSO in accordance with the provisions of WAC 275-54-240, and eligibility for federal or state medical assistance has been established in compliance with applicable mental health division issuance, the department shall be responsible for payment of transportation costs incurred in transporting the eligible minor to an evaluation and treatment facility for seventy-two-hour detention, fourteen-day commitment, or one hundred eighty-day commitment. Such payments shall be made in accordance with instructions set forth in mental health division issuance.

(3) Transportation shall be provided to involuntarily committed minors under chapter 354, Laws of 1985 by the most appropriate, safest, and most cost-effective means available. Transporting by ambulance shall be used only in those circumstances dictated by medical necessity.

(4) If a minor is released from a long-term evaluation and treatment facility and no other transportation is available, that facility shall furnish transportation to the minor's residence or other appropriate place.

[00-23-089, recodified as § 388-860-270, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-270, filed 12/23/85.]

WAC 388-860-280 Involuntary treatment program—Legal costs. (1) Responsible others shall bear the costs of attorneys appointed for the minor or his or her parent if financially able according to standards set by the court of the county in which the proceeding is held.

(2) If all responsible others are indigent as determined by these standards, the costs of the legal services shall be borne by the county in which the proceeding is held.

[00-23-089, recodified as § 388-860-280, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-280, filed 12/23/85.]

WAC 388-860-290 Patient rights. Absent a risk to self or others, minors treated under this chapter have the following rights, which shall be prominently posted in the evaluation and treatment facility:

(1) To wear their own clothes and to keep and use personal possessions;

(2) To keep and be allowed to spend a reasonable sum of their own money for canteen expenses and small purchases;

(3) To have individual storage space for private use;

(4) To have visitors at reasonable times;

(5) To have reasonable access to a telephone, both to make and receive confidential calls;

(6) To have ready access to letter-writing materials, including stamps, and to send and receive uncensored correspondence through the mail;

(7) To discuss treatment plans and decisions with mental health professionals;

(8) To have the right to adequate care and individualized treatment;

(9) Not to consent to the administration of antipsychotic medications or the performance of electroconvulsive treatment or surgery, unless the procedures below are followed:

(a) Emergency life-saving surgery may be performed; however, nonemergency surgery may only be provided involuntarily upon an order of the court or upon the approval of the parent;

(b) Antipsychotic medications may be administered when an emergency exists, provided there is a review of this decision by a nonattending physician within twenty-four hours. An emergency exists if:

(i) The patient presents an imminent likelihood of serious harm to self or others; and

(ii) Medically acceptable alternatives to administration or antipsychotic medications are not available or are unlikely to be successful; and

(iii) In the opinion of the physician, the patient's condition constitutes an emergency requiring that treatment be instituted before obtaining a second opinion by a nonattending physician.

(c) Antipsychotic medications may be administered involuntarily for up to thirty days if a nonattending physician concurs with the treating physician's decision to medicate. Thereafter, antipsychotic medications may be administered involuntarily only upon an order of the court;

(d) Electronconvulsive [Electroconvulsive] treatment may be administered involuntarily upon an order of the court;

(e) In any court proceeding the minor must be present and represented by counsel, and the court shall appoint a psychiatrist, psychologist, or physician designated by the minor or the minor's counsel to testify on behalf of the minor. The minor's parent may exercise this right on the minor's behalf, and must be informed of any impending treatment;

(10) Not to have psychosurgery performed on the minor under any circumstances.

[00-23-089, recodified as § 388-860-290, filed 11/20/00, effective 11/20/00. Statutory Authority: 1991 c 105. 91-21-025 (Order 3265), § 275-54-290, filed 10/8/91, effective 11/8/91. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-290, filed 12/23/85.]

WAC 388-860-300 Confidentiality. The fact of admission and all information obtained through treatment under this chapter is confidential. Confidential information may be disclosed only:

(1) In communications between mental health professionals to meet the requirements of this chapter, in the provision of services to the minor, or in making appropriate referrals;

(2) In the course of guardianship or dependency proceedings;

(3) To persons with medical responsibility for the minor's care;

(4) To the minor, the minor's parent, and the minor's attorney, subject to RCW 13.50.100;

(5) When the minor or the minor's parent designates in writing the persons to whom information or records may be released;

(6) To the extent necessary to make a claim for financial aid, insurance, or medical assistance to which the minor may be entitled or for the collection of fees or costs due to providers for services rendered under this chapter;

(7) To the courts as necessary to the administration of this chapter;

(8) To law enforcement officers or public health officers as necessary to carry out the responsibilities of their office. However, only the fact and date of admission, and the date of discharge, the name and address of the treatment provider, if any, and the last known address shall be disclosed upon request;

(9) To law enforcement officers, public health officers, appropriate relatives, and other governmental law enforcement agencies, if a minor has escaped from custody, disappeared from an evaluation and treatment facility, violated conditions of a less-restrictive treatment order, or failed to return from an authorized leave, and then only such information as may be necessary to provide for public safety or to assist in the apprehension of the minor. The officers are obligated to keep the information confidential in accordance with this chapter;

(10) To the secretary for assistance in data collection and program evaluation or research, provided the secretary adopts rules for the conduct of such evaluation and research. The rules shall include, but need not be limited to, the requirement that all evaluators and researchers sign an oath of confidentiality substantially as follows:

"As a condition of conducting evaluation or research concerning persons who have received services from (fill in the facility, agency, or person) I,..... ., agree not to divulge, publish, or otherwise make known to unauthorized persons or the public any information obtained in the course of such evaluation or research regarding minors who have received services in a manner such that the minor is identifiable.

I recognize unauthorized release of confidential information may subject me to civil liability under state law.

/s/..... ."

(11) To appropriate law enforcement agencies and to a person, when the identity of the person is known to the public or private agency, whose health and safety has been threatened, or who is known to have been repeatedly harassed, by the patient. The person may designate a representative to receive the disclosure. The disclosure shall be made by the professional person in charge of the public or private agency or his or her designee and shall include the dates of admission, discharge, authorized or unauthorized absence from the agency's facility, and only such other information pertinent to the threat or harassment. The decision to disclose or not shall not result in civil liability for the agency or the agency's employees so long as the decision was reached in good faith and without gross negligence;

(12) To a minor's next-of-kin, attorney, guardian, or conservator, if any, the information that the minor is presently in the facility or that the minor is seriously physically ill and a

statement evaluating the mental and physical condition of the minor as well as a statement of the probable duration of the minor's confinement;

(13) Upon the death of a minor, to the minor's next-of-kin;

(14) To a facility where the minor resides or will reside. This section shall not be construed to prohibit the compilation and publication of statistical data for use by government or researchers under standards, including standards to assure maintenance of confidentiality, set forth by the secretary. The fact of admission and all information obtained pursuant to this chapter are not admissible as evidence in any legal proceeding outside this chapter, except guardianship or dependency, without the written consent of the minor or the minor's parent;

(15) When disclosure of information on records is made, the date and circumstances, the name or names of the person or agencies to whom such disclosure was made, the relationship to the minor, if any, and the information disclosed shall be entered in the minor's clinical record.

[00-23-089, recodified as § 388-860-300, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-300, filed 12/23/85.]

WAC 388-860-310 Confidentiality of court proceeding records. The records and files maintained in any court proceeding are confidential and available only to the minor, the minor's parents, and the minor's attorney. The court may order release or use of these records if the court finds appropriate safeguards for strict confidentiality will be maintained.

[00-23-089, recodified as § 388-860-310, filed 11/20/00, effective 11/20/00. Statutory Authority: 1985 c 354. 86-02-019 (Order 2323), § 275-54-310, filed 12/23/85.]

WAC 388-860-315 Mental health service provider license and certification fees. (1) An annual fee, based on a range of client service hours provided per year, shall be assessed as follows:

Range	Client Service Hours	Annual Fee
1	0 - 3,999	$ 281.00
2	4,000 - 14,999	422.00
3	15,000 - 29,999	562.00
4	30,000 - 49,999	842.00
5	50,000 and over	1,030.00

(2) Fee ranges shall be determined from provider information reported to the department's community mental health information system.

(3) Providers applying for a license or certification and not reporting to the department's community mental health information system shall submit the number of annual client service hours as part of their application.

(4) Fee for an applicant not licensed or certified shall be equal to the fees for licensure or certification of licensed and certified providers with similar annual client service hours.

(5) Certified short-term inpatient component, or new applicants seeking certification for a short-term inpatient component, shall be assessed an annual fee of thirty-two dollars per bed. This annual fee shall not be assessed for inpatient hospitals licensed under chapter 70.41 RCW.

[00-23-089, recodified as § 388-860-315, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 43.20B.110. 91-23-089 (Order 3291), § 440-44-090, filed 11/19/91, effective 12/20/91. Statutory Authority: RCW 43.20A.055. 85-20-031 (Order 2287), § 440-44-090, filed 9/24/85.]

WAC 388-860-316 Fee payment and refunds. (1) Fees are due with applications for initial license or renewal. The department will not proceed on applications until required fees are paid.

Except as otherwise provided in these rules, fees shall be paid for a minimum of one year.

(2) Fees for licenses issued for other than yearly periods shall be prorated based on the stated annual fee.

(3) When the department issues a license for more than one year:

(a) Fees may be paid for the entire licensing period by paying at the rate established at the time the application was submitted, or

(b) If the licensee does not pay the fee for the entire license period, annual fees shall be due thirty days prior to each annual anniversary date of the license, at the annual fee rate established by these rules at the time such fee is paid.

(4) Except as otherwise provided in these rules, if an application is withdrawn prior to issuance or denial, one-half of the fee shall be refunded.

(5) If there is a change of or by the licensee requiring a new license, the fee paid for a period beyond the next license anniversary date shall be refunded. Changes requiring a new license shall require a new application and payment of fee as provided herein.

(6) If there is a change by the applicant or licensee that requires an amendment placing the licensee in a higher fee category, the additional fee shall be prorated for the remainder of the license period.

(7) Fees becoming due on or after the effective date of this chapter shall be at the rates provided herein.

(8) To the extent fees are reduced through regular rule adoption of this chapter on or before December 31, 1982, fees shall be refunded.

(9) Fee payments shall be by mail. Payment shall be by check, draft, or money order made payable to the department of social and health services.

[00-23-089, recodified as § 388-860-316, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-010, filed 6/4/82.]

WAC 388-860-317 Denial, revocation, suspension, and reinstatement. (1) If a license is denied, revoked, or suspended, fees shall not be refunded.

(2) Application for license after denial or revocation must include fees as provided for in these rules.

(3) Failure to pay fees when due will result in suspension or denial of license.

[00-23-089, recodified as § 388-860-317, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-015, filed 6/4/82.]

Chapter 388-861 WAC

VOLUNTARY ADMISSION—INVOLUNTARY COMMITMENT, TREATMENT AND/OR EVALUATION OF MENTALLY ILL PERSONS

(Formerly chapter 275-55 WAC)

WAC

WAC 388-861-010 Purpose. These regulations are adopted pursuant to and in accordance with chapters 71.05 and 72.23 RCW. These regulations are adopted to provide operational procedures for the voluntary treatment, involuntary commitment, evaluation and/or treatment of mentally ill persons; to provide standards for certification of evaluation and treatment facilities; and to provide procedures for financial assistance to counties and evaluation and treatment facilities.

[00-23-089, recodified as § 388-861-010, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-010, filed 3/11/82; Order 900, § 275-55-010, filed 1/25/74.]

WAC 388-861-020 Definitions. (1) "Department" means the department of social and health services of the state of Washington.

(2) "Secretary" means the secretary of the department of social and health services or his or her designee.

(3) "Director" means the director of the mental health division of the department of social and health services or his or her designee.

(4) "Superintendent" means the superintendent of a state hospital or his or her designee.

(5) "Chapter" means chapter 275-55 WAC.

(6) "County-designated mental health professional" means a person appointed by the county to perform the duties specified in chapters 71.05 and 72.23 RCW, and

(a) Who meets the educational and/or experience requirements as specified in WAC 275-55-020 (33)(a), (b), (c), or

(b) Where exception has been granted by the director pursuant to WAC 275-55-020 (33)(d).

(7) "Professional person in charge" as used in chapters 71.05 and 72.23 RCW, and these rules, unless otherwise defined, means the mental health professional having chief clinical responsibility for the mental health evaluation and treatment unit within the agency, or his or her designee who must also be a mental health professional.

(8) "Available physician or other professional person" as used in RCW 71.05.090 means either a licensed physician or a mental health professional as defined in subsection (33) of this section.

(9) "Agency" means a public or private agency as specified in RCW 71.05.020 (6) and (7), respectively.

(10) "Rule" means a rule within these rules and regulations.

(11) "Facility" means an evaluation and treatment facility.

(12) "Component" means any one of the three evaluation and treatment services required to be provided within an evaluation and treatment program as specified by RCW 71.05.020(16) and WAC 275-55-020 (14)(a) and (b), and required to be certified as specified by WAC 275-55-020 (13)(b).

(13) "Evaluation and treatment facility" means a public or private agency providing one or more components in compliance with the following:

(a) The agency shall be under contract or written agreement with an evaluation and treatment program pursuant to WAC 275-55-261. Exceptions to this rule are specified in WAC 275-55-020 (13)(c).

(b) Each component of the agency shall be certified by the department pursuant to WAC 275-55-261 (3) and (6), and 275-55-263. Exceptions to this rule are specified in WAC 275-55-020 (13)(c). Certification is required for any component serving involuntary patients. Certification of a component shall not preclude such component from also serving voluntary patients. A certified component shall comply with all rules and regulations of this chapter and with chapter

71.05 RCW as applicable to both involuntary and voluntary patients.

(c) Exceptions:

(i) Any agency operating a component serving voluntary patients exclusively will not require certification of such component nor require being under contract to an evaluation and treatment program.

(ii) A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility.

(iii) A facility which is part of, or operated by, the department or any federal agency will not require certification of the facility's component or components nor require being under contract to an evaluation and treatment program.

(14) "Evaluation and treatment program" means a coordinated system of evaluation and treatment services administered by an agency or a county pursuant to RCW 71.05.020(16) and WAC 275-55-261, and is provided to involuntary patients and to persons voluntarily seeking treatment for a mental disorder.

(a) Such evaluation and treatment services shall include at least all three of, but are not limited to, the following components:

(i) Outpatient.

(ii) Emergency.

(iii) Short-term inpatient.

(b) Such evaluation and treatment services shall be provided by an evaluation and treatment facility or facilities.

(15) "Medical evaluation" means an evaluation performed by a licensed physician including both a mental status and physical examination.

(16) "Patient" means a person admitted to an agency, facility, or component, voluntarily or involuntarily, for observation, evaluation, care, and/or treatment for a mental disorder.

(17) "Mental disorder" means any organic, mental, or emotional impairment having substantial adverse effects on an individual's cognitive or volitional functions, classified in accordance with the current diagnostic and statistical manual of the American psychiatric association.

(18) "Involuntary patient" means a person who, as a result of a mental disorder, presents a likelihood of serious harm (RCW 71.05.020(3)) or is gravely disabled (RCW 71.05.020(1)), and is initially detained and/or court-committed for evaluation and treatment.

(19) "Detention" means a person being held in a facility involuntarily pursuant to applicable sections of chapter 71.05 RCW, and the person not being permitted willful physical movement beyond the facility without express prior permission.

(20) "Initial detention" means the first seventy-two hour period, or part thereof, or involuntary evaluation and treatment required by a petition for initial detention, emergency detention, or supplementary petition for initial detention.

(21) "Seventy-two hour period" shall be computed to:

(a) Start on the time and date the inpatient or outpatient component of the evaluation and treatment facility provisionally accepts the person to be detained as specified in RCW 71.05.170, and

(b) Exclude Saturdays, Sundays, and holidays.

(22) Deleted.

(23) "Admission" means acceptance of a person as an inpatient or outpatient by the facility.

(24) "Discharge" means release of a patient from a component or from a facility.

(25) "Transfer," unless otherwise defined, means a move of the patient by a facility between treatment services or components of the facility, or between facilities, and may or may not include a discharge from the transferring service, component, or facility.

(26) "Release from commitment" means legal termination of the order of commitment.

(27) "Early release" means release of the involuntary patient from the order of commitment prior to the original expiration date of the commitment order.

(28) "Conditional release" means a transfer of the involuntary patient from inpatient to outpatient treatment pursuant to conditions specified for the patient by the transferring facility or component. The involuntary patient remains under order of commitment.

(29) "Shock treatment" means electroconvulsive therapy.

(30) Whenever used in this chapter, the masculine shall include the feminine and the singular shall include the plural.

(31) "County" means a county, or a combination of counties jointly agreeing to provide or cause to be provided the services required by this section.

(32) "Coordinator" means county mental health coordinator, and is the person appointed by the county to supervise and/or otherwise coordinate the community mental health program services of a county.

(33) "Mental health professional" means a person regularly involved in mental health evaluation and treatment, and qualifying as one of the following:

(a) A psychiatrist, psychologist, psychiatric nurse, or social worker.

(b) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional.

(c) A licensed physician permitted to practice medicine or osteopathy in the state of Washington.

(d) A person otherwise qualified to perform the duties of a mental health professional but does not meet the requirements listed in subsection (33)(a), (b), or (c) of this section, where an exception to such requirements has been granted by the director upon submission of a written request by the county involved, such request to document the following:

(i) The extent to which the county has made an effort to provide and has the capability of providing a mental health professional;

(ii) The amount and type of employment experience the applicant possesses. Such an applicant shall have had at least three years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional, as defined under subsection (33)(a), (b), or (c) of this section;

(iii) The overall needs of the mental health program in the particular county involved; and

(iv) Such factors as shall be brought to the attention of the director by the county involved.

(34) "Psychiatrist" means a physician licensed to practice medicine in the state of Washington having, in addition, completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association.

(35) "Psychologist" means persons defined as such in RCW 71.05.020(14).

(36) "Social worker" means persons defined as such in RCW 71.05.020(15).

(37) "Psychiatric nurse" means a registered nurse having had, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional as defined in subsection (33)(a), (b), or (c) of this section.

(38) "Psychiatric nurse clinician" means a registered nurse having a masters degree or further advanced degree from an accredited college or university and whose graduate specialization was in psychiatric nursing.

[00-23-089, recodified as § 388-861-020, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-020, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-020, filed 3/11/82; Order 1122, § 275-55-020, filed 6/2/76; Order 955, § 275-55-020, filed 7/26/74; Order 900, § 275-55-020, filed 1/25/74.]

WAC 388-861-030 Private agencies which may admit voluntary patients. Any private agency, as defined in RCW 71.05.020(7), may receive as a voluntary patient any person suffering from a mental disorder.

[00-23-089, recodified as § 388-861-030, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-030, filed 3/11/82; Order 900, § 275-55-030, filed 1/25/74.]

WAC 388-861-040 Voluntary admission to public or private agency—Voluntary adult. Any private agency receiving a voluntary patient eighteen years of age or older pursuant to WAC 275-55-030 and any public agency as defined in RCW 71.05.020(6) receiving such patient, shall require written application signed by the voluntary patient stating such application is a voluntary action by the patient, and shall advise such patient of his or her rights pursuant to WAC 275-55-211(1).

[00-23-089, recodified as § 388-861-040, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-040, filed 3/11/82; Order 955, § 275-55-040, filed 7/26/74; Order 900, § 275-55-040, filed 1/25/74.]

WAC 388-861-081 Periodic review—Voluntary inpatient. The condition and status of a voluntary patient shall be reviewed at least each one hundred eighty days. (Reference RCW 71.05.050) At the time of such review, the patient shall again be advised orally of his or her right to release and in writing of his or her rights as set forth under WAC 275-55-241 (1) and (2). The patient's review shall include but not be limited to an evaluation of the patient's individual treatment program and progress, recommendations for future treatment, and consideration of possibly less restrictive treatment. Such review shall be undertaken under the supervision and direction of the professional person in charge. Written documentation of such review shall be maintained in the patient's clinical record.

[00-23-089, recodified as § 388-861-081, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-081, filed 3/11/82.]

WAC 388-861-090 Limitation on length of stay—Readmission voluntary patients. No person shall be carried continuously as a voluntary patient for a period of more than one year. (Reference RCW 72.23.100 and 71.05.050) However, a patient may be readmitted pursuant to admission procedures at the end of any one-year period.

[00-23-089, recodified as § 388-861-090, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-090, filed 3/11/82; Order 900, § 275-55-090, filed 1/25/74.]

WAC 388-861-110 Discharge of voluntary patient—Release of clinical summary. (1) For the purposes of this section, "hospital" includes state and federal hospitals for the mentally ill.

(2) Nothing in these rules and regulations shall be construed so as to prohibit the superintendent or professional person in charge from discharging a patient at any time when, in the opinion of the superintendent or professional person in charge, the patient's condition is no longer appropriate for treatment at the hospital or facility.

(3) Upon discharge of the voluntary patient the hospital or facility shall:

(a) Seek the patient's permission for release of a clinical summary concerning the patient's condition to the physician, psychiatrist or therapist of his or her choice, or to the local treatment facility or community mental health program. However, information may be shared with others involved in providing services consistent with RCW 71.05.390.

(b) Advise the patient of his or her competency pursuant to WAC 275-55-221.

[00-23-089, recodified as § 388-861-110, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-110, filed 3/11/82; Order 1122, § 275-55-110, filed 6/2/76; Order 955, § 275-55-110, filed 7/26/74; Order 900, § 275-55-110, filed 1/25/74.]

WAC 388-861-115 Transfer of a patient between state-operated facilities for persons with mental illness. In some instances, it is appropriate for the department to transfer a patient currently residing in a state facility to another state facility for ongoing treatment. The department shall accomplish the transfer with the utmost care given to the therapeutic needs of the patient. This section describes the procedures for handling a patient transfer between state facilities in a manner consistent with the best interest of the patient.

(1) The department may use the following criteria when determining the appropriateness of a patient transfer:

(a) The patient's family resides within the receiving facility's catchment area; or

(b) The patient's primary home of residence is in the receiving facility's catchment area; or

(c) A particular service or need of the patient is better met at the receiving facility; or

(d) Transfer to the receiving facility may facilitate community discharge due to the availability of community service in the receiving facility's catchment area; or

(e) The county, regional support network, or patient requests a transfer.

(2) Prior to any proposed transfer of a patient, the state facility shall comply with the following:

(a) The sending facility, at the request of the superintendent, shall in writing forward information necessary to make a decision on whether transfer is appropriate to the receiving facility's liaison and the regional support network liaison;

(b) The receiving facility's and regional support network designated liaisons shall recommend appropriate action to the superintendent of the sending facility in writing within five calendar days of receipt of the transfer request;

(c) If the receiving facility accepts the proposed patient transfer, the sending facility shall notify the patient, guardian, regional support network liaison, and attorney, if known, at least five days before the proposed patient transfer;

(d) The sending facility is responsible for all patient transfer arrangements, e.g., transportation, staff escort, etc., and shall coordinate the day and time of arrival with the receiving facility's liaison; and

(e) The sending facility shall arrange for the transfer of patient's medical record to the receiving facility.

(3) The sending state facility shall document the following in the patient's record:

(a) Physician documentation of the medical suitability of the patient for transfer; and

(b) Social worker documentation regarding:

(i) Justification as to why the transfer is considered in the patient's best interests; and

(ii) The patient's wishes regarding transfer.

(4) If a transfer is proposed for a court-ordered patient, the sending facility shall contact the prosecuting attorney's office for persons committed for up to fourteen days or the attorney general's office for persons committed for ninety or hundred eighty days to determine if legal action is necessary prior to the transfer.

[00-23-089, recodified as § 388-861-115, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 74.05.560 [71.05.560]. 91-22-044 (Order 3275), § 275-55-115, filed 10/31/91, effective 12/1/91. Statutory Authority: RCW 71.05.560. 88-23-021 (Order 2724), § 275-55-115, filed 11/7/88.]

WAC 388-861-131 Nonadmission of involuntarily detained person—Transportation. (1) Admission shall not be denied to a person under initial detention except pursuant to the circumstances specified in WAC 275-55-263 (2)(a).

(2) If the person is not admitted by a facility, transportation or arrangements for custody shall be made in accordance with RCW 71.05.190.

[00-23-089, recodified as § 388-861-131, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-131, filed 3/11/82.]

WAC 388-861-141 Protection of patient's property—Involuntary patient. (1) Articles brought to the facility shall be inventoried and articles not kept by the patient shall be housed by the facility giving due regard to reasonable precautions necessary to safeguard such property.

(2) The peace officer or mental health professional escorting the patient to the facility shall take reasonable precautions to safeguard the property of the patient in the immediate vicinity of the point of apprehension.

(3) Reasonable precautions shall be taken to safeguard belongings not in the immediate vicinity of the patient by the escorting officer or mental health professional, and/or facility when notice of possible danger thereto is received. Further, reasonable precautions shall be taken to lock and otherwise secure the domicile of the patient as soon as possible after the patient's initial detention. (Reference RCW 71.05.220)

[00-23-089, recodified as § 388-861-141, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-141, filed 3/11/82.]

WAC 388-861-151 Evaluation and examination—Involuntary patient. Persons doing the initial detention evaluation and treatment pursuant to RCW 71.05.210 shall not include the county-designated mental health professional responsible for the detention, unless no other mental health professional is reasonably available and specific exemption has been granted by the director.

[00-23-089, recodified as § 388-861-151, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-151, filed 3/11/82.]

WAC 388-861-161 Treatment prior to hearings—Involuntary patient. Any involuntary patient may refuse all but emergency lifesaving treatment beginning twenty-four hours prior to any hearing. On admission to the facility such patient shall be informed of his or her right to refuse all treatment except lifesaving treatment during such twenty-four hour period and shall again be so informed prior to the twenty-four hour period before court hearing. The patient shall be asked if he or she wishes to decline treatment during such twenty-four hour period, and the answer shall be in writing and signed where possible. Compliance with this procedure shall be documented in the patient's clinical record. This section does not preclude use of physical restraints and/or seclusion to protect against injury to the patient or others. (Reference RCW 71.05.200.)

[00-23-089, recodified as § 388-861-161, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-161, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-161, filed 3/11/82.]

WAC 388-861-171 Early release or discharge of involuntary patient—Release of clinical summary—Notification of court. (1) Nothing in these rules and regulations shall be construed so as to prohibit the superintendent or professional person in charge from granting an early release to and/or discharging an involuntary patient at any time when, in the opinion of the superintendent or professional person in charge, the involuntary patient:

(a) May be granted an early release on the grounds such patient:

(i) No longer presents a likelihood of serious harm to others, and is no longer gravely disabled; or

(ii) Is an appropriate candidate for and will accept voluntary treatment elsewhere upon referral; or

(iii) Is an appropriate candidate for and will accept voluntary treatment at the hospital or facility where the person is currently a patient.

(b) May be concurrently discharged, if granted an early release, on the grounds his or her condition is no longer appropriate for treatment at the hospital or facility.

(c) May not qualify for early release, but on the grounds his or her condition is no longer appropriate for treatment at the hospital or facility may be transferred or discharged under the provisions for conditional release as specified in WAC 275-55-181.

(2) Upon transfer or discharge of the involuntary patient not granted an early release, the hospital or facility shall notify the patient a clinical summary will be forwarded without his or her consent to the receiving facility or component for the purposes of effecting a conditional release, and such disclosure shall remain confidential.

(3) Upon early release, discharge or transfer, the patient shall be advised of his or her competency pursuant to WAC 275-55-221.

(4) Whenever an involuntary patient is granted an early release, the court ordering the original commitment shall be notified in writing of the date of release and release plans. The county-designated mental health professional shall be sent a copy of such written court notification. (Reference RCW 71.05.330)

[00-23-089, recodified as § 388-861-171, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-171, filed 3/11/82.]

WAC 388-861-181 Conditional release—Involuntary patient. (1) At any time during the period of commitment, the superintendent or professional person in charge may determine the involuntary patient receiving inpatient services can be more appropriately served by outpatient treatment, such treatment may be required in accordance with RCW 71.05.340.

(2) Ongoing determination for conditional release shall be based on periodic personal contacts with the patient by the facility designated to provide outpatient treatment, (see WAC 275-55-271(2)), and will be documented in the patient's clinical record. Such contacts shall occur at the following intervals during the period of conditional release:

(a) Fourteen-day period - At least once weekly.

(b) Ninety-day period - At least once each month.

(c) One hundred and eighty-day period - At least once each month.

(3) Any patient conditionally released pursuant to RCW 71.05.340 and this section shall be notified orally and in writing of the terms and conditions of the release and shall be notified in writing of any subsequent modifications of such terms and conditions. Other notifications shall be as set forth in RCW 71.05.340. All conditions and modifications thereof shall be made a part of the patient's clinical record. Written acknowledgement from the patient shall:

(a) Be obtained for receipt of the terms and conditions of release by the superintendent or the professional person in charge of the releasing facility or component.

(b) Be obtained for any subsequent modification of the terms of conditional release by the professional person in charge of the receiving facility or component.

[00-23-089, recodified as § 388-861-181, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-181, filed 3/11/82.]

WAC 388-861-191 Revocation of conditional release—Secretary's designee—Involuntary patient. (1) The secretary's designee for purposes of revocation of conditional release under RCW 71.05.340 shall be:

(a) The superintendent of the state hospital or his or her specified designee where the patient was conditionally released, or

(b) The director of the division of mental health or his or her specified designee.

(2) Revocation procedures will be as otherwise specified in RCW 71.05.340, including the responsibilities of the designated county mental health professional.

[00-23-089, recodified as § 388-861-191, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-191, filed 3/11/82.]

WAC 388-861-201 Discharge of indigent patient—Involuntary patient. (1) No indigent patient who is an inpatient in any evaluation and treatment facility shall be discharged or conditionally released during or at the expiration of any involuntary confinement period without suitable clothing and funds of at least the minimum specified under RCW 72.02.100. If such patient has funds of less than such minimum amount, the patient shall be provided an amount necessary to reach such minimum. If the indigent patient has no funds, the total minimal amount shall be provided. Request for suitable clothing or funding therefor and funds shall be made by the person in charge of the facility to the superintendent of the nearest state hospital and the superintendent shall furnish such clothes or funds as required under RCW 71.05.350. Such request shall be made at least seventy-two hours ahead of expected release in the case of any patient under a fourteen-day or longer involuntary confinement period.

(2) In the case of an indigent patient under initial detention, the person in charge of the facility may provide suitable clothing and funds as specified in this section, from resources of the facility, and shall immediately notify the superintendent of such action. The department may then be billed by the facility.

(3) For the purposes of this rule, the superintendent may designate a staff member within the department to handle funding and clothing requests.

(4) If funding is available, the superintendent may provide in addition to the minimum funding required by RCW 72.02.100, an additional amount of up to the optional amount specified in RCW 72.02.100 to any indigent patient applying therefor if such extra funding is necessary for personal and/or living expenses of such patient.

(5) As funds are available, the secretary may provide, as an alternative to the funding specified in subsection (1) of this section, for the conditionally released patient, a weekly pay-

ment of an amount specified in RCW 72.02.110 for a period of up to the total time of conditional release.

(6) No patient regardless of the length of involuntary confinement shall be released without transportation to his or her place of residence or other suitable place. If the patient has no suitable means of transportation and is also indigent, then the facility shall provide for transportation by the least expensive method of public transportation not to exceed a cost of one hundred dollars, or, in the alternative, the facility may provide such transportation.

(7) If the superintendent has reasonable cause to believe the patient to be released has ample funds to assume expenses of clothing, transportation, or other payments made herein, the person released shall be required to assume such expenses and the superintendent shall so advise.

(8) Where funding is available, the secretary or the superintendent may at his or her discretion provide funds or clothing pursuant to this rule and the laws of the state of Washington to voluntary patients.

[00-23-089, recodified as § 388-861-201, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-201, filed 3/11/82.]

WAC 388-861-211 Advising patient of rights. (1) Any person voluntarily admitted for inpatient treatment to any agency shall, upon admission, be advised in writing or orally by the agency of his or her right to immediate release and shall be further advised in writing of all rights secured to him or her pursuant to RCW 71.05.050 and to WAC 275-55-241 (1) and (2).

(2) All persons involuntarily admitted to the inpatient, outpatient or emergency component of a facility shall, upon admission, be advised in writing or orally by the component of the following (reference RCW 71.05.200 and 71.05.210):

(a) Each right the patient has as an involuntary patient (listed in WAC 275-55-241 (1) and (3)). In addition, when possible, a responsible member of the immediate family, guardian, or conservator, if any, and such other person as designated by the patient shall receive notification in writing of the patient's confinement and his or her rights retained as an involuntary patient. The patient shall be informed who has been notified.

(b) Within twenty-four hours of admission, the patient will undergo a medical and psychosocial evaluation to determine whether continued detention within the facility will be necessary.

(c) If the patient is not released within seventy-two hours, excluding Saturdays, Sundays, and holidays, the patient will be entitled to a judicial hearing before a superior court to decide whether the patient's continued detention within the facility is necessary.

(3) Upon discharge and/or early release as specified in WAC 275-55-110 and 275-55-171, every patient voluntarily admitted or involuntarily committed pursuant to chapter 71.05 RCW shall be advised in writing of the following: No person is presumed incompetent nor does any person lose any civil rights as a consequence of receiving evaluation and/or treatment services for a mental disorder, whether voluntary or involuntary, pursuant to Washington law dealing with mental illness. (Reference RCW 71.05.450)

[00-23-089, recodified as § 388-861-211, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-211, filed 3/11/82.]

WAC 388-861-221 Restoration procedure for a former involuntarily committed person's right to firearm possession. (1) The department and mental health professionals implementing chapter 71.05 RCW shall recognize and affirm that a person is entitled to the immediate restoration of the right to firearm possession, as described under RCW 9.41.040 (6)(c), when the person no longer requires treatment or medication for a condition related to the commitment.

(2) Mental health professionals implementing the provisions of chapter 71.05 RCW shall provide to the court of competent jurisdiction such relevant information concerning the commitment and release from commitment as the court may request in the course of reaching a decision on the restoration of the person's right to firearm possession. (See RCW 9.41.097.)

(3) A person who has been barred from firearm possession under RCW 9.41.040(6) and 71.05.240 and who wishes to exercise this right, may petition the court which ordered involuntary treatment or, the superior court of the county in which the person resides for restoration of the right to possess firearms. At a minimum, such petition shall include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the most recent order of commitment with the findings of fact and conclusions of law.

(4) A petitioner shall show that the petitioner no longer requires treatment or medication for a condition related to the commitment.

[00-23-089, recodified as § 388-861-221, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 9.41.040(6). 94-06-025 (Order 3709), § 275-55-221, filed 2/23/94, effective 3/26/94.]

WAC 388-861-231 Conversion to voluntary status by involuntary patient—Rights. Patients committed by court order to involuntary treatment shall have all the rights of voluntary patients as specified in WAC 275-55-241 (1) and (2). The facility may convert the patient to voluntary status when the patient has signed an application to receive voluntary treatment.

[00-23-089, recodified as § 388-861-231, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-231, filed 3/11/82.]

WAC 388-861-241 Rights of patient. Any agency, facility, or component providing services defined in this chapter to persons with a mental disorder shall not withhold from any patient the following rights. The facility shall prominently post a list of such rights within the department or ward where such person is housed if the person is an inpatient or receiving services from an emergency component. Outpatient facilities or components shall prominently post a list of such rights drawn from the following as are appropriate to an outpatient facility or component and such list shall be posted within the reception area. The agency, facility, or component

shall ensure, unless an imminent danger to the person or others would result, each patient shall have the rights listed in subsection (1)(a), (j), (l), (p), (2)(a), (b), (3)(a), (c), (d), (f), and (g) of this section.

(1) Rights of all patients. All patients shall have the right:

(a) Not to be restrained from sending written communications of the fact of the patient's detention, commitment, or admission. The facility, director, or the facility's designee shall mail such written communication to the person to whom addressed;

(b) To adequate care and individualized treatment;

(c) To make an informed decision regarding the use of antipsychotic medication. Documentation shall be entered in the medical record of the physician's attempt to obtain informed consent and the reasons why antipsychotic medication is being administered over the patient's objection or lack of consent. The physician may administer antipsychotic medications over the patient's objection or lack of consent:

(i) When an emergency exists, provided there is a review of this decision by a nonattending physician within twenty-four hours. An emergency exists if:

(A) The patient presents an imminent likelihood of serious harm to self or others; and

(B) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and

(C) In the opinion of the physician, the patient's condition constitutes an emergency requiring that treatment be instituted before obtaining a second opinion by a nonattending physician.

(ii) For up to thirty days, provided there is an additional concurring opinion by a nonattending physician;

(iii) For continued treatment beyond thirty days through the hearing on any one hundred eighty-day petition filed under RCW 71.05.370(7), provided the facility medical director or director's medical designee reviews the decision to medicate a patient. The review shall occur at least every sixty days:

(A) The examining physician shall sign all one hundred eighty-day petitions for antipsychotic medications filed under the authority of RCW 71.05.370(7);

(B) Persons committed for one hundred eighty days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing under RCW 71.05.370(7) prior to the involuntary administration of antipsychotic medications. In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining physician must file a petition for an antipsychotic medication order the next judicial day.

(iv) All involuntary medication orders shall be consistent with the provisions of RCW 71.05.370 (7)(a) and (b), whether ordered by a physician or the court;

(d) To wear the patient's own clothes and to keep and use the patient's own personal possessions, except when deprivation of same is essential to the protection and safety of the patient or other persons;

(e) [Of] [To] keep and be allowed to spend a reasonable sum of the patient's own money;

(f) To access to individual storage space for the patient's own private use;

(g) To have visitors at reasonable times;

(h) To have reasonable access to a telephone, both to make and receive confidential calls;

(i) To have ready access to letter writing material, including stamps, and to send and receive uncensored correspondence through the mails;

(j) Not to consent to the performance of electroconvulsive therapy or surgery, except emergency life-saving surgery, upon the patient, and not to have electroconvulsive therapy or nonemergency surgery in such circumstances unless ordered by a court under a judicial hearing where:

(i) The patient is present and represented by counsel; and

(ii) The court appoints a psychiatrist, psychologist, or physician designated by such patient or the patient's counsel to testify on behalf of the patient as described under RCW 71.05.210, 71.05.370, and 71.05.380.

(k) To dispose of property and sign contracts unless the patient has been adjudicated as incompetent in a court proceeding directed to the particular issue;

(l) Not to have psychosurgery performed under any circumstances;

(m) To object to detention or request release through writ of habeas corpus;

(n) To maintain the right to be presumed competent and not lose any civil rights as a consequence of receiving evaluation or treatment for a mental disorder;

(o) Of access to attorneys, courts, and other legal redress;

(p) To have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential, under the provisions of RCW 71.05.390 through 71.05.420.

(2) All voluntary patients shall have the right to:

(a) Release, unless involuntary commitment proceedings are initiated. Specific patients' rights to release are as follows:

(i) Adult patient, no guardian - Release at request of patient;

(ii) Consenting adult admitted who has a guardian - Release at request of guardian or patient;

(iii) Minor, thirteen years of age or under - Release at request of parent(s), conservator, guardian, or other person entitled to custody;

(iv) Minor, fourteen years of age or over - Release upon request of both minor and the minor's parent(s), conservator, guardian, or other person entitled to custody. If requested by minor only, release on next judicial day.

(b) A review of condition and status at least each one hundred and eighty days as required under RCW 71.05.050, 71.05.380, and 72.23.070.

(3) All involuntary patients shall:

(a) Unless released within seventy-two hours as defined under WAC 275-55-020(21), have a right to a judicial hearing, as defined, after initial detention to determine whether probable cause exists to detain such patient after seventy-two hours for a further period up to fourteen days;

(b) Have the right to:

(i) Communicate immediately with an attorney and, if indigent, the right to have an attorney appointed to represent the patient before and at such hearing; and

(ii) Be told the name and address of the attorney appointed.

(c) Have the right to remain silent;

(d) Have the right to be told statements the patient makes may be used in the involuntary proceedings;

(e) Have the right to present evidence and to cross-examine witnesses testifying against the patient at the probable cause hearing;

(f) Have the right to refuse medication beginning twenty-four hours before any court proceeding wherein the patient has the right to attend and which bears upon the continued commitment of the patient;

(g) When taken into custody by a peace officer and then placed in a facility without prior authorization by the county-designated mental health professional, the involuntary patient shall be:

(i) Examined by a mental health professional within three hours of the patient's arrival; and

(ii) Released within twelve hours unless the county-designated mental health professional files a supplemental petition for initial detention and the detained person receives a copy as described under RCW 71.05.150(5).

[00-23-089, recodified as § 388-861-241, filed 11/20/00, effective 11/20/00. Statutory Authority: 1991 c 105. 91-21-025 (Order 3265), § 275-55-241, filed 10/8/91, effective 11/8/91. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-241, filed 3/11/82.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-861-261 Requirements for certifying evaluation and treatment components. (1) Each county or Regional Support Network shall develop and coordinate an evaluation and treatment program consistent with chapters 71.05 and 71.24 RCW. Such program shall include, but is not limited to, components of outpatient services, emergency services, and short-term inpatient services. The county or Regional Support Network may provide one or more of these components directly. The county or Regional Support Network may also contract or have a written agreement with one or more agencies to provide each component in its entirety. Component(s) obtained on this basis from an agency or agencies shall be subject to all applicable provisions of this chapter and chapter 71.05 RCW. The county or Regional Support Network shall maintain coordination responsibility over the program.

Any contract or agreement between county or Regional Support Network and agencies, or between two or more agencies, shall be required to comply with the standards for evaluation and treatment components, WAC 275-55-263. In addition, each contract or agreement shall indicate the department will consider those standards in the department's site visit and certification procedure as directed by WAC 275-55-293.

(2) In addition to the responsibilities specified, the following shall be required of the county or Regional Support Network or of such individual designated by the county as administrator of the evaluation and treatment program to:

(a) Identify, recommend to the department for certification, and coordinate the various facilities and components of the evaluation and treatment program;

(b) Assist the department in ensuring facilities and components are in compliance with all applicable rules and regulations set forth in chapter 71.05 RCW and this chapter;

(c) Make periodic reviews of a certified component consistent with county procedures.

(3) Any agency desiring certification of a component or components in order to become an evaluation and treatment facility, shall make application for such to the county or Regional Support Network administrator of the evaluation and treatment program.

(4) The department is responsible for certifying each component of an agency desiring to become an evaluation and treatment facility. Upon formal request of the county or Regional Support Network administrator of the evaluation and treatment program, the department may:

(a) Inspect and evaluate the applicant agency's component or components for certification in accordance with the provisions of WAC 275-55-293.

(b) Conduct on-site visits for the purposes of certification including, where possible, the county or Regional Support Network administrator of the evaluation and treatment program as part of the site visit team.

(5) All facilities shall be recognized elements of the county or Regional Support Network mental health plan. The plan shall list the agencies for which certification is requested, and the components to be provided by each. The plan shall also specify the method whereby components will be coordinated when more than one agency provides evaluation and treatment services, and the method whereby the services of the facility will be coordinated with other elements of the county or Regional Support Network mental health program. (Reference RCW 71.24.130)

[00-23-089, recodified as § 388-861-261, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 74.05.560. 91-16-061 (Order 3222), § 275-55-261, filed 8/1/91, effective 9/1/91. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-261, filed 3/11/82.]

WAC 388-861-263 Certification standards for evaluation and treatment program. (1) The following general requirements shall apply to any agency desiring certification as a component or components of the evaluation and treatment program:

(a) The spectrum of evaluation and treatment services provided by the agency shall include at least one of the following:

(i) Outpatient.

(ii) Emergency.

(iii) Short-term inpatient.

(b) The agency may directly provide one or more of the components specified in subsection (1)(a) of this section, or may indirectly provide one or more through contractual arrangement or agreements with other agencies. Such arrangements shall be set forth in WAC 275-55-261(1).

(c) The agency shall maintain a written statement describing the organizational structure and objectives. The statement shall include contractual affiliates (if any).

(d) The agency shall document and otherwise ensure:

(i) Care for patients is provided in a therapeutic environment.

(ii) Patient rights as described in WAC 275-55-211 and 275-55-241 are incorporated into this environment.

(iii) The use of a less restrictive treatment alternative is considered for each patient at the time of detention, admission, discharge, and development of fourteen, ninety, and one hundred eighty-day petitions.

(iv) Continuity of care, coordination, and integration of services is provided.

(v) Referral services and assistance in obtaining supportive services appropriate to treatment are provided to each patient.

(e) The agency desiring certification of the agency's component or components shall make application for such certification pursuant to WAC 275-55-261(3).

(2) In addition to the requirements specified for each in WAC 275-55-271, 275-55-281, and 275-55-291, the following general requirements shall apply to all facilities:

(a) Treatment plan and clinical record. All components shall:

(i) Maintain, for each patient, a plan of treatment, and a plan for discharge including a plan for follow-up where appropriate. Such treatment and discharge plans shall be entered in the patient's clinical record, as appropriate.

(ii) Maintain, for each patient, a clinical record containing sufficient information to justify the diagnosis, delineate the individual treatment plan, and document the course of treatment. The responsibility of the agency is to safeguard the record against loss, defacement, tampering, or use by unauthorized persons.

(b) Treatment. The evaluation and treatment program shall:

(i) Have available, as needed, professional personnel including, but not limited to, a licensed physician and a mental health professional.

(ii) Ensure each patient has access to necessary medical treatment, emergency life-sustaining treatment, and medication.

(iii) Have psychiatric consultation available to other physicians or mental health professionals when treatment is not provided by or under the supervision of a psychiatrist.

(c) Use of restraints and seclusion. The use of medication, physical restraints, or locked seclusion rooms in response to assaultive, self-destructive, or unruly patient behavior shall occur only to the extent necessary to ensure the safety of patients and staff, and subject to the following conditions:

(i) In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour and shall authorize the restraints or seclusion.

(ii) No patient shall be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. Such patient must be directly observed every fifteen minutes and the observation recorded in the patient's clinical record.

(iii) If restraint or seclusion exceeds twenty-four hours, the patient shall be examined by a licensed physician. The facts determined by his or her examination and any resultant decision to continue restraint or seclusion over twenty-four hours shall be recorded in the patient's clinical record over the signature of the authorizing physician. This procedure must be repeated for each subsequent twenty-four-hour period of restraint or seclusion.

(d) Periodic evaluation. Each involuntary patient shall be evaluated periodically for release from commitment. Such evaluation shall occur at least weekly for fourteen-day commitments, at least monthly for ninety and one hundred eighty-day commitments, and documented in each involuntary patient's clinical record.

(e) Training. All components shall develop an inservice training plan and provide regular training to all clinical personnel having responsibility for any aspect of patient care. Documentation of the type and amount of training received by staff members shall be maintained. Such training shall include information about:

(i) The availability and utilization of less restrictive alternatives.

(ii) Methods of patient care.

(iii) Managing assaultive and self-destructive behavior.

(iv) The provisions and requirements of this chapter and chapter 71.05 RCW, and standards and guidelines promulgated by the department.

(v) Other appropriate subject matter.

(f) Administration. All components shall:

(i) Maintain written procedures for managing assaultive and/or self-destructive patient behavior, and assure staff has access to and are familiar with these procedures.

(ii) Maintain adequate fiscal accounting records.

(iii) Prepare and submit such reports as are required by the secretary.

(iv) Maintain a procedure for collection of fees and third-party payments.

(3) Whenever a component is also subject to licensure under other federal or state statutes or regulations, the more restrictive standard shall apply.

[00-23-089, recodified as § 388-861-263, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 34.04.020. 87-19-071 (Order 2536), § 275-55-263, filed 9/16/87. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-263, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-263, filed 3/11/82.]

WAC 388-861-271 Outpatient component. (1) The outpatient component is defined as a setting where evaluation and treatment services are provided on a regular basis to patients. These services are intended to stabilize, sustain, and facilitate recovery of the individual within his or her living setting. Services shall be provided directly by a licensed physician licensed pursuant to chapter 18.57 or 18.71 RCW, a psychologist licensed pursuant to chapter 18.83 RCW, a psychiatric nurse licensed pursuant to chapter 18.88 RCW, or by an agency licensed pursuant to chapter 71.24 RCW and chapter 275-56 WAC.

(2) In addition to the general requirements stated in WAC 275-55-263(2), the following requirements shall apply to all outpatient components:

(a) Such component shall provide a therapeutic program which may include, but is not limited to, at least one of the following:

(i) Individual therapy.

(ii) Group therapy.

(iii) Family/marital therapy.

(iv) Medication management.

(v) Case management.

(b) Such component shall provide treatment to each patient under the supervision of a mental health professional.

(c) Each patient should be seen at least weekly by assigned staff during the period of involuntary treatment. A mental health professional must review each outpatient case at least monthly to ensure updating of the treatment plan and such review must be recorded in the patient's clinical record. The frequency of patient contact and case review may be modified if in the opinion of a mental health professional such is warranted and the reasons for so doing are recorded in the patient's clinical record.

(d) Such component must have access to consultation by a psychiatrist or a physician with at least one year's experience in the direct treatment of mentally ill or emotionally disturbed persons.

(e) Such component shall include medical consultation with the involuntary patient to assess and prescribe psychotropic medication to meet the needs of the patient. Such consultation shall occur at least weekly during the fourteen-day period, and monthly during the ninety-day period and the one hundred eighty-day period of involuntary treatment unless determined otherwise by the attending physician and the reasons for so doing are recorded in the patient's clinical record.

[00-23-089, recodified as § 388-861-271, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 34.04.020. 87-19-071 (Order 2536), § 275-55-271, filed 9/16/87. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-271, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-271, filed 3/11/82.]

WAC 388-861-281 Emergency component. (1) The emergency component is defined as a public or private agency or hospital having the capacity to detain an individual posing an imminent threat to the safety and/or well-being of self or others, or is gravely disabled.

(2) The department may upon the formal request of the county or Regional Support Network, accept a hospital licensed under WAC 246-318-280 or 246-322 as a certified emergency component for an evaluation and treatment program, in lieu of requiring a hospital to meet the requirements set forth by WAC 275-55-263, 275-55-281, and 275-55-293.

(3) In addition to the general requirements stated in WAC 275-55-263(2), the following requirements shall apply to all emergency components. Such components shall:

(a) Be available seven-days-per-week, twenty-four-hours-per-day;

(b) Follow a written protocol for detaining an individual and contacting the county or Regional Support Network designated mental health professional;

(c) Provide or have access to medical services;

(d) Have a written agreement with a certified short-term inpatient component for admission on a seven-day-per-week, twenty-four-hour-per-day basis; and

(e) Follow a written protocol for transporting individuals to short-term inpatient components or state hospitals.

[00-23-089, recodified as § 388-861-281, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 74.05.560. 91-16-061 (Order 3222), § 275-55-281, filed 8/1/91, effective 9/1/91. Statutory Authority: RCW 34.04.020. 87-19-071 (Order 2536), § 275-55-281, filed 9/16/87. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-281, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-281, filed 3/11/82.]

WAC 388-861-291 Short-term inpatient component. (1) The inpatient component is a hospital or residential setting where treatment services are provided on a twenty-four-hour-per-day basis for individuals on seventy-two hour detentions or fourteen-day commitments.

(2) The department may accept a hospital licensed under WAC 246-318-280 or 246-322 as a certified short-term inpatient component for an evaluation and treatment program, in lieu of requiring a hospital to meet the requirements set forth by WAC 275-55-263, 275-55-291, and 275-55-293.

(3) In addition to the general requirements stated in WAC 275-55-263(2), the following requirements shall apply to all inpatient components:

(a) The inpatient component shall meet the standards required for state licensing as a skilled nursing facility, intermediate care facility, or residential treatment facility;

(b) Such component shall have the capability to admit the individual on a twenty-four-hour-per-day, seven-day-per-week basis;

(c) Such component shall not deny admission except under the following circumstances:

(i) After a psychosocial evaluation, there is a determination by a mental health professional that the individual does not present a likelihood of serious harm, or an imminent likelihood of serious harm, or the individual is not gravely disabled, and does not require inpatient care. Reference RCW 71.05.190 for necessary action in this case;

(ii) The individual requires specialized medical care and support services of a type not provided by the facility;

(iii) A greater degree of control is required than can be provided by the facility;

(iv) Treatment space is not available and is so documented;

(v) A less restrictive alternative provided by another facility is more appropriate and available; and

(vi) For situations arising under subsection (3)(c)(i) through (iv) of this section, the county or Regional Support Network-designated mental health professional shall make arrangements for the most appropriate placement available.

(d) Such component shall within twenty-four hours of initial detention, to include Saturday, Sunday, and holidays, conduct evaluations to determine the nature of the disorder, the treatment necessary, and whether or not detention is required. Such evaluations shall include at least a:

(i) Medical evaluation by a licensed physician; and

(ii) Psychosocial evaluation by a mental health professional.

(e) Such component shall have the capability to detain persons dangerous to self, others, or gravely disabled, and shall provide or have access to at least one seclusion room meeting the requirements of WAC 248-18-001(65);

(f) Such component shall provide therapeutic services including generally accepted treatment modalities such as:

(i) Individual therapy; and

(ii) Medication management.

(g) Such component shall provide treatment to each individual under the supervision of the professional person in charge;

(h) A mental health professional must have contact with each involuntary patient daily for the purpose of observation, evaluation, and the provision of continuity of treatment; and

(i) Such component shall have access to a mental health professional and a licensed physician for consultation and communication with the individual and the component staff on a twenty-four-hour-per-day, seven-day-per-week basis.

[00-23-089, recodified as § 388-861-291, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 74.05.560. 91-16-061 (Order 3222), § 275-55-291, filed 8/1/91, effective 9/1/91. Statutory Authority: RCW 34.04.020. 87-19-071 (Order 2536), § 275-55-291, filed 9/16/87. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-291, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-291, filed 3/11/82.]

WAC 388-861-293 Certification procedure—Waivers—Provisional certification—Renewal of certification. (1) In order to certify an agency's component or components, the department shall:

(a) Receive a formal request from the county-designated administrator of the evaluation and treatment program; and

(b) Conduct a site visit of the component or components including an inspection and examination of any records, procedures, materials, areas, programs, staff, and patients necessary to determine compliance with WAC 275-55-263, and the appropriate sections of WAC 275-55-271 through 275-55-331.

(2) The department shall issue full certification to a component only if the component is in full compliance with the applicable sections of this chapter.

(3) Variances from a rule may be granted by the department in the form of a waiver, pursuant to the provisions of WAC 275-55-371.

(4) Provisional certification may be granted by the director to a component or components which are in substantial compliance with the applicable sections of this chapter. Such provisional certification shall specify the number and type of deficiencies temporarily allowed and the length of provisional status.

(5) Renewal of certification is required at least every other year, and may require a complete site visit of the component or components as specified in subsection (1)(b) of this section.

[00-23-089, recodified as § 388-861-293, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-293, filed 1/13/84; 83-03-010 (Order 1935), § 275-55-293, filed 1/12/83; 82-07-024 (Order 1775), § 275-55-293, filed 3/11/82.]

WAC 388-861-295 Decertification. The department may decertify any component in accordance with the provisions of RCW 71.05.540 (4) and (5), guidelines promulgated and procedures for investigation of complaints set forth by the director.

[00-23-089, recodified as § 388-861-295, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-295, filed 3/11/82.]

WAC 388-861-297 Appeal procedure. (1) Any agency whose component or components have been denied certification, or have been decertified by the department may appeal such a decision.

(2) Such appeal shall:

(a) Be made in writing;

(b) Specify the date of the decision being appealed;

(c) Specify clearly the issue to be reviewed;

(d) Be signed by, and include the address of the agency;

(e) Be made within thirty days of notification of the decision being appealed.

(3) An appeal on decisions should be made in accordance with the Administrative Procedure Act, chapter 34.04 RCW.

[00-23-089, recodified as § 388-861-297, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-297, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-297, filed 3/11/82.]

WAC 388-861-301 Alternatives to inpatient treatment. In considering all petitions for involuntary commitments to inpatient treatment as to whether the patient's presenting problem is appropriate for care and treatment, the professional person in charge of the inpatient component shall explore less restrictive alternatives, including possible outpatient or residential treatment, and shall consider possible better, or equal treatment elsewhere, preferably within the patient's home community.

[00-23-089, recodified as § 388-861-301, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-301, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-301, filed 3/11/82.]

WAC 388-861-341 Use of restraints and seclusion by agency not certified as an evaluation and treatment facility. An agency not certified as an evaluation and treatment facility pursuant to WAC 275-55-263, or not covered by other appropriate statutes or regulations, may use restraints and seclusion only as specified in WAC 275-55-263 (2)(e).

[00-23-089, recodified as § 388-861-341, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-341, filed 3/11/82.]

WAC 388-861-351 Research. All research concerning mentally ill persons, whose cost of care is paid for by the department and who are voluntarily admitted or involuntarily committed under this chapter or involving disclosure of personal records shall be undertaken in accordance with department rules on the protection of human research subjects as specified in chapter 388-10 WAC. Furthermore, any person involved in evaluation or research concerning persons under this chapter shall be required to sign a statement as provided for in RCW 71.05.390. Such statement will be filed with the director.

[00-23-089, recodified as § 388-861-351, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-351, filed 3/11/82.]

WAC 388-861-361 Involuntary evaluation and treatment costs—Responsibility of involuntary patient. (1) Any person, or his or her estate, or his or her spouse, or the parents of a minor becoming an involuntary patient pursuant to chapter 71.05 RCW shall be responsible for the cost of such evaluation and treatment. (Reference RCW 71.05.100)

Payment of such costs by the involuntary patient, or on behalf of the involuntary patient by third-party payors, or other legally responsible persons or entities shall be made to:

(a) The state in instances where evaluation and treatment is provided in a facility maintained and operated by the department, pursuant to RCW 71.02.411.

(b) The local agency in instances where evaluation and treatment is provided by the agency and the agency is not a facility maintained and operated by the department.

(2) In instances where inability to pay or substantial hardship is determined for an involuntary patient pursuant to WAC 275-55-363(4), any unpaid costs for evaluation and treatment provided to such involuntary patient by a nondepartment agency shall be borne by the department, subject to the provisions of WAC 275-55-363, and 275-55-365.

[00-23-089, recodified as § 388-861-361, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-361, filed 3/11/82.]

WAC 388-861-363 Involuntary evaluation and treatment costs—Collection by agency. (1) Definitions. For the purposes of this section:

(a) "Involuntary patient" is as defined by WAC 275-55-020(18).

(b) "Title XIX" means Title XIX of the Social Security Act.

(c) "CSO" means community services office of the department.

(2) Collection of costs for evaluation and treatment provided an involuntary patient by an agency not operated and maintained by the department shall be the responsibility of the agency. Such agency shall make reasonable efforts to make such collection pursuant to the agency's own regulations and policies. Such effort shall also include, but is not limited to, billing all appropriate resources of the involuntary patient and the patient's family, third-party payors, and other legally responsible persons and entities.

(3) Any involuntary patient not having private insurance to cover his or her costs, not already eligible for Title XIX or other state or federal assistance for his or her costs, or not otherwise paying for his or her evaluation and treatment costs, shall be referred by the agency providing the inpatient component to a local CSO for determination of eligibility for Title XIX benefits. If such patient is determined so eligible by the CSO, the agency shall bill according to the instructions set forth by the department.

(4) In the case of any involuntary patient not eligible for Title XIX benefits the agency providing the inpatient component shall determine the amount, if any, the patient should participate in the treatment costs. Such participation shall be in accordance with department instructions as set forth in the applicable mental health division issuance. Physicians, community mental health centers and other agencies not providing inpatient care are not required to make this patient participation calculation.

(5) The agency may bill the department for the balance of costs not collectable by actions taken in accordance with subsections (2), (3), and (4) of this section and not recoverable by any other means or from any other sources. Such billing shall be subject to the following:

(a) Reimbursement is sought through the appropriate county as defined by WAC 275-55-365(1). All bills shall be verified by the county or the county's designee before forwarded by the county to the department for payment.

(b) Certification is made by the agency that every reasonable effort has been made to collect payment from all appropriate resources of the involuntary patient and the patient's family, third-party payors, and other legally responsible persons and entities prior to submitting a claim through the county. This would include, where appropriate, referral to a CSO for medicaid eligibility determination.

(c) Any collections made prior to such billing shall be shown and deducted from such billing. Any collections made subsequent to such billings shall be submitted to the department.

(6) In the event an involuntary patient is determined by the agency or by the local CSO (in instances where such patient had been referred for eligibility determination) to be fully capable of paying for his or her evaluation and treatment services, and such patient refuses to do so, the agency shall have primary responsibility for collection of costs and shall not expect the department to reimburse the agency for any uncollected balance, except as stated in the applicable mental health division issuance.

(7) The agency shall maintain appropriate records and other supporting material necessary to document billings and collection of costs for evaluation and treatment provided any involuntary patient, and shall permit authorized representatives of the county and/or the department to make such review of the records of the agency as may be deemed necessary to satisfy audit purposes. Such review shall be restricted to records for involuntary patients only.

[00-23-089, recodified as § 388-861-363, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-363, filed 3/11/82.]

WAC 388-861-365 Involuntary evaluation and treatment costs—Responsibility of county. (1) All requests for reimbursement shall be made through the county of detention which shall review and approve requests pursuant to the following:

(a) The person being billed for was in fact an involuntary patient for the period of evaluation and treatment specified.

(b) The date of initial detention is indicated.

(c) Date of the seventy-two hour (probable cause) hearing is indicated.

(d) Date of conversion to voluntary patient status is shown (if appropriate).

(e) Date of release, transfer or discharge is shown.

(f) Days allowed by an approved extension request are shown (if appropriate).

(g) The "patient participation" calculation is shown on inpatient facility invoices, or the patient is shown to be eligible for medicaid or LCP-MI.

(h) If insurance coverage is indicated, such coverage collections have been deducted.

(2) All reimbursement payments for evaluation and treatment costs for involuntary patients shall be made directly to the service-providing agency.

(3) No payments will be made to agencies not certified pursuant to WAC 275-55-263, and not a part of a county's evaluation and treatment program pursuant to WAC 275-55-261, except in the case of licensed physicians.

(4) The counties shall maintain appropriate records and other supporting material necessary to document related administrative costs, and shall submit such reports as the department shall request and shall permit authorized representatives of the department to make such review of records as may be deemed necessary to satisfy audit purposes.

[00-23-089, recodified as § 388-861-365, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-365, filed 3/11/82.]

WAC 388-861-367 Involuntary evaluation and treatment costs—Responsibility of department. (1) In instances where an involuntary patient is unable to pay any or all of the costs of evaluation and treatment from all of the personal, family when legally responsible, or third-party payor resources available to him or her as required by WAC 275-55-361, or if payment would result in substantial hardship upon such patient or his or her family, the department shall be responsible for paying any uncollected balance of such costs, as set forth in the applicable mental health division issuance, except costs for which the CSO has determined the patient should continue to be liable.

(2) The department shall reimburse the counties for increased administrative costs, if any, resulting from implementation of the provisions of the 1973 Involuntary Treatment Act. Additional costs to the counties shall be reimbursed in accordance with the following rules, subject to the availability of state and federal funds.

(3) For all increased involuntary commitment administrative costs, the department shall award an amount to the counties to pay such costs pursuant to RCW 71.05.550. "Increased costs" as used here shall mean costs exceeding the level financed by the county for calendar year 1973, resulting from implementation of the provisions of the 1973 involuntary treatment act, and subsequent amendments.

(a) Involuntary commitment administrative costs are for services not listed under the Title XIX modality schedule. Such costs include:

(i) All travel and transportation expenses, whether for staff or involuntary patients;

(ii) All investigative costs not otherwise recoverable as a Title XIX listed service;

(iii) Expenses for hearings, testimony, legal services, courts, and prosecutors; and

(iv) The percentage of total staff time of the county mental health coordinator and agency administrative staff allocated to and expended in the involuntary commitment process.

(b) State funds shall in no case be used to replace local funds from any source used to finance administrative costs for involuntary commitment procedures conducted prior to January 1, 1974.

(4) For the evaluation and treatment provided each and every involuntary patient by a qualifying agency, the department shall reimburse the agencies in the amount of the actual expenditures incurred pursuant to this chapter and applicable departmental instructions. Such reimbursement by the department shall not exceed the Title XIX rate and shall not be allowed for any costs already reimbursed by other means. Such reimbursement by the department shall cover the following involuntary evaluation and treatment statuses only:

(a) Emergency component services for individuals where a petition for initial detention is filed under RCW 71.05.160 within twelve hours of admission to that component.

(b) Initial detention period including Saturdays, Sundays, holidays and up to three judicial days.

(c) Fourteen-day period, including any involuntary outpatient treatment or less restrictive placement recommended by agency staff for the remainder of this period. Reimbursement beyond this fourteen-day period shall require approval from the department consistent with the applicable mental health division issuance.

(d) Conditional release effected pursuant to the applicable provisions of this chapter and chapter 71.05 RCW. Reimbursement shall be restricted to the initial seventeen-day period.

(e) Conversion to voluntary status. Reimbursement shall be restricted to inpatient or outpatient services provided during the initial seventeen-day period, regardless of the day within that period the involuntary patient converts to voluntary status.

(5) The department may withhold department reimbursement in whole or in part from any county or agency in the event of a failure to comply with the provisions of this chapter.

[00-23-089, recodified as § 388-861-367, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 82-07-024 (Order 1775), § 275-55-367, filed 3/11/82.]

WAC 388-861-371 Exceptions to rules—Waivers. Any person or agency subject to the provisions of this chapter may seek a waiver of any requirement of this chapter, as set forth in this section.

(1) The applicant shall file an application for a waiver with the director.

(2) Any application for a waiver from any person or agency shall state, in writing, the following:

(a) The name and address of the person or agency seeking the waiver;

(b) The specific section or subsection of this chapter sought to be waived, and the specific practice or procedure required by such section or subsection;

(c) An explanation of why a waiver of the section or subsection is necessary;

(d) The variance the applicant proposes to follow in lieu of that required by the section or subsection;

(e) A plan and timetable for compliance with the section or subsection for which the waiver is sought; and

(f) Signed documentation from the county-designated administrator of the evaluation and treatment program indicating the proposed waiver has been reviewed and what degree of support has been extended.

(3) The director shall grant or deny the waiver in writing, and shall so notify the applicant. This notice shall be given

the applicant within sixty days of receipt of the original application by the director.

(a) If the waiver is granted, the notice shall include:

(i) The section or subsection waived;

(ii) Any conditions with which the applicant must comply;

(iii) The duration of the waiver, in no case to exceed one year from the date the waiver is granted;

(iv) The reason why the waiver is considered necessary.

(b) If the waiver is denied, the notice shall include reasons for the decision.

(4) Appeal of the denial of a waiver request shall be made in accordance with the Administrative Procedure Act, chapter 34.04 RCW.

(5) Requirements prescribed by chapter 71.05 RCW and other legislation are not subject to waiver by the director.

(6) A waiver granted by the director shall be attached to and become part of the county plan.

[00-23-089, recodified as § 388-861-371, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 71.05.560. 84-03-035 (Order 2065), § 275-55-371, filed 1/13/84; 82-07-024 (Order 1775), § 275-55-371, filed 3/11/82.]

WAC 388-861-400 Mental health service provider license and certification fees. (1) An annual fee, based on a range of client service hours provided per year, shall be assessed as follows:

Range	Client Service Hours	Annual Fee
1	0 - 3,999	$ 281.00
2	4,000 - 14,999	422.00
3	15,000 - 29,999	562.00
4	30,000 - 49,999	842.00
5	50,000 and over	1,030.00

(2) Fee ranges shall be determined from provider information reported to the department's community mental health information system.

(3) Providers applying for a license or certification and not reporting to the department's community mental health information system shall submit the number of annual client service hours as part of their application.

(4) Fee for an applicant not licensed or certified shall be equal to the fees for licensure or certification of licensed and certified providers with similar annual client service hours.

(5) Certified short-term inpatient component, or new applicants seeking certification for a short-term inpatient component, shall be assessed an annual fee of thirty-two dollars per bed. This annual fee shall not be assessed for inpatient hospitals licensed under chapter 70.41 RCW.

[00-23-089, recodified as § 388-861-400, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 43.20B.110. 91-23-089 (Order 3291), § 440-44-090, filed 11/19/91, effective 12/20/91. Statutory Authority: RCW 43.20A.055. 85-20-031 (Order 2287), § 440-44-090, filed 9/24/85.]

WAC 388-861-401 Fee payment and refunds. (1) Fees are due with applications for initial license or renewal. The department will not proceed on applications until required fees are paid.

Except as otherwise provided in these rules, fees shall be paid for a minimum of one year.

(2) Fees for licenses issued for other than yearly periods shall be prorated based on the stated annual fee.

(3) When the department issues a license for more than one year:

(a) Fees may be paid for the entire licensing period by paying at the rate established at the time the application was submitted, or

(b) If the licensee does not pay the fee for the entire license period, annual fees shall be due thirty days prior to each annual anniversary date of the license, at the annual fee rate established by these rules at the time such fee is paid.

(4) Except as otherwise provided in these rules, if an application is withdrawn prior to issuance or denial, one-half of the fee shall be refunded.

(5) If there is a change of or by the licensee requiring a new license, the fee paid for a period beyond the next license anniversary date shall be refunded. Changes requiring a new license shall require a new application and payment of fee as provided herein.

(6) If there is a change by the applicant or licensee that requires an amendment placing the licensee in a higher fee category, the additional fee shall be prorated for the remainder of the license period.

(7) Fees becoming due on or after the effective date of this chapter shall be at the rates provided herein.

(8) To the extent fees are reduced through regular rule adoption of this chapter on or before December 31, 1982, fees shall be refunded.

(9) Fee payments shall be by mail. Payment shall be by check, draft, or money order made payable to the department of social and health services.

[00-23-089, recodified as § 388-861-401, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-010, filed 6/4/82.]

WAC 388-861-402 Denial, revocation, suspension, and reinstatement. (1) If a license is denied, revoked, or suspended, fees shall not be refunded.

(2) Application for license after denial or revocation must include fees as provided for in these rules.

(3) Failure to pay fees when due will result in suspension or denial of license.

[00-23-089, recodified as § 388-861-402, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-015, filed 6/4/82.]

Chapter 388-862 WAC
COMMUNITY MENTAL HEALTH PROGRAMS
(Formerly chapter 275-57 WAC)

WAC

WAC 388-862-010 Purpose and authority. The purpose of chapter 275-57 WAC is to implement a locally-managed community mental health program to help people experiencing mental disorders retain or gain respected and productive positions in their community or, when appropriate, to achieve and maintain their optimal level of functioning. This chapter replaces chapter 275-56 WAC and establishes rules and regulations for regional support networks (RSNs), prepaid health plans (PHPs), licensed service providers, information, accountability, contracts, and services. The department's legal authority for adopting this chapter is chapter 71.24 RCW.

(1) Compliance with the rules and regulations for RSN duties shall be phased in according to the contract with the department. The department shall apply all rules and regulations in this chapter pertaining to RSNs to non-RSN counties, unless noted otherwise. Rules and regulations for RSNs are specified in sections 050 through 170 of this chapter.

(2) Compliance with the rules and regulations for PHP duties shall be phased in according to the contract with the department. PHPs shall also be certified as an RSN or licensed as a provider. Rules and regulations for PHPs are specified in sections 150 through 260 of this chapter. If the PHP is not an RSN, sections 070 through 120 shall also apply to the PHP.

(3) Rules and regulations for licensed service providers which provide services under contract to a PHP or RSN are specified in sections 030 and 270 through 450 of this chapter.

(4) Rules and regulations for licensed providers which do not contract with either an RSN or PHP are specified in sections 030, 270 through 380, and applicable services as described in sections 400 through 450.

[00-23-089, recodified as § 388-862-010, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-010, filed 9/27/94, effective 10/28/94.]

WAC 388-862-020 Definitions. (1) **"Acutely mentally ill"** means a condition limited to a short-term severe crisis episode of:

(a) A mental disorder as defined in RCW 71.05.020 (2) or in the case of a child, as defined in RCW 71.34.020 (12);

(b) Being gravely disabled as defined in RCW 71.05.020 (1) or, in the case of a child, as defined in RCW 71.34.020 (8); or

(c) Presenting a likelihood of serious harm as defined in RCW 71.05.020 (3) or, in the case of a child, as defined in RCW 71.34.020 (11).

(2) **"Allied service providers"** means providers of social services not licensed under this chapter, but serving RSN consumers. These include, but are not limited to, child and family services, alcohol and substance abuse services, vocational rehabilitation services, developmental disability services, and schools.

(3) **"Certified marriage and family therapist"** means a person certified to practice marriage and family therapy under RCW 18.19.130.

(4) **"Certified mental health counselor"** means a person certified to practice mental health counseling under RCW 18.19.120.

(5) **"Certified social worker"** means a person certified to practice social work under RCW 18.19.110.

(6) **"Child"** means a person seventeen years of age or younger.

(7) **"Chronically mentally ill adult"** means an adult who has a mental disorder and meets at least one of the following criteria:

(a) Has undergone two or more episodes of hospital care for a mental disorder within the preceding two years; or

(b) Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding year; or

(c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for a continuous period of not less than twelve months.

(8) **"Clinical services"** means those direct age and culturally appropriate consumer services which either:

(a) Assess a consumer's condition, abilities, or problems; or

(b) Provide therapeutic interventions which are designed to ameliorate psychiatric symptoms and improve a consumer's functioning.

(9) **"Consumers"** means persons, couples, or families who are eligible to or are receiving clinical, coordinative, or support services.

(10) **"Consultation"** means review and recommendations regarding the job responsibilities, activities, or decisions of administrative, clinical or clerical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations.

(11) **"Crisis"** means a situation where a person is acutely mentally ill or experiencing serious disruption in cognitive, volitional, psychosocial, or neurophysiological functioning.

(12) **"Cultural competence"** means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

(13) **"Department"** means the department of social and health services.

(14) **"Disabled,"** for the purposes of this chapter only, means an individual with a developmental disability, serious physical impairment, or sensory impairment.

(15) **"Elderly"** means a person sixty years of age or older.

(16) **"Employment services"** means supported employment, transitional work, placement in competitive employment, and other work-related services that result in persons with a mental illness becoming engaged in meaningful and gainful full-time or part-time work.

(17) **"Enrolled recipient"** means, for purposes of a prepaid health plan (PHP), a person eligible for Medicaid services, and eligible to receive community mental health rehabilitation services.

(18) **"Fair hearing"** means an adjudicative proceeding as defined under chapter 34.05 RCW.

(19) **"Gravely disabled"** means a condition where a person, as a result of a mental disorder:

(a) Is in danger of serious physical harm resulting from a failure to provide for such person's essential human needs of health or safety; or

(b) Manifests severe deterioration in routine functioning;

(i) Evidenced by repeated and escalating loss of cognition or volitional control over such person's actions; and

(ii) Is not receiving such care as is essential for such person's health or safety.

(20) **"Individualized plan"** means a plan developed by the provider in collaboration with the consumer and others providing supports to the consumer. The individualized plan:

(a) Is developed with the consumer and people who know the consumer best;

(b) Focuses on and enhances consumer strengths as defined by the consumer;

(c) Is flexible and responsive to the consumer's changing needs; and

(d) Focuses on meeting those basic needs that persons of similar age, gender, and culture have.

(21) **"Integrated work setting"** means a setting which offers regular contact with nondisabled coworkers and includes social interaction and integration at the work site.

(22) **"Licensed provider"** means an agency licensed by the department under this chapter.

(23) **"Limited-English proficient"** means persons applying for or receiving services from the department or its contractors who have difficulty understanding what an English speaking staff person says or who have trouble being understood by the English speaking staff person.

(24) **"Mental disorder"** means organic, mental, or emotional impairment having substantial adverse effect on a person's cognitive or volitional functions.

(25) **"Mental health professional"** means:

(a) A physician or osteopath licensed under chapter 18.57 or 18.71 RCW, who is board eligible in psychiatry;

(b) A psychologist licensed under chapter 18.83 RCW;

(c) A psychiatric nurse, which means a registered nurse licensed under chapter 18.88 RCW and having at least two years' experience in the direct treatment of mentally ill persons;

(d) A person having at least a masters degree in behavioral sciences, social work, nursing sciences, or related field from an accredited college or university and having at least two years' experience in the direct treatment of mentally ill persons;

(e) A mental health counselor, social worker, or marriage and family therapist certified under chapter 18.19 RCW and having at least two years' experience in the direct treatment of mentally ill persons; or

(f) A person otherwise qualified to perform the duties of a mental health professional but does not meet the requirements listed in (a) through (e) of this subsection, where the department has granted an exception to such requirements upon review of a written request by the RSN or PHP involved.

(26) **"Minority"** or **"ethnic minority"** or **"racial/ethnic groups"** means any of the following general population groups:

(a) African American; or

(b) An American Indian or Alaskan native, which includes:

(i) An enrolled Indian:

(A) A person enrolled or eligible for enrollment in a recognized tribe;

(B) A person determined eligible to be found Indian by the secretary of the interior; and

(C) An Eskimo, Aleut, or other Alaskan native.

(ii) A Canadian Indian: A person being a member of a treaty tribe, Metis community, or nonstatus Indian community from Canada.

(iii) An unenrolled Indian: A person considered Indian by a federally or nonfederally recognized Indian tribe or off reservation Indian/Alaskan native community organization;

(c) Asian or Pacific Islander; or

(d) Hispanic.

(27) **"Nonclinical services"** means those services designed to support the consumer and facilitate community living and do not require licensing under this chapter. Nonclinical services include, but are not limited to:

(a) Peer support and advocacy;

(b) Assistance accessing or locating services;

(c) Help with daily living; and

(d) Provision of transportation.

(28) **"Prepaid health plan (PHP)"** means an organization that provides and/or pays for Medicaid mental health services provided to an eligible enrolled consumer for a prepaid capitated rate under the terms of a department contract.

(29) **"Priority populations"** means:

(a) Acutely mentally ill adults and children;

(b) Chronically mentally ill adults;

(c) Severely emotionally disturbed children; or

(d) Seriously disturbed adults and children at risk of becoming acutely or chronically mentally ill, or seriously emotionally disturbed, as determined by the RSN at their sole discretion.

(30) **"Primary care provider "(PCP)"** means a person with primary responsibility for implementing the individualized plan for community mental health rehabilitation services with the enrolled recipient.

(31) **"Provider"** means licensed provider as defined under this chapter.

(32) **"Regional support network"** (RSN) means a county authority or group of county authorities recognized by the secretary that enter into joint operating agreements to contract with the secretary under this chapter.

(33) **"Research"** means a planned and systematic sociological, psychological, epidemiological, biomedical, or other scientific investigation carried out by a state agency, by scientific research organization, or by a graduate student currently enrolled in an advanced academic degree curriculum, with an objective to contribute to scientific knowledge, the solution of social and health problems, or the evaluation of public benefit and service programs. This shall not include program evaluation conducted for internal monitoring or review purposes.

(34) **"Seriously disturbed person"** means a person who:

(a) Is gravely disabled or presents a likelihood of serious harm to oneself or others as a result of a mental disorder as defined in chapter 71.05 RCW;

(b) Has been on conditional release status at some time during the preceding two years from an evaluation and treatment facility or a state mental health hospital;

(c) Has a mental disorder which causes major impairment in several areas of daily living;

(d) Exhibits suicidal preoccupation or attempts; or

(e) Is a child diagnosed by a mental health professional, as defined in RCW 71.05.020, as experiencing a mental disorder which is clearly interfering with the child's functioning in family or school or with peers or is clearly interfering with the child's personality development and learning.

(35) **"Severely emotionally disturbed child"** means a child who has been determined by the regional support network to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:

(a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;

(b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;

(c) Is currently served by at least one of the following child-serving systems: Juvenile justice, child-protection/welfare, special education, or developmental disabilities;

(d) Is at risk of escalating maladjustment due to:

(i) Chronic family dysfunction involving a mentally ill or inadequate caretaker;

(ii) Changes in custodial adult;

(iii) Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home, or a correctional facility;

(iv) Subject to repeated physical abuse or neglect;

(v) Drug or alcohol abuse; or

(vi) Homelessness.

(36) **"Substantial gainful activity"** means work involving significant physical or mental activities done for pay or profit. For the purposes of this chapter only, substantial gainful activity also means:

(a) For children, the ability to productively participate in educational activities;

(b) For elderly, retired persons, the ability to manage retirement income and activities of daily living; and

(c) For persons disabled due to physical impairment, the ability to manage disability income and activities of daily living.

(37) **"Supervision"** means regular monitoring of the administrative, clinical, or clerical work performance of staff, students, volunteers, or contracted employees by persons with the authority to give direction and require change.

(38) **"Supported employment"** means competitive employment in an integrated work setting with ongoing support services and reasonable accommodations for persons with mental illness, for whom competitive employment has not traditionally occurred or which has been interrupted.

(39) **"Transitional employment"** means competitive work in an integrated setting for persons with mental illness who may need support services (but not necessarily job skill training services) and reasonable accommodations, provided either at the work site or away from the work site. The job placement may not necessarily be a permanent employment outcome for the person.

(40) **"Tribal authorities,"** for the purposes of this chapter and RCW 71.24.300, means: The federally recognized Indian tribes and the major Indian organizations recognized by the secretary of the department insofar as these organiza-

tions do not have a financial relationship with any regional support network that would present a conflict of interest.

(41) **"Underserved"** means persons who are:

(a) Minorities;

(b) Children;

(c) Elderly;

(d) Disabled; and

(e) Low-income persons.

[00-23-089, recodified as § 388-862-020, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-020, filed 9/27/94, effective 10/28/94.]

WAC 388-862-030 Waiver of rules. (1) An RSN, PHP, licensed provider or applicant subject to the provisions of this chapter may seek a waiver of any requirement of this chapter by completing and submitting forms furnished by the department. The RSN, PHP, licensed provider, or applicant shall ensure the waiver request includes:

(a) The specific section for which the waiver is being requested;

(b) A description of the hardship or opportunity for service improvement to be addressed by the waiver;

(c) A description of the plan to achieve compliance, or to implement, test, and report results of a possible service improvement;

(d) Duration requested for the waiver;

(e) For agencies contracting with an RSN or PHP, a statement by the RSN or PHP recommending approval for the request;

(f) Recommendations, if any, from the quality review team or ombuds staff, as defined in sections 150 and 160 of this chapter; and

(g) A description of how consumers shall be notified of changes made as a result of the waiver.

(2) Upon receipt of a request for waiver, the department shall consider:

(a) Impact on accountability, accessibility, efficiency, consumer satisfaction, and quality of care;

(b) Degree of noncompliance sought; and

(c) Whether the requirement is also in statute and therefore may not be waived.

(3) The department shall respond to the waiver request in writing within thirty days of receipt of the request.

(a) If the waiver is granted, the department shall issue a notice which includes:

(i) Section or subsection waived;

(ii) Conditions;

(iii) Duration of the waiver which shall in no case extend past the date of renewal of the agency license or RSN certification;

(iv) Notification that the waiver shall be subject to review and possible renewal, if requested.

(b) If the department denies the waiver, the department shall ensure the notice includes reasons for the decision.

(4) The RSN, PHP, licensed provider, or applicant may appeal the denial of a waiver request to the secretary in accordance with the Administrative Procedure Act, chapter 34.05 RCW.

[00-23-089, recodified as § 388-862-030, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-030, filed 9/27/94, effective 10/28/94.]

WAC 388-862-040 Department responsibilities and duties. The department shall:

(1) Comply with duties as specified under chapter 71.24 RCW;

(2) Coordinate state mental health policy and advocate to promote age and culturally competent services for consumers;

(3) Maintain minimum service delivery standards. Under such standards, the department shall license and certify providers and certify RSNs. In licensing and certification reviews, the department shall:

(a) Coordinate reviews with other audits and inspections of the state and RSNs to minimize overlap and duplication of effort;

(b) Evaluate the effectiveness of local processes which address consumer satisfaction, enable consumer needs to be met, and provide for prudent expenditure of public funds; and

(c) Have reasonable access at reasonable times to the records of RSNs, PHPs, and licensed providers.

(4) Establish and implement outcome-based contracts with RSNs and PHPs;

(5) Develop and implement an outcome-based plan in collaboration with consumers, families, RSNs, providers, and diverse communities. The department shall ensure the plan is periodically reviewed and resources applied toward its implementation;

(6) Be designated as the county authority if a county or RSN fails to significantly meet contractual requirements or minimum standards or chooses not to exercise responsibilities under RCW 71.24.045;

(7) Be designated as the PHP if:

(a) An RSN or provider is not available to serve as the PHP; or

(b) The department can administer community mental health rehabilitation services more efficiently and cost effectively than other available RSNs or providers without loss of quality of care. Evidence that it would be more efficient and cost effective than other available RSNs or providers includes, but is not limited to, lower administrative costs, lower unit cost for comparable services, higher productivity, and increased service quality.

(8) Implement policies to maximize system efficiency and resources which go to services. The department shall assess new policies in terms of intended results and cost-effectiveness;

(9) Advocate for cross-system collaboration and sharing of resources for consumers served by multiple systems;

(10) Support and promote technical assistance, community education, stigma reduction, training and research; and

(11) Maintain an effective, internal quality improvement process to assess and improve the above requirements of this section.

[00-23-089, recodified as § 388-862-040, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-040, filed 9/27/94, effective 10/28/94.]

WAC 388-862-050 Regional support networks—General responsibilities and duties. The RSN shall:

(1) Comply with duties as specified under chapter 71.24 RCW.

(2) Identify the single point of responsibility to administer and provide community mental health services to priority populations;

(3) Provide resource management services, as described in section 110 of this chapter;

(4) Provide, or ensure the provision of, crisis response services as described in section 390 of this chapter;

(5) Provide, or ensure the provision of, a full array of brief intervention and community support services, including residential services, as described in sections 400 through 450, and 470 of this chapter;

(6) Meet the terms of the state department contract;

(7) Require its contractors and their subcontractors to comply with applicable requirements of the contract with the department;

(8) Contract for clinical services only with licensed service providers or providers licensed under chapters 18.57, 18.71, 18.83 or 18.88 RCW. If the department notifies the RSN of a provider's failure to attain or maintain licensure, the RSN shall terminate its contract with that provider;

(9) Operate as a licensed provider only when:

(a) Another provider is not available to provide the mental health services; or

(b) The RSN demonstrates to the department that it can provide the mental health services more efficiently and cost effectively than other available providers without loss of quality of care. Evidence that it would be more efficient and cost effective than other available providers includes, but is not limited to:

(i) Lower administrative costs;

(ii) Lower unit cost for comparable services;

(iii) Higher productivity; and/or

(iv) Increased service quality.

(10) Notify the department of observations indicating that providers may not be in compliance with licensing requirements. The RSN shall maintain written report of its evaluations and audits of providers for department inspection;

(11) Allow the department reasonable access at reasonable times to RSN records;

(12) Collaborate with and make reasonable efforts to obtain and use nonclinical resources in the community to maximize services to consumers; and

(13) Educate the community regarding mental illness to diminish stigma.

[00-23-089, recodified as § 388-862-050, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-050, filed 9/27/94, effective 10/28/94.]

WAC 388-862-060 Regional support networks—Recognition and certification. (1) A county or group of counties desiring recognition as a regional support network (RSN) shall submit to the department:

(a) A statement of intent for recognition as an RSN;

(b) Documentation showing a total RSN population greater than forty thousand;

(c) For RSNs of more than one county, or RSNs encompassing tribal authority or authorities, documentation of interlocal agreements, including:

(i) Identification of a single authority;

(ii) Assignment of all responsibilities to specified parties; and

(iii) Participation by tribal authorities in the agreement, where applicable; and

(d) A preliminary plan completed according to departmental guidelines;

(2) Within thirty days of application, the department shall provide written response either:

(a) Recognizing the RSN; or

(b) Denying recognition and stating the reasons for denial under subsection (1) of this section.

(3) The department's recognition and initial certification of an RSN shall depend on the RSN meeting the standards for planning and provision of services specified in this chapter.

(4) The department shall conduct a survey to renew RSN certification before each biennial contract between the department and the RSN.

[00-23-089, recodified as § 388-862-060, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-060, filed 9/27/94, effective 10/28/94.]

WAC 388-862-070 Regional support networks—Penalties for noncompliance. The department may impose penalties on RSNs for noncompliance.

(1) An RSN's failure to provide the department with requested data, statistics, schedules, or information; filing of fraudulent reports; or failure to meet contractual terms may result in the following actions, under the RSN's contract with the department:

(a) Withholding payment;

(b) Financial penalties;

(c) Suspension, revocation, limitation, or restriction of certification;

(d) Refusal to grant certification; or

(e) Other departmental action under chapter 71.24 RCW.

(2) The department shall deny partial or full funding to RSNs based solely on findings of substantial noncompliance with the terms of the RSN's contract.

[00-23-089, recodified as § 388-862-070, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-070, filed 9/27/94, effective 10/28/94.]

WAC 388-862-080 Regional support networks—Governance and community accountability. The RSN shall ensure services are responsive in an age and culturally appropriate manner to the mental health needs of its community, within available resources. The RSN shall:

(1) Establish a governance structure which includes, where applicable, representation from tribal authorities, consistent with chapter 71.24 RCW.

(2) Appoint an RSN advisory board which shall:

(a) Be broadly representative of the demographic character of the region and the mentally ill persons served. By December 31, 1995, fifty-one percent of the members of the advisory board will include:

(i) Consumers or past consumers of public mental health services; and

(ii) Family or foster family members of consumers, including parents of emotionally disturbed children.

(b) Review and comment on plans, budgets, and policies developed by the RSN to implement the requirements of chapter 71.24 RCW and this chapter. The RSN advisory board shall forward its comments to the RSN governance body and elected officials responsible for the mental health program;

(3) Develop and implement an outcome-based biennial plan in accordance with department guidelines. In developing the plan, the RSN shall:

(a) Seek and incorporate input concerning service needs and priorities from community stakeholders, including:

(i) Consumers;

(ii) Family members;

(iii) Culturally diverse communities and tribal authorities;

(iv) Social service agencies;

(v) Organizations representing persons with a disability; and

(b) Identify trends and address service gaps, including specialized services for underserved groups.

(4) Periodically review the biennial plan and ensure resources are applied in support of its goals and outcomes.

[00-23-089, recodified as § 388-862-080, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-080, filed 9/27/94, effective 10/28/94.]

WAC 388-862-090 Regional support networks—Financial management. (1) The RSN shall prudently manage public resources and shall employ accounting procedures that:

(a) Are consistent with applicable state and federal requirements and generally accepted accounting principles (GAAP); and

(b) Enable accurate reporting of revenues and expenditures in a form as issued by the department.

(2) The RSN shall require specific accounting and auditing procedures from agencies contracting with the RSN to ensure the RSN shall meet its reporting requirements to the department. The RSN may choose not to apply these accounting and auditing requirements to agencies when:

(a) The contractor is a small contractor, as defined by the RSN, and the RSN is able to account for the expenditure of such funds;

(b) RSN payments to a contractor are below a specified proportion of the contractor's total receipts, as determined by the RSN; or

(c) The contract reimbursement mechanisms are specifically tied to units of service or episodes of care, and pricing has been competitively determined or is comparable to prices paid by other purchasers of comparable services.

(3) The RSN shall expend funds received by the department in accordance with its contract with the department. The RSN shall not expend funds received by the department for any purpose other than those purposes that are intended to achieve:

(a) The performance and outcome terms of its contract with the department; and

(b) Compliance with the requirements of this chapter and chapters 275-54 and 275-55 WAC, chapters 71.05, 71.24, and 71.34 RCW, and the intentions of the State Appropriations Act.

(4) The RSN shall deliver and/or purchase goods and services prudently. The RSN shall comply with this requirement by:

(a) Purchasing all services consistent with state or county procurement procedures;

(b) Employing contract reimbursement mechanisms which ensure payments are tied to outcome and performance requirements in the RSN's contract with the department;

(c) Employing reimbursement pricing strategies which result in the highest level of desired performance, outcome and quality for the least cost. Examples of reimbursement pricing strategies which meet this requirement include:

(i) Competitive pricing, in which proposed prices for a specific package of services are compared among many providers;

(ii) Actuarial analysis, in which capitated payment levels are determined through analysis of comparative service and payment databases; and

(iii) Zero-based cost analysis, in which the price of a package of services is developed by determining the reasonable cost of the components required to deliver that package of services.

(5) The RSN shall manage assets of the RSN under applicable state and federal requirements and generally accepted accounting principles (GAAP) and under the following additional specific requirements:

(a) Assets of the RSN include all property, equipment, vehicles, buildings, capital reserve funds, operating reserve funds, risk reserve funds, or self insurance funds.

(b) Interest accrued on funds stated in this section shall be accounted for and retained for use by the RSN for purposes in subsection (3) of this section;

(c) Property, equipment, vehicles, and buildings shall be properly inventoried with a physical inventory conducted at least every two years. Proceeds from the disposal of any assets shall be retained by the RSN for purposes in subsection (3) of this section.

[00-23-089, recodified as § 388-862-090, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-090, filed 9/27/94, effective 10/28/94.]

WAC 388-862-100 Regional support network—Awareness of services. The RSN, or its designee, shall:

(1) Maintain listings of services in telephone and other public directories of the service area. The RSN, or its designee shall prominently display listings for crisis services in telephone directories;

(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all individuals, including those who may be visually impaired, limited-English proficient, or unable to read.

(3) Post and make information available to consumers regarding the ombuds service, under section 160 of this chap-

ter, and local advocacy organizations that may assist consumers in understanding their rights.

[00-23-089, recodified as § 388-862-100, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-100, filed 9/27/94, effective 10/28/94.]

WAC 388-862-110 Regional support networks—Resource management. The RSN shall establish mechanisms which maximize access to and use of mental health services, and ensure people receive appropriate levels of care. The RSN shall:

(1) Develop, implement, and enforce culturally competent written criteria for admissions, placements, transfers, and discharges to and from:

(a) Brief intervention services;

(b) Community support services, including residential services; and

(c) Inpatient services funded by the department or RSN, including:

(i) State hospitals;

(ii) Community psychiatric hospital services; and

(iii) Free standing evaluation and treatment facilities.

(2) Regularly manage utilization through a process independent of direct service providers. The RSN shall collect and analyze data regarding which consumers receive brief intervention and community support services. The RSN shall take measures to ensure:

(a) Providers implement the criteria described in subsection (1) of this section.

(b) Consumers in need of brief intervention and community support services receive medically necessary services;

(c) Consumers in brief intervention and community support services receive sufficient but not excessive services;

(d) Services are appropriate to the needs of the person and address:

(i) Age;

(ii) Culture; and

(iii) Disability.

(e) Consumers whose needs are not met through routinely available services receive flexible, individualized services, including consumer-operated services, if appropriate.

(3) Provide resource management services for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program as specified in contract with the department.

(4) Develop and implement formal agreements with inpatient services funded by the department or RSN (i.e., state psychiatric hospitals, local evaluation and treatment facilities, and other local inpatient psychiatric facilities) regarding:

(a) Referrals;

(b) Admissions; and

(c) Discharges, including RSN responsibility for discharge planning for consumers residing at the state hospitals.

(5) Identify a single person with primary responsibility for implementation of each consumer's individualized plan. The consumer shall have the right to choose a primary care provider from the primary care providers available.

(6) Ensure access to seven-day-a-week, twenty-four-hour-a-day availability of information regarding mentally ill adults and children receiving services and their individualized plans to county-designated mental health professionals, evaluation and treatment facilities, and others as determined by the RSN and consistent with section 360 of this chapter, confidentiality of consumer information.

(7) Specify in contract the delegation of the duties described in this section when such duties are assigned to a subcontractor.

[00-23-089, recodified as § 388-862-110, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-110, filed 9/27/94, effective 10/28/94.]

WAC 388-862-120 Regional support networks—Management information. RSNs and their subcontractors shall report required management information to the department. To this end, the RSN shall operate an information system and ensure information for persons receiving mental health services funded by public dollars is reported to the state mental health information system, according to departmental guidelines.

(1) The department and the RSN shall use the mental health information system for state-wide and/or RSN management reports and for locating case managers.

(2) The department, RSN, and provider shall maintain confidentiality of information contained in the mental health information system according to this chapter and chapters 70.02, 71.05 and 71.34 RCW.

(a) The RSN shall ensure all RSN, county, or provider staff having access to the mental health information systems are instructed in the confidentiality requirements.

(b) The RSN, county, or provider shall maintain on file a statement signed by the staff acknowledging understanding and agreement to abide by these requirements.

(c) The department shall ensure violation of confidentiality of information shall result in appropriate disciplinary or civil action, as described in chapter 71.05 RCW.

[00-23-089, recodified as § 388-862-120, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-120, filed 9/27/94, effective 10/28/94.]

WAC 388-862-130 Regional support networks—Staff qualifications. The RSN shall employ and retain respectful, effective staff. To this end, the RSN shall:

(1) Maintain job descriptions with qualifications for each position. Staff shall have education, experience, or skills relevant to job requirements; and

(2) Provide orientation and ongoing training in the skills pertinent to the position and the treatment population, including age and culturally competent consultation with consumers, families, and community members.

[00-23-089, recodified as § 388-862-130, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-130, filed 9/27/94, effective 10/28/94.]

WAC 388-862-140 Regional support networks—Housing. The RSN shall actively promote consumer access to, and choice in, safe, decent, and affordable housing, which is integrated into the community and appropriate to the age, culture, and residential needs of the person. The RSN shall:

(1) Designate staff knowledgeable in and responsible for housing-development activities;

(2) Maintain an inventory of housing stock for consumers;

(3) In cooperation or partnership with interested parties and financial institutions, promote access to and use of community housing available to consumers, including:

(a) Ownership or leases by the RSN or its providers;

(b) Agreements between landlords and the RSN or its providers;

(c) Securing HUD Section 8 or other rental subsidies, including rental subsidies provided directly by the RSN;

(d) Loans or grants for low-income or special need housing by federal, state or local funding sources; or

(e) Other means.

(4) Emphasize housing:

(a) With less than nine units;

(b) Which provides for maximum integration of consumers into the community and avoids concentration of individuals with severe and persistent mental illness in a single location.

[00-23-089, recodified as § 388-862-140, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-140, filed 9/27/94, effective 10/28/94.]

WAC 388-862-150 Regional support networks and prepaid health plans—Quality improvement. The RSN or PHP shall establish a process responsive to the demographic character of the RSN or PHP to improve service quality and promote customer satisfaction.

(1) **Quality improvement process.** The RSN or PHP shall develop and implement a quality improvement process as approved by the department and set forth in the terms of the contract between the department and the RSN or PHP.

(2) **Quality review team.** The RSN or PHP shall:

(a) Establish and maintain a quality review team responsive to the demographic character of the RSN and as set forth in the terms of the contract between the department and the RSN or PHP. The department and RSN or PHP shall include representatives of consumer and family advocate organizations when revising contract terms regarding the requirements of this section; and

(b) Take measures to assure the quality review team can fairly and independently execute the team's duties.

(3) The quality review team shall:

(a) Regularly review provider and RSN or PHP performance; and

(b) Meet with interested consumers and family members, allied service providers, and persons reflecting the age and ethnic diversity of the RSN to:

(i) Determine whether services are accessible and address the needs of consumers; and

(ii) Work with interested consumers, service providers, the RSN or PHP, and the department to resolve identified problems.

[00-23-089, recodified as § 388-862-150, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-150, filed 9/27/94, effective 10/28/94.]

WAC 388-862-160 Regional support networks and prepaid health plans—Ombuds service. The RSN or PHP shall establish a service responsive to the age and demographic character of the region to assist and advocate for consumers with complaints and grievances concerning services.

(1) The RSN or PHP shall establish an independent ombuds service, as set forth in this section and contract between the department and the RSN or PHP. The department and RSN or PHP shall include representatives of consumer and family advocate organizations when revising contract terms regarding the requirements of this section.

(2) The RSN or PHP shall ensure the ombuds service:

(a) Is independent of service provision;

(b) Receives consumer, family member, and other interested party complaints and assists in the complaint's resolution with the consumer's consent, at the lowest possible level;

(c) For the purposes of outreach and resolving complaints, has access to consumers, service sites, and records relating to the consumer. The RSN or PHP shall ensure access to records is contingent upon written consent as described under this chapter; and

(d) Intercedes on behalf of consumers and family members and, at the consumer's request, in the complaint and grievance process.

(3) The ombuds service staff shall:

(a) Be accessible to all persons;

(b) Involve other persons, at the consumer's request;

(c) Assist consumers in the pursuit of informal resolution of complaints;

(d) If necessary, continue to assist the consumer through the grievance and, if applicable, fair hearing processes; and

(e) Maintain confidentiality consistent with this chapter.

[00-23-089, recodified as § 388-862-160, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-160, filed 9/27/94, effective 10/28/94.]

WAC 388-862-170 Regional support networks and prepaid health plans—Consumer grievances. The RSN or PHP shall establish an age and culturally appropriate process for consumers to pursue grievances. To this end, a consumer or enrolled recipient aggrieved by a decision of an RSN, PHP or the department shall have the right to a fair hearing, as required under chapter 388-08 WAC. The RSN or PHP shall establish a grievance process which:

(1) Is published and made known to consumers who are current or potential users of community mental health rehabilitation services in a readily understandable language and manner;

(2) Give consumers the opportunity to report grievances, and have the grievances investigated, and resolved promptly;

(3) Ensures retaliation, formal or informal, against a grievant does not occur;

(4) Ensures the retention of full records of all grievances in confidential files, separate from the grievant's case records, for five years from completion of the grievance process;

(5) Ensures the availability of ombuds service staff to assist grievants at all levels of the grievance and fair hearing processes;

(6) May progress through levels as established by the RSN or PHP, beginning at the provider level and ending at

the RSN or PHP governance board or the board's designee. The RSN or PHP shall:

(a) Ensure the entire process, from the written request for grievance up to the request for fair hearing, shall not exceed thirty days. If the consumer orally reports a grievance, the RSN or PHP shall promptly refer the consumer to the ombuds service for assistance in writing the request; and

(b) Notify the grievant in writing of the reason for the decision and the right to request a fair hearing;

(7) Allows the participation of other persons, at the grievant's choice; and

(8) Allows the grievant to request a fair hearing when the grievance concerns eligibility, enrollment or disenrollment, or the medical necessity for services, and when the:

(a) Grievance decision is adverse to the grievant;

(b) RSN or PHP does not respond, in writing, within thirty days from the date the grievant submitted the grievance in writing; or

(c) RSN or PHP denies an enrolled recipient urgently needed community mental health rehabilitation services and the enrolled recipient files a grievance in writing.

[00-23-089, recodified as § 388-862-170, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-170, filed 9/27/94, effective 10/28/94.]

WAC 388-862-180 Prepaid health plans—Purpose. For contracts effective on or after October 1, 1993, the department may contract with prepaid health plans (PHPs) to:

(1) Provide community mental health rehabilitation services directly to an enrolled recipient; or

(2) Arrange for an enrolled recipient to receive community mental health rehabilitation services according to the contract between the department and a PHP.

[00-23-089, recodified as § 388-862-180, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-180, filed 9/27/94, effective 10/28/94.]

WAC 388-862-190 Prepaid health plans—Eligible consumers. (1) The department shall enroll a Medicaid recipient in a PHP when the person resides in the PHP's contracted service area. The community services office (CSO) shall designate a person's residence in the Title XIX eligibility record.

(2) An enrolled recipient requesting or receiving medically necessary nonemergency community mental health rehabilitation services shall request and receive such services from the assigned PHP.

[00-23-089, recodified as § 388-862-190, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-190, filed 9/27/94, effective 10/28/94.]

WAC 388-862-200 Prepaid health plans—Exemptions. (1) The department shall not require a person to enroll or continue enrollment in a PHP when the person has good cause for exemption.

(2) A person requesting an exemption from enrolling in the designated PHP shall file a request with the department. The department shall, in writing, timely notify the person of the exemption decision and the reasons for the decision.

(3) The person may request a fair hearing when the person is not satisfied with the department's decision regarding exemption.

[00-23-089, recodified as § 388-862-200, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-200, filed 9/27/94, effective 10/28/94.]

WAC 388-862-210 Prepaid health plans—Enrolled recipient's choice of primary care provider. (1) Each enrolled recipient receiving nonemergency community mental health rehabilitation services shall have a primary care provider (PCP). For an enrolled recipient with an assigned case manager, the PCP shall be the case manager.

(2) An enrolled recipient requesting or receiving community mental health rehabilitation services shall have the right to choose a PCP from the available PCP staff in the PHP.

(3) A PHP shall assign an enrolled recipient to a PCP when the enrolled recipient requests community mental health rehabilitation services and does not choose a PCP in the PHP.

(4) A person enrolled in a PHP shall have the right to change the person's PCP:

(a) One time during a calendar year for any reason;

(b) For subsequent changes during the calendar year, only for documented good cause; and

(c) By notifying the PHP of the:

(i) Desired change, including the name of the new PCP; and

(ii) Reason for a desired change.

[00-23-089, recodified as § 388-862-210, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-210, filed 9/27/94, effective 10/28/94.]

WAC 388-862-220 Prepaid health plans—Other services. (1) The department shall pay for mental health or other services covered under the department's medical care programs that are excluded from the community mental health rehabilitation services managed care contract.

(2) The department's mental health or ancillary services may include, but are not limited to:

(a) Transportation as described under WAC 388-86-085; and

(b) Inpatient services.

[00-23-089, recodified as § 388-862-220, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-220, filed 9/27/94, effective 10/28/94.]

WAC 388-862-230 Prepaid health plans—Emergency services. The department shall exempt emergencies and transportation for emergencies required by the enrolled recipient within the PHP from any routine preservice authorization procedures employed by the PHP.

[00-23-089, recodified as § 388-862-230, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-230, filed 9/27/94, effective 10/28/94.]

WAC 388-862-240 Prepaid health plans—Consumer request for a second opinion. An enrolled recipient in a

PHP shall have the right to a second opinion by another participating staff in the enrolled recipient's assigned PHP:

(1) When the enrolled recipient needs more information as to the medical necessity of treatment recommended by the PCP; or

(2) If the enrolled recipient believes the PCP is not authorizing medically necessary community mental health rehabilitation services.

[00-23-089, recodified as § 388-862-240, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-240, filed 9/27/94, effective 10/28/94.]

WAC 388-862-250 Prepaid health plans—Enrollment termination. (1) The department may terminate enrollment of a enrolled recipient in a PHP when:

(a) An enrolled recipient loses eligibility for Title XIX categorically needy and medically needy services;

(b) An enrolled recipient requests disenrollment from the PHP, and the department approves the request; or

(c) A PHP requests, in writing, to the department the disenrollment of the enrolled recipient from the PHP and the PHP's requested disenrollment is approved by the department.

(2) The department shall:

(a) Disenroll only when the enrolled recipient:

(i) Is no longer eligible for Title XIX categorically and medically needy services;

(ii) Is deceased; or

(iii) Requests disenrollment from the PHP and meets the requirements of WAC 275-57-200.

(b) Make a decision on the requested disenrollment within fifteen days of the receipt of the request; and

(c) Notify the enrolled recipient ten days in advance of the effective date of the proposed disenrollment for any approved disenrollment.

[00-23-089, recodified as § 388-862-250, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-250, filed 9/27/94, effective 10/28/94.]

WAC 388-862-260 Prepaid health plans—Audit. (1) At least once a year, the department shall conduct a PHP audit to promote the quality and accessibility of community mental health rehabilitation services a PHP provides or arranges for enrolled recipients. When reasonable, the audit shall coincide with the certification and licensure reviews of RSNs and providers.

(2) The PHP shall permit the department to conduct an audit.

(3) The department may conduct or contract independently for such an audit.

[00-23-089, recodified as § 388-862-260, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-260, filed 9/27/94, effective 10/28/94.]

WAC 388-862-270 Licensing procedures for service providers—Application and approval. The department shall protect persons using licensed community mental health services by ensuring that the minimum standards under this chapter are uniformly applied and maintained statewide.

(1) Upon receipt of an inquiry concerning licensure of service under this chapter, the department shall provide written information to an interested party.

(2) A prospective applicant shall complete and return an application provided by the department and send a copy of the application to the RSN authority.

(3) The application shall identify the service components for which the applicant is requesting licensure. Licensed service components include:

(a) Crisis response services (section 390);

(b) Brief intervention services (section 400);

(c) Case management services (section 420);

(d) Residential services (section 430);

(e) Employment services (section 440); and

(f) Psychiatric and medical services (section 450).

(4) The RSN shall review the application and send written comments either recommending or not recommending licensure to the department with a copy to the applicant. If the RSN does not approve the application, the department shall not process the application. If the department does not receive a response from the RSN or designee within thirty days, the department shall proceed with the application. This subsection does not apply to agencies not contracting or intending to contract with an RSN or PHP.

(5) The department shall acknowledge receipt from the applicant of the application, the fee, and all required materials, including waiver requests.

(6) After required materials have been received, the department shall conduct an on-site review to collect information to determine if a provider is in compliance with the minimum standards of this chapter, as described in the application packet.

(7) At the exit interview, the department shall define a plan of corrective action, if necessary.

(8) The department shall provide written notification to the provider and the RSN within sixty days of the exit interview of one of the following:

(a) Provisional licensure for one year if the provider has:

(i) An acceptable detailed plan for the development and operation of the services;

(ii) The availability of administrative and clinical expertise required to develop and provide the planned services;

(iii) The fiscal management and existence or projection of resources to reasonably ensure stability and solvency; and

(iv) Signed a corrective action plan, if applicable, for any deficiencies.

(b) Denial of the application if there is not substantial compliance with the above.

(i) The department shall specify the reasons for denial in writing.

(ii) The department's notice of denial, revocation, suspension, or modification of a licensing decision is governed by chapter 43.20A.205 RCW as existing or hereafter amended. The provider's right to a fair hearing is described in same law.

(iii) A provider wanting to contest a department licensing decision shall, within twenty-eight days of receipt of the decision:

(A) File a written application for a fair hearing by a method showing proof of receipt with the Office of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(B) Include in the application a specific statement of the issue or issues and law involved, the grounds for contesting the department decision, and a copy of the department decision being contested.

(iv) If licensure is denied, the applicant may reapply for licensure not earlier than six months following the date of notification of denial.

(9) Within one year of a provider's provisional licensure, the department may conduct another on-site visit to verify the correction of previously noted deficiencies, and review other requirements for licensure, as necessary.

[00-23-089, recodified as § 388-862-270, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-270, filed 9/27/94, effective 10/28/94.]

WAC 388-862-275 Mental health service provider license and certification fees. (1) An annual fee, based on a range of client service hours provided per year, shall be assessed as follows:

Range	Client Service Hours	Annual Fee
1	0 - 3,999	$ 281.00
2	4,000 - 14,999	422.00
3	15,000 - 29,999	562.00
4	30,000 - 49,999	842.00
5	50,000 and over	1,030.00

(2) Fee ranges shall be determined from provider information reported to the department's community mental health information system.

(3) Providers applying for a license or certification and not reporting to the department's community mental health information system shall submit the number of annual client service hours as part of their application.

(4) Fee for an applicant not licensed or certified shall be equal to the fees for licensure or certification of licensed and certified providers with similar annual client service hours.

(5) Certified short-term inpatient component, or new applicants seeking certification for a short-term inpatient component, shall be assessed an annual fee of thirty-two dollars per bed. This annual fee shall not be assessed for inpatient hospitals licensed under chapter 70.41 RCW.

[00-23-089, recodified as 388-862-275, filed 11/20/00, effective 11/20/00. Statutory Authority: RCW 43.20B.110. 91-23-089 (Order 3291), § 440-44-090, filed 11/19/91, effective 12/20/91. Statutory Authority: RCW 43.20A.055. 85-20-031 (Order 2287), § 440-44-090, filed 9/24/85.]

WAC 388-862-276 Fee payment and refunds. (1) Fees are due with applications for initial license or renewal. The department will not proceed on applications until required fees are paid.

Except as otherwise provided in these rules, fees shall be paid for a minimum of one year.

(2) Fees for licenses issued for other than yearly periods shall be prorated based on the stated annual fee.

(3) When the department issues a license for more than one year:

(a) Fees may be paid for the entire licensing period by paying at the rate established at the time the application was submitted, or

(b) If the licensee does not pay the fee for the entire license period, annual fees shall be due thirty days prior to each annual anniversary date of the license, at the annual fee rate established by these rules at the time such fee is paid.

(4) Except as otherwise provided in these rules, if an application is withdrawn prior to issuance or denial, one-half of the fee shall be refunded.

(5) If there is a change of or by the licensee requiring a new license, the fee paid for a period beyond the next license anniversary date shall be refunded. Changes requiring a new license shall require a new application and payment of fee as provided herein.

(6) If there is a change by the applicant or licensee that requires an amendment placing the licensee in a higher fee category, the additional fee shall be prorated for the remainder of the license period.

(7) Fees becoming due on or after the effective date of this chapter shall be at the rates provided herein.

(8) To the extent fees are reduced through regular rule adoption of this chapter on or before December 31, 1982, fees shall be refunded.

(9) Fee payments shall be by mail. Payment shall be by check, draft, or money order made payable to the department of social and health services.

[00-23-089, recodified as 388-862-276, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-010, filed 6/4/82.]

WAC 388-862-277 Denial, revocation, suspension, and reinstatement. (1) If a license is denied, revoked, or suspended, fees shall not be refunded.

(2) Application for license after denial or revocation must include fees as provided for in these rules.

(3) Failure to pay fees when due will result in suspension or denial of license.

[00-23-089, recodified as 388-862-277, filed 11/20/00, effective 11/20/00. Statutory Authority: 1982 c 201. 82-13-011 (Order 1825), § 440-44-015, filed 6/4/82.]

WAC 388-862-280 Licensing procedures for providers—Licensure status. The department shall define the conditions under which a provider may receive and maintain a license. The department shall, based on findings of a licensure review, assign the provider, or specific services of the provider, one of the following licensure statuses:

(1) **Full licensure.**

(a) Under this status, the RSN or PHP may contract with the provider to provide those mental health services for which the provider is licensed.

(b) The department shall require the provider to submit and implement a plan of correction to resolve deficiencies, if present. The department may revoke the license if the provider does not implement the plan of correction.

(c) At any time the department receives information indicating the provider is not in compliance with minimum standards for community mental health programs, the department

may conduct a licensure review and revoke the license if the review shows the provider is not in substantial compliance.

(d) If evidence indicates that the health and safety of the consumer is in danger, the department may suspend the license immediately.

(2) **Probationary licensure.**

(a) Under this status, the provider may be eligible to contract with the RSN or PHP on conditions specified by the department.

(b) To achieve full licensure, the provider shall demonstrate to the department that it has met the conditions of the probationary status.

(c) The provider shall request that the department review its corrective actions within six months of notification of probationary status or the department shall revoke its licensure.

(d) The department shall review the provider's corrective actions and make a redetermination of licensure status within six months of the date of the provider's request for review.

(e) The department shall only assign probationary status to a provider as an outcome of the department's first licensure review of a provider or a new provider service.

(3) **Provisional licensure.**

Under this status, the provider may be eligible to contract with the RSN or PHP. The department may give a new provider or a provider planning to offer a new service a provisional license for up to one year as described under section 270 of this chapter.

(4) **Suspended license.**

(a) Under this status, the department may find the provider substantially out of compliance with minimum standards, or is jeopardizing consumer health and safety.

(b) The RSN or PHP shall not contract with a provider with a suspended license.

(c) To reachieve full licensure, the provider shall demonstrate to the department that the provider has completed all required corrective actions and complies with relevant WAC.

(d) The provider may request that the department review its corrective actions within six months of notification of suspended status. In the absence of such request, the department shall revoke the provider's license.

(5) **Revoked license.**

(a) Under this status, the department removes the provider's license.

(b) The RSN or PHP shall not contract with a provider with a revoked license.

(c) To achieve full licensure, the provider shall make a new application as described under subsection (1) of this section.

(6) **Deemed status.**

A provider may request the department deem licensure, accreditation, or certification from another regulatory agency or accrediting organization equivalent to licensure by the department. "Deemed status" will be contingent on continued licensure, accreditation, or certification. Upon receipt of the request, the department shall consider:

(a) The extent to which requirements of the other regulatory agency or accrediting organization are pertinent to the services provided under this chapter;

(b) The extent to which the requirements of the other agency maintain, meet, or exceed the standards described under this chapter; and

(c) Whether the requirement is in statute and, therefore, may not be waived.

(7) A provider failing to attain licensure or whose licensure is revoked may reapply for licensure not earlier than six months following the date of the department's notification.

(a) The provider shall ensure the application documents the actions the provider has taken to correct deficiencies found in the prior licensure review.

(b) If the application demonstrates the provider has substantially corrected deficiencies, the department shall schedule a licensure review to evaluate compliance with those standards previously unmet.

(8) The department shall determine a provider's license in effect for at least one year or until the department conducts a review for relicensure or accreditation.

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WAC 388-862-290 Licensed service providers—Written schedule of fees. The provider shall ensure consumers receive necessary mental health services, regardless of ability to pay the full rate.

(1) The provider, excepting services also licensed under chapters 248-14, 246-316 or 246-325 WAC, shall establish and use a sliding fee schedule approved by the department and based on the resources available to the consumer to pay for mental health services and the provider's actual cost of care.

(2) The department shall only approve sliding scale fee schedules not requiring payment from consumers with income levels equal to or below the grant standards for the general assistance program, as required under WAC 388-29-100.

(3) A provider shall ensure the fee schedule is posted and accessible to the provider's staff and consumers.

(4) A provider not contracting with an RSN or PHP shall maintain a sliding fee schedule in accordance with subsections (1) and (3) of this section.

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WAC 388-862-300 Licensed service providers—Quality assurance. A provider shall maintain an internal process to improve quality of care.

(1) A provider shall develop and implement a quality assurance process which:

(a) Provides for at least an annual review of each staff member providing direct services, considering any complaints or grievances against the person;

(b) Reviews all serious incidents;

(c) Assesses the quality of intake evaluations; and

(d) Assesses the extent to which medications are effectively prescribed.

(2) A person providing mental health services shall not review their own work.

(3) A provider shall use collected data to correct deficiencies and improve services.

[00-23-089, recodified as § 388-862-300, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-300, filed 9/27/94, effective 10/28/94.]

WAC 388-862-310 Licensed service providers—Staff qualifications. A provider shall employ and retain respectful, competent staff. The provider shall:

(1) Require that all clinical services be provided by a mental health professional or under the clinical supervision of a mental health professional as defined under section 020 of this chapter. The supervisor shall have two years' experience working with priority populations;

(2) Maintain job descriptions with qualifications for each position. Staff shall have education, experience, or skills relevant to the job requirements;

(3) Assure staff providing clinical services be, at a minimum, registered as counselors under chapter 18.19 RCW.

(4) Conduct a Washington State Patrol background check and reference check on all staff providing direct services;

(5) Orient direct service staff with less than one year's experience in providing community support services in skills pertinent to the position and the population served.

(a) The provider shall include training in:

(i) Characteristics of severe and persistent mental illness;

(ii) Effective age and culturally competent community support interventions relevant to the population served;

(iii) Psychopharmacology;

(iv) Advocacy and linking consumers to community resources;

(v) Working with and supporting families;

(vi) For staff providing crisis response services under section 390 of this chapter: Crisis intervention and managing assaultive/suicidal behavior; and

(vii) For staff providing vocational services under section 440 of this chapter: Training in vocational assessment and concepts of supported employment.

(b) Persons providing direct services to consumers shall complete this orientation within three months of employment. However, the RSN may waive the requirement for orientation in specific topics when the staff person can provide documentation to the RSN demonstrating training, knowledge, or experience in the waived topics.

(6) Provide annual training and staff development under an individualized training plan with time frames for each direct service staff person in the skills pertinent to the position and the population served. Such training includes consumers, families and community members as trainers. At minimum, the provider shall make training available in the following topics:

(a) Effective community support interventions;

(b) Providing individualized, needs-driven planning and services;

(c) Providing services responsive to the unique needs of underserved populations and other special populations. Examples of special populations are persons with mental illness who:

(i) Use high amounts of hospital services;

(ii) Receive services from multiple systems;

(iii) Are sexual minorities;

(iv) Abuse substances;

(v) Have a developmental disability;

(vi) Are homeless; and

(vii) Have AIDS or who are HIV positive.

(d) Psychopharmacology;

(e) Ethical behavior, including professional conduct and confidentiality.

(7) Provide regular supervision. Supervision may include routine team case reviews; and

(8) Conduct staff evaluations, at least annually.

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WAC 388-862-320 Licensed service providers—Qualifications appropriate to the needs of the consumer population. The clinical qualifications of persons providing and/or supervising clinical services shall reflect the diverse needs of the consumer population.

(1) **Child mental health specialist.** The provider shall ensure services directed to children are provided by, under the supervision of, or with consultation from a child mental health specialist defined as:

(a) A mental health professional having completed a minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to:

(i) The study of child development; and

(ii) The treatment of seriously disturbed children and their families.

(b) Having the equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and their families under the supervision of a child mental health specialist.

(2) **Geriatric mental health specialist.** The provider shall ensure services directed to the elderly are provided by, under the supervision of, or with consultation from a geriatric mental health specialist defined as:

(a) A mental health professional having completed a minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the problems and treatment of the elderly; and

(b) Having the equivalent of one year of full-time experience in the treatment of the elderly, under the supervision of a geriatric mental health specialist.

(3) **Ethnic minority mental health specialist.** The provider shall ensure services directed to ethnic minority consumers are provided by, under the supervision of, or with consultation from an ethnic minority mental health specialist defined as:

(a) A mental health professional having the equivalent of one year of full-time experience in the treatment of consumers in the ethnic minority group served; and

(b) Demonstrating cultural competence attained through major commitment, ongoing training, experience or specialization in serving ethnic minorities. In assessing such commitment, the department shall consider whether the individual meets two or more of the following:

(i) Evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist;

(ii) Evidence of support from the ethnic minority community attesting to the person's commitment to service to that community;

(iii) Citations of specific examples of the person's competence; or

(iv) Having completed a minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) **Disability mental health specialist.** The provider shall ensure services directed to consumers with a disability shall be provided by, under the supervision of, or with consultation from a mental health specialist with special expertise in working with that disabled group.

(a) If the consumer is deaf, the specialist shall be a mental health professional knowledgeable of deaf culture and psychosocial problems, and able to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities shall be a mental health professional who:

(i) Has at least one year's experience with people with developmental disabilities; or

(ii) Is a developmental disabilities professional.

(5) Where the mental health specialists required under this section are unavailable within the RSN, the RSN shall:

(a) Document effort to acquire the services of the required specialists; and

(b) Develop a training program using in-service training or outside resources to assist service providers to acquire necessary skills and experience to serve the needs of the consumer population. If a significant ethnic minority population, as defined by department guidelines, exists in the RSN, the RSN shall develop the training program to assist provider staff members to acquire the specialized training and supervision to become qualified specialists; or

(c) Contract or otherwise establish a working relationship with the required specialists to:

(i) Provide all or part of the clinical services for these populations; or

(ii) Supervise or provide consultation to staff members providing clinical services to these populations.

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WAC 388-862-330 Personnel management—Affirmative action. The provider shall have an affirmative action program complying with:

(1) The Equal Pay Act of 1963;

(2) Title VII of the Civil Rights Act of 1964;

(3) Section 504 of the 1974 Rehabilitation Act;

(4) The Americans with Disabilities Act;

(5) The department's affirmative action guidelines; and

(6) Other applicable federal, state, and local laws and regulations.

[00-23-089, recodified as § 388-862-330, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-330, filed 9/27/94, effective 10/28/94.]

WAC 388-862-340 Consumer rights. The provider shall ensure consumers are knowledgeable of and protected by certain rights.

(1) The provider shall ensure consumers, prospective consumers, and/or legally responsible others are verbally informed, in their primary language, of consumer rights at admission to brief intervention and community support services.

(2) The provider shall post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of only telephone services (e.g., crisis lines) shall post the statement of consumer rights in a location visible to staff and volunteers during working hours.

(3) The provider shall ensure the statement of consumer rights incorporates the following statement or a variation approved by the department: "You have the right to:

(a) Be treated with respect and dignity;

(b) Develop a plan of care and services which meets your unique needs;

(c) Refuse any proposed treatment, consistent with the requirements in the Involuntary Treatment Acts, chapters 71.05 and 71.34 RCW;

(d) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;

(e) Be free of any sexual exploitation or harassment;

(f) Review your case record;

(g) Receive an explanation of all medications prescribed, including expected effect and possible side effects;

(h) Confidentiality, as described in relevant statutes (chapters 70.02, 71.05 and 71.34 RCW) and regulations (chapters 275-54 and 275-55 WAC and this chapter); and

(i) Lodge a complaint with the ombuds person, RSN or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you shall be free of any act of retaliation. The ombuds person may, at your request, assist you in filing a grievance. The ombuds person's phone number is: _____."

[00-23-089, recodified as § 388-862-340, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-340, filed 9/27/94, effective 10/28/94.]

WAC 388-862-350 Consent to treatment and access to records. This section defines the conditions for informed consent to treatment and enables a consumer to access a consumer's own records. To this end, the RSN and licensed providers shall protect and ensure the rights of all consumers and former consumers.

(1) Any minor over twelve years of age may request and receive treatment without consent of the minor's parents. Parental consent for evaluation and treatment services shall not be necessary in the case of a child referred by child protective services or other public agency because of physical, sexual, or psychological abuse or neglect by a parent or parent surrogate.

(2) The department, RSN, PHP, or provider shall presume an adult is competent to consent to treatment unless otherwise established.

(3) When the consumer, or the consumer's legally responsible other, requests review of case records, the provider shall:

(a) Grant the request within seven days, unless the provider knows or has reason to believe the parent or parent surrogate has been a child abuser or might otherwise harm the child;

(b) Review the case record in order to identify and remove any material confidential to another person;

(c) Allow the consumer sufficient time and privacy to review the record. At the request of the consumer, a clinical staff member shall be available to answer questions;

(d) Permit persons requested by the consumer to also be present; and

(e) Assess a reasonable and uniform charge for reproduction, if so desired.

(4) The department, RSN, PHP or provider shall obtain written, informed consent of the consumer or legally responsible other before:

(a) Use of medication;

(b) Use of unusual diagnostic or treatment procedures;

(c) Use of audio and/or visual device to record the consumer's behavior; and

(d) The consumer serves as a subject for research.

[00-23-089, recodified as § 388-862-350, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-350, filed 9/27/94, effective 10/28/94.]

WAC 388-862-360 Services administration—Confidentiality of consumer information. The RSN, PHP, and provider shall ensure information about person consumers not be shared or released except as specified under statute and rule.

The RSN and the provider shall protect the confidentiality of all information relating to consumers or former consumers under all confidentiality requirements as defined in chapters 70.02, 71.05, and 71.34 RCW.

[00-23-089, recodified as § 388-862-360, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-360, filed 9/27/94, effective 10/28/94.]

WAC 388-862-370 Research—Requirements. (1) The RSN, PHP, or provider shall conduct research involving human subjects in accordance with 45 CFR, Part 46, Protection of Human Subjects.

(2) An institutional review board (IRB), as defined in chapter 70.02.010 RCW, shall review and approve research prior to contact with subjects.

(3) The RSN, PHP, or provider shall ensure disclosure of patient records without written consent adheres to requirements in chapters 42.48, 70.02, 71.05.390, 71.05.630, and 71.34 RCW.

(4) The RSN, PHP, or provider shall require certification that proposed research has IRB approval before allowing research activities to commence.

[00-23-089, recodified as § 388-862-370, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-370, filed 9/27/94, effective 10/28/94.]

WAC 388-862-380 Licensed service providers—Accessibility. The provider shall ensure services are easily accessible to consumers. The provider shall make services readily accessible to consumers when and where they are needed and shall reduce or eliminate barriers to service. The provider shall ensure:

(1) Facilities in which services are provided comply with the Americans with Disabilities Act;

(2) Services are compatible with the culture and in the language of ethnic minority consumers where a significant ethnic minority population, as defined by department guidelines, exists in the RSN;

(3) Alternative service delivery models are provided, where possible, to enhance utilization by underserved groups;

(4) Access to TDD or other telecommunication device or service, and certified interpreters for deaf or hearing impaired consumers; and

(5) Services are brought to the consumer or located at sites where transportation is available to consumers.

[00-23-089, recodified as § 388-862-380, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-380, filed 9/27/94, effective 10/28/94.]

WAC 388-862-390 Crisis response services. The RSN, or its designee, shall provide an integrated crisis response system (CRS) twenty-four-hours-a-day and seven-days-a-week, serving persons of all ages and cultures in crisis. When direct intervention is necessary, the RSN shall, when possible, bring services directly to the person in crisis, stabilizing and supporting the person until the crisis is resolved or a referral made. The RSN shall:

(1) Provide telephone screening which:

(a) Includes a prominently displayed phone number in the emergency and white page sections of the local phone directory;

(b) Ensures all phone calls are answered by people and not recordings; and

(c) Limits busy signals.

(2) Ensure the least restrictive resolution of the crisis by providing the following services twenty-four-hours-a-day and seven-days-a-week:

(a) Initial screening and assessment to determine:

(i) Whether the crisis has a mental disorder basis; and

(ii) Course of action to resolve the crisis.

(b) Mobile outreach to:

(i) Conduct face-to-face evaluations; and

(ii) Provide in-home or in-community stabilization services, including flexible supports to the person where the person lives. The CRS shall continuously provide stabilization services until the crisis is resolved or a referral made.

(c) Access to:

(i) Medical services, including:

(A) Emergency medical services;

(B) Preliminary screening for organic disorders;

(C) Prescription services; and

(D) Medication administration.

(ii) Interpretative services enabling staff to communicate with persons who are limited English proficient;

(iii) Voluntary and involuntary psychiatric inpatient care (chapters 71.05 and 71.34 RCW); and

(iv) Other needed resources.

(d) Investigation and detention services (chapters 71.05 and 71.34 RCW).

(3) Engage family, significant others, and other relevant treatment providers as necessary to provide support to the person in crisis.

(4) Document all telephone and face-to-face contacts to include:

(a) Source of referral;

(b) Nature of crisis;

(c) Time elapsed from initial contact to response; and

(d) Outcomes, including:

(i) Decision not to respond in person, if applicable;

(ii) Follow-up; and

(iii) Referrals made.

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WAC 388-862-400 Brief intervention services. The provider shall implement a streamlined process to provide planned, brief therapeutic interventions to persons within the priority populations and eligible recipients in the Medicaid program who require time-limited medically necessary services.

(1) The RSN shall define the number of allowable brief intervention services.

(2) A person receiving more than fifteen hours of service in a twelve-month period shall receive a full intake evaluation as described in section 410(2) of this chapter.

(3) The provider of brief intervention services shall gather the following information in the intake to brief interventions:

(a) Mental status examination;

(b) Functioning in daily life domains, showing strengths as well as needs;

(c) Substance use and abuse;

(d) The name of the consumer's most recent physician and prescribed medications, if known;

(e) A brief plan of action to achieve mutually agreed upon outcomes; and

(f) The intake evaluation shall not present a barrier to service. When seeking information from the consumer might pose a barrier to service, any of the above items may be left incomplete, providing that noncompletion and reasons are documented in the record.

(4) Licensed providers not contracting with an RSN or PHP are exempt from the requirements of subsection (1) of this section.

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WAC 388-862-410 Community support services—General requirements. The RSN, or its designee, shall provide community support services to persons requiring ongoing supports to live in the community. Each community support service, as defined in sections 420 through 450 of this chapter, shall meet the requirements of this section.

(1) **Admission.** Resource management services shall approve consumer admission to community support services.

(2) **Intake evaluation.** The provider and consumer, or legally responsible other, shall collaboratively identify consumer strengths and needs through a full intake evaluation completed within thirty days of initiating community support services. Staff conducting an intake evaluation shall have training in this activity.

(a) The provider shall address in an intake evaluation:

(i) Psycho-social and cultural history;

(ii) Functioning in daily life domains, showing strengths as well as needs;

(iii) Substance use and abuse;

(iv) Medical history, including medications used. For persons receiving care from a health care professional, the provider shall seek permission to receive pertinent medical information. For persons not under the care of a health care professional, the provider shall offer to make a referral for a physical examination; and

(v) For children, a developmental history.

(b) The provider shall, when possible, include input from family members and/or other natural support systems, when acceptable to the person.

(c) The provider may reference or include historical information from other providers as part of the intake evaluation.

(d) When seeking information from the consumer might pose a barrier to service, the provider may leave incomplete requirements of subsection (2) of this section, providing that the provider documents noncompletion and reasons in the record.

(3) **Individualized plan.** The provider shall implement an individualized plan in collaboration with the consumer within thirty days of initiating community support services. The provider shall:

(a) For adults, develop the plan with the consumer and include people who provide active support to the consumer (e.g., family members, teachers, etc.), at the consumer's request;

(b) For children, develop the plan with the child, family and others who provide active support to the child. For children under three, the plan shall be integrated with the individualized family service plan (IFSP), when applicable;

(c) Focus on normalization and address needs identified by the consumer, which may include:

(i) Least-restrictive housing;

(ii) Income;

(iii) Work or school;

(iv) Social life;

(v) Treatment including psychotherapy; and

(vi) Services to address the specialized needs of underserved populations.

(d) Link outcomes to specific goals and time frames for achieving the outcomes;

(e) Define services to achieve the identified outcomes. The provider shall flexibly develop or purchase services to meet the unique needs of the person;

(f) Be responsive to the consumer's age, culture, and disability; and

(g) Assure the plan is mutually reviewed every six months, or more often at the request of the consumer.

(4) **Documentation.**

(a) The provider shall periodically document consumer progress in achieving treatment goals in the case record.

(b) The provider shall include in the case record specific progress toward established goals, changes in individualized plans, and extraordinary events.

(c) A mental health professional shall review and sign off on the intake evaluation, the individualized plan, and revisions to the individualized plan.

[00-23-089, recodified as § 388-862-410, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-410, filed 9/27/94, effective 10/28/94.]

WAC 388-862-420 Community support services—Case management services. The RSN, or its designee, shall provide case management services including outreach and support to achieve the individualized plan's outcomes. Case management services shall:

(1) Maximize the consumer's desired level of independence and appropriate interdependence. To this end, case management staff shall help the consumer:

(a) Access basic needs in an age and culturally competent manner, including:

(i) Housing;

(ii) Food;

(iii) Income;

(iv) Health and dental care; and

(v) Transportation.

(b) Work or participate in other daily activities appropriate to the consumer's age and culture;

(c) Link with the regular social life of the community;

(d) Access other needed services, such as substance abuse treatment, and health care;

(e) Resolve crises in least-restrictive settings; and

(f) Manage symptoms by providing information and education about the consumer's illness and treatment;

(2) Assist family members and other care givers in their efforts to support and care for the consumer;

(3) Include, as necessary, flexible application of funds, such as rent subsidies, rental deposits, and in-home care to enable stable community living; and

(4) Provide services where and when needed.

[00-23-089, recodified as § 388-862-420, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-420, filed 9/27/94, effective 10/28/94.]

WAC 388-862-430 Community support services—Residential services. The RSN, or its designee, shall provide residential services emphasizing least-restrictive, stable living situations appropriate to the age, culture, and residential needs of each consumer.

(1) The RSN's array of residential services shall emphasize supporting consumers in their own homes in the community. When supervised group living is necessary, the RSN shall emphasize supervised settings which:

(a) Maximize personal privacy and independence; and

(b) Have eight or fewer beds.

(2) Where the RSN provides supervised residential services in an adult family home, the adult family home shall comply with chapter 388-76 WAC.

(3) Where the RSN provides supervised residential services in a children's foster home, the children's foster home shall comply with chapter 388-73 WAC.

(4) Where the RSN provides residential services in a boarding home facility, the boarding home facility shall comply with chapter 246-316 WAC.

(5) Where the RSN provides residential services in an adult residential rehabilitative center facility, the adult residential rehabilitative facility shall comply with chapter 246-325 WAC.

[00-23-089, recodified as § 388-862-430, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-430, filed 9/27/94, effective 10/28/94.]

WAC 388-862-440 Community support services—Employment services. The RSN, or its designee, shall provide age and culturally appropriate employment services as a treatment option to consumers wanting to work.

(1) Employment services shall include:

(a) A vocational assessment of work history, skills, training, education, and personal career goals;

(b) Public assistance information;

(c) Active involvement with consumers served in establishing individualized job and career development plans and revision of the individualized plan accordingly;

(d) Assistance in locating employment opportunities consistent with consumer skills, goals, and interests;

(e) Integrated supported employment, including outreach and support services in the place of employment, if required, as well as the use of other interventions such as job coaching; and

(f) Interaction with the consumers' employer to maintain stability of employment and advise on reasonable accommodation in accordance with the Americans with Disabilities Act (ADA) of 1990.

(2) Any RSN, or RSN subcontractor, employing consumers as part of the pre-vocational or vocational program shall:

(a) Pay consumers in accordance with the Fair Labor Standards Act; and

(b) Ensure safety standards are in place in full compliance with local and state regulations.

(3) The RSN shall coordinate efforts with rehabilitation and employment services, such as the division of vocational rehabilitation, the state employment services and the business community and job placement services within the community.

(4) Agencies accredited by commission on accreditation of rehabilitation facilities (CARF), or rehabilitation services accreditation system (RSAS) shall be considered the same as licensed by the state for employment services. Other organizations with equivalent standards may be considered for state licensure for employment services.

[00-23-089, recodified as § 388-862-440, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-440, filed 9/27/94, effective 10/28/94.]

WAC 388-862-450 Community support services—Psychiatric and medical services. The RSN, or its designee, shall provide psychiatric and medical services to ensure consumers are prescribed medications, when necessary, to treat symptoms, become knowledgeable about any prescribed medications and side effects, and are referred to treatment for nonpsychiatric medical problems.

(1) The provider shall vest overall medical responsibility in a physician licensed to practice under chapter 18.57 or 18.71 RCW, and board eligible in psychiatry. Providers unable to recruit a psychiatrist may employ a physician without board eligibility in psychiatry provided:

(a) Psychiatric consultation is provided to the physician at least monthly; and

(b) A psychiatrist is accessible in person, by telephone, or by radio communication to the physician for emergency consultation.

(2) Only staff licensed to do so may prescribe medications. Prescribing staff shall review medications at least every three months.

(3) Only staff licensed to do so may administer medications.

(4) When a consumer receives only medication services from a provider, the provider may develop and implement a brief intake and plan, as defined in section 400 of this chapter in place of the intake evaluation, as defined in section 410 of this chapter.

(5) The provider shall maintain medication information in the consumer record documenting at least the following for each prescribed medication:

(a) Name and purpose of medication;

(b) Dosage and method of administration;

(c) Dates prescribed, reviewed, and/or renewed;

(d) Observed and reported effects, interactions, and side effects. Staff shall query consumers concerning such information;

(e) Any laboratory findings;

(f) Reasons for change or termination of medication; and

(g) Name and signature of prescribing person.

(6) When physical health problems are suspected or identified, the provider shall consult with and/or offer to make a referral to a physician or alternative health care provider. The provider shall include current medical concerns, as necessary, in the individualized plan.

(7) Provider staff shall inspect and inventory medication storage areas at least quarterly:

(a) Medications shall be kept in locked, well-illuminated storage;

(b) Medications kept in a refrigerator containing other items shall be kept in a separate container with proper security;

(c) No outdated medications shall be retained, and medications shall be disposed of in accordance with regulations of the state board of pharmacy;

(d) Medications for external use shall be stored separately from oral and injectable medications;

(e) Poisonous external chemicals and caustic materials shall be stored separately.

[00-23-089, recodified as § 388-862-450, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-450, filed 9/27/94, effective 10/28/94.]

WAC 388-862-460 Community support services—In-home services. The RSN, or its designee, may provide, when needed, in-home services to assist consumers with daily living and/or adaptive skills to enable continued living in the consumer's own home.

(1) The consumer's case manager or other designee of the RSN shall periodically make home visits to assess:

(a) The consumer's satisfaction with in-home services;

(b) Quality of services provided; and

(c) Need for continued services.

(2) Persons providing in-home services shall either be immediate family members, or shall have:

(a) A Washington state patrol background check to ensure against a history of theft, abuse, or assault, except if such conduct was associated with a mental disorder that is currently stabilized; and

(b) Three reference checks.

(3) The in-home service worker shall have an age and culturally competent orientation and training based on the worker's experience, but ensuring basic knowledge in:

(a) Nutrition;

(b) Hygiene;

(c) Symptoms of decompensation; and

(d) Symptoms of medication reaction.

[00-23-089, recodified as § 388-862-460, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-460, filed 9/27/94, effective 10/28/94.]

WAC 388-862-470 Community support services—Consumer or advocate run services. The RSN, or its designee, shall provide services operated or staffed by consumers, former consumers, family members of consumers, or other advocates.

(1) The department shall not require a consumer or advocate run service to maintain licensure under this chapter if the service is nonclinical. If a service is clinical, the service shall comply with the requirements for licensed services in this chapter.

(2) Consumer or advocate run services may include, but are not limited to:

(a) Consumer and/or advocate operated businesses;

(b) Consumer and/or advocate operated and managed clubhouses, such as the Fountain House model;

(c) Consumer and/or advocate operated crisis respite services;

(d) Advocacy and referral services;

(e) Consumer and/or advocate operated household assistance programs;

(f) Self-help and peer support groups;

(g) Ombuds service; or

(h) Other services.

[00-23-089, recodified as § 388-862-470, filed 11/20/00, effective 11/20/00. Statutory Authority: Chapter 71.24 RCW, Title XIX Waiver and SSB 6547. 94-20-033 (Order 3783), § 275-57-470, filed 9/27/94, effective 10/28/94.]

Chapter 388-875 WAC

CRIMINALLY INSANE PERSON COMMITTED TO THE CARE OF THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES—EVALUATION, PLACEMENT, CARE AND DISCHARGE

(Formerly chapter 275-59 WAC)

WAC

WAC 388-875-0010 Purpose. These regulations are adopted pursuant to and in accordance with chapter 117, Laws of 1973 1st ex. sess. They are adopted to provide procedures for the evaluation, placement, care and discharge of persons committed to the care of the department of social and health services, under the aforementioned Act, relating to the criminally insane.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0010, filed 12/6/00, effective 1/6/01; Order 846, § 275-59-010, filed 8/9/73.]

WAC 388-875-0020 Definitions. "Department" means the state department of social and health services.

"Division" means the mental health division, department of social and health services.

"Evaluation" means the initial procedure when a court requests the department to provide an opinion if a person charged with a crime is competent to stand trial or, if indicated and appropriate, if the person was suffering under a mental disease or defect excluding responsibility at the time of the commission of the crime.

"Indigent" means any person who is financially unable to obtain counsel or other necessary expert or professional services without causing substantial hardship to himself or his family.

"Professional person" means:

(1) A psychiatrist. This is defined as a person having a license as a physician and surgeon in this state, who has in addition, completed three years of graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association and who is certified or is eligible to be certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(2) A psychologist. This is defined as a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW.

(3) A social worker. This is defined as a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

"Secretary" means the secretary of the department of social and health services or his designee.

"Superintendent" means the person responsible for the functioning of a treatment facility.

"Treatment facility" means any facility operated or approved by the department of social and health services for the treatment of the criminally insane. Such definition shall not include any state correctional institution or facility.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0020, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-020, filed 3/1/79; Order 846, § 275-59-020, filed 8/9/73.]

WAC 388-875-0030 Mental health division. The secretary designates to the division the responsibility for:

(1) Evaluation and treatment of any person committed to the secretary for evaluation or treatment, under chapter 10.77 RCW;

(2) Assisting the court in obtaining nondepartmental experts or professional persons to participate in the evaluation or a hearing on behalf of the defendant and supervising the procedure whereby such professionals will be compensated, according to fee schedule if the person being evaluated or treated is an indigent;

(3) Assuring that any nondepartmental expert or professional person requesting compensation has maintained adequate evaluation and treatment records which justify compensation;

(4) Assisting the court by designation of experts or professional persons to examine the defendant and report to the court when the defendant is not committed to the secretary;

(5) Determination of what treatment facility shall have custody of persons committed to the secretary under chapter 10.77 RCW.

(6) If the court is advised by any party that the defendant may be developmentally disabled, at least one of the experts or professional persons appointed shall be a developmental disabilities professional.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0030, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-030, filed 3/1/79; Order 846, § 275-59-030, filed 8/9/73.]

WAC 388-875-0040 Schedule of maximum payment for defendant expert or professional person. Department payments to an expert or professional person for department services an indigent person receives shall not exceed:

(1) One hundred dollars an hour for services; or

(2) Eight hundred dollars total payment for services.

The department shall only approve an exception to this section ruling when the exception is approved, in writing, by the division director. The department shall only approve payment for one mental health examination per indigent person in each six month period.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0040, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 91-24-045 (Order 3298), § 275-59-041, filed 11/27/91, effective 1/1/92; 79-03-038 (Order 1373), § 275-59-041, filed 3/1/79.]

WAC 388-875-0050 Time limitations and requirements. If a person is committed to the secretary as criminally insane, commitment and treatment cannot exceed the maximum possible sentence for any offense charged. Therefore:

(1) The superintendent, if no superintendent then the division, with the assistance of the office of the attorney general where necessary shall determine at the time of commitment the maximum possible sentence for any offense charged, and thereby compute a maximum release date for every individual so committed.

(2) If the committed person has not been released by court order six months prior to the expiration of the maximum possible release date, the superintendent, if no superintendent, the division, shall notify the committing court and prosecuting attorney of its computation of maximum release date and the requirement that the person must be released on that date unless civil proceedings are instituted or the court determines that the computation of maximum release date is incorrect.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0050, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-050, filed 3/1/79; Order 846, § 275-59-050, filed 8/9/73.]

WAC 388-875-0060 Individualized treatment. (1) Whenever a person is committed to the secretary as criminally insane, the treatment facility to which the person is assigned shall, within fifteen days of admission to the facility, evaluate and diagnose the committed person for the purpose of devising an individualized treatment program.

(2) Every person, committed to the secretary as criminally insane, shall have an individualized treatment plan formulated by the treatment facility. This plan shall be developed by appropriate treatment team members and implemented as soon as possible but no later than fifteen days after the person's admission to the treatment facility as criminally insane. Each individualized treatment plan shall include, but not be limited to:

(a) A statement of the nature of the specific problems and specific needs of the patient;

(b) A statement of the physical setting necessary to achieve the purposes of commitment;

(c) A description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

(d) A statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

(e) A specification of staff responsibility and a description of proposed staff involvement with a patient in order to attain these treatment goals;

(f) Criteria for recommendation to the court for release.

(3) This individualized treatment plan shall be reviewed by the treatment facility periodically, at least every six months, and a copy of the plan shall be sent to the committing court.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0060, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-060, filed 3/1/79; Order 846, § 275-59-060, filed 8/9/73.]

WAC 388-875-0070 Transfer of a patient between state-operated facilities for persons with mental illness. In some instances, it is appropriate for the department to transfer a patient currently residing in a state facility to another state facility for ongoing treatment. The department shall accomplish the transfer with the utmost care given to the therapeutic needs of the patient. This section describes the procedures for handling a patient transfer between state facilities in a manner consistent with the best interest of the patient.

(1) The department may use the following criteria when determining the appropriateness of a patient transfer:

(a) The patient's family resides within the receiving facility's catchment area; or

(b) The patient's primary home of residence is in the receiving facility's catchment area; or

(c) A particular service or need of the patient is better met at the receiving facility; or

(d) Transfer to the receiving facility may facilitate community discharge due to the availability of community service in the receiving facility's catchment area; or

(e) The county, regional support network, or patient requests a transfer.

(2) Prior to any proposed transfer of a patient, the state facility shall comply with the following:

(a) The sending facility, at the request of the superintendent, shall in writing forward information necessary to make a decision on whether transfer is appropriate to the receiving facility's liaison and the regional support network liaison;

(b) The receiving facility's liaison and the regional support network liaison shall recommend appropriate action to the superintendent of the sending facility in writing within five calendar days of receipt of the request;

(c) If the receiving facility accepts the proposed patient transfer, the sending facility shall notify the patient, guardian, regional support network liaison, and attorney, if known, at least five days before the proposed patient transfer;

(d) The sending facility is responsible for all patient transfer arrangements, e.g., transportation, staff escort, etc., and shall coordinate the day and time of arrival with the receiving facility's liaison; and

(e) The sending facility shall arrange for the transfer of patient's medical record to the receiving facility.

(3) The sending state facility shall document the following in the patient's record:

(a) Physician documentation of the medical suitability of the patient for transfer; and

(b) Social worker documentation regarding:

(i) Justification as to why the transfer is considered in the patient's best interests; and

(ii) The patient's wishes regarding transfer.

(4) The sending facility shall contact the prosecuting attorney's office of the committing county prior to the transfer.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0070, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.05.560 [71.05.560]. 91-22-044 (Order 3275), § 275-59-071, filed 10/31/91, effective 12/1/91. Statutory Authority: RCW 71.05.560. 88-23-021 (Order 2724), § 275-59-071, filed 11/7/88.]

WAC 388-875-0080 Restoration procedure for a former involuntarily committed person's right to firearm possession. (1) The department and mental health professionals implementing chapter 10.77 RCW shall recognize and affirm that a person is entitled to the immediate restoration of the right to firearm possession, as described under RCW 9.41.040 (6)(c), when the person no longer requires treatment or medication for a condition related to the commitment.

(2) Mental health professionals implementing the provisions of chapter 71.05 RCW shall provide to the court of competent jurisdiction such relevant information concerning the commitment and release from commitment as the court may request in the course of reaching a decision on the restoration of the person's right to firearm possession. (See RCW 9.41.097.)

(3) A person who has been barred from firearm possession under RCW 9.41.040(6) and who wishes to exercise this right, may petition the court which ordered involuntary treatment or, the superior court of the county in which the person resides for restoration of the right to possess firearms. At a minimum, such petition shall include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the order of final discharge entered by the committing court.

(4) A petitioner shall show that the petitioner no longer requires treatment or medication for a condition related to the commitment.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0080, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 9.41.040(6). 94-06-025 (Order 3709), § 275-59-072, filed 2/23/94, effective 3/26/94.]

WAC 388-875-0090 Conditional release. (1) Any person committed to the secretary as criminally insane may make application to the secretary for conditional release.

(2) The secretary designates the superintendent of the treatment facility, if no superintendent, then the director of the division, as the person to receive and act on such application for conditional release.

(3) The person making application for conditional release shall not, under any circumstances, be released until there is a court hearing on the application and recommendations and a court order authorizing conditional release has been issued.

(4) If conditional release is denied by the court the person making the applications may reapply after a period of six months from the date of denial.

(5) If the court grants conditional release and places the person making application under the supervision of a department employee, that supervising department employee shall make monthly reports, unless indicated otherwise by the court, concerning the conditionally released person's progress and compliance with the terms and conditions of conditional release. Such reports shall be forwarded to the committing court, the division, the prosecuting attorney, and the treatment facility in which the person was most recently housed.

(6) The following persons are designated to exercise power and authority of the secretary contained in RCW 10.77.190:

(a) The director or designee of the division;

(b) The probation and parole office, if any, supervising the conditionally released person; and

(c) The treatment facility supervising the conditionally released person or from which the person was conditionally released.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0090, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-080, filed 3/1/79; Order 846, § 275-59-080, filed 8/9/73.]

WAC 388-875-0100 Retroactivity. (1) This chapter shall apply to persons committed to the secretary or the department, under prior rules and regulations, as incompetent to stand trial or as being criminally insane and therefore requires that these individuals be provided:

(a) An individualized treatment plan;

(b) An evaluation to be forwarded to the committing court;

(c) Applicability of time limitations and requirements provided herein;

(d) A maximum release date; and

(e) An opportunity to apply for conditional release.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0100, filed 12/6/00, effective 1/6/01; Order 846, § 275-59-090, filed 8/9/73.]

WAC 388-875-0110 Access to records by criminal justice agencies. Upon written request, criminal justice agencies shall have access to the following documents developed pursuant to the procedures set forth in chapter 10.77 RCW. the most recent forensic:

(1) Psychiatric assessment;

(2) Release summary; and

(3) Pre-trial report of the examination, either inpatient or outpatient.

Other relevant information may be provided by agreement between the requesting criminal justice agency and the treatment facility, subject to federal and state confidentiality provisions.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, § 388-875-0110, filed 12/6/00, effective 1/6/01.]

Chapter 388-880 WAC

SEXUAL PREDATOR PROGRAM—SPECIAL COMMITMENT—ESCORTED LEAVE

(Formerly chapter 275-155)

WAC

WAC 388-880-005 Special commitment of sexually violent predators—Legal basis. (1) Chapter 71.09 RCW authorizes the department to develop a sexual predator program (SPP) for a person the court determines is a sexually violent predator.

(2) Beginning July 1, 1990, the department's SPP shall provide:

(a) Evaluation of a person court-ordered to the SPP to determine if the person meets the definition of a sexually violent predator under this chapter; and

(b) Control, care, and treatment services to a person court-committed as a sexually violent predator.

[99-21-001, recodified as § 388-880-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-005, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-005, filed 8/21/90, effective 9/21/90.]

WAC 388-880-010 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Appropriate facility" means a facility the department uses for evaluating and determining if a person meets the definition of a sexually violent predator as defined in this section.

(2) "Care" means a service the department provides during a person's commitment to the SPP to sustain adequate health, shelter, and physical sustenance.

(3) "Control" means a restraint, restriction, or confinement the department applies protecting a person from endangering self, others, or property during a commitment under this chapter.

(4) "Department" means the department of social and health services.

(5) "Escorted leave" means a leave of absence from a facility housing persons detained or committed under chapter 71.09 RCW under the continuous supervision of an escort.

(6) "Evaluation" means an examination, report, or recommendation a professionally qualified person makes determining if a person meets or continues to meet the definition of a sexually violent predator as defined in this section.

(7) "Immediate family" includes a resident's parents, stepparents, parent surrogates, legal guardians, grandparents, spouse, brothers, sisters, half or stepbrothers or sisters, children, stepchildren, and other dependents.

(8) "Indigent" means a resident who has not been credited with twenty-five dollars or more total from any source for deposit to the resident's trust fund account during the thirty days preceding the request for an escorted leave and has less than a twenty-five dollar balance in his/her trust fund account on the day the escorted leave is requested, and together with his/her requesting immediate family member affirm in writing that they cannot afford to pay the costs of the escorted leave without undue hardship. A declaration of indigency shall be signed by the resident and the resident's requesting immediate family member on forms provided by the department.

(9) "Individual treatment plan (ITP)" means an outline the SPP staff persons develop detailing how control, care, and treatment services are provided to a SPP-committed person.

(10) "Mental abnormality" means a congenital or acquired condition affecting a person's emotional or volitional capacity, including personality disorders, predisposing the person to commit criminal acts of sexual violence placing other persons in danger.

(11) "Predatory" means acts a person directs toward strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization.

(12) "Professionally qualified person" includes:

(a) "Mental health counselor" means a person certified as a mental health counselor under chapter 18.19 RCW;

(b) "Psychiatric nurse" means a person licensed as a registered nurse under chapter 18.88 RCW and having two or more years supervised clinical experience;

(c) "Psychiatrist" means a person licensed as a physician under chapters 18.71 and 18.57 RCW. In addition, the person shall:

(i) Have completed three years of graduate training in a psychiatry program approved by the American Medical Association or the American Osteopathic Association; and

(ii) Be certified, or eligible to be certified, by the American Board of Psychiatry and Neurology;

(d) "Psychologist" means a person licensed as a doctor of psychology under chapter 18.83 RCW; and

(e) "Social worker" means a person certified as a social worker under chapter 18.19 RCW.

(13) "Resident" means a person detained or committed pursuant to chapter 71.09 RCW.

(14) "Secretary" means the secretary of the department of social and health services.

(15) "Secure facility" means a department-operated facility, not located on the grounds of a state mental facility or residential habilitation center, with the purpose of confining and treating a person committed to the SPP.

(16) "Sexual predator program (SPP)" means a department-administered and operated program established for:

(a) A court-ordered person's evaluation; or

(b) Control, care, and treatment of a court-committed person defined as a sexually violent predator under this chapter.

(17) "Sexually violent offense" means an act defined under chapter 71.09 RCW and for which a person is charged or convicted on, before, or after July 1, 1990.

(18) "Sexually violent predator" means a person defined under chapter 71.09 RCW who has been convicted or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence.

(19) "Superintendent" means the person delegated by the secretary of the department to be responsible for the facility housing persons detained or committed under chapter 71.09 RCW.

[99-21-001, recodified as § 388-880-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-010, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-010, filed 8/21/90, effective 9/21/90.]

WAC 388-880-020 Authorization for indefinite commitment to the sexual predator program. The department shall admit a person to the SPP as a sexually violent predator only when all of the following requirements are met:

(1) Petition. The prosecuting attorney or attorney general if requested by the prosecutor files a petition with the superior court in the county where a person was most recently charged or convicted of a sexually violent offense;

(2) Probable cause. A court determines probable cause exists and orders a person transferred to an appropriate facility for evaluation as to whether the person is a sexually violent predator;

(3) Evaluation. A person is evaluated by one or more professionally qualified persons and is found to have:

(a) Been charged with or convicted of a sexually violent offense;

(b) A mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence; and

(c) A sentence or commitment about to expire or having expired.

(4) Trial. A court commences a trial determining if a person is a sexually violent predator within forty-five days of the petition filing date, not including continuances requested by the alleged sexually violent predator; and

(5) Judgment. A court or jury finds a person, beyond a reasonable doubt, to be a sexually violent predator and the person is committed to the department's custody for control, care, and treatment.

[99-21-001, recodified as § 388-880-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050. 93-17-027 (Order 3609), § 275-155-020, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-020, filed 8/21/90, effective 9/21/90.]

WAC 388-880-030 Sexual predator program evaluation—Reporting. (1) When a court orders a person transferred to an appropriate facility for evaluation, the department shall, within forty-five days of the petition filing date, evaluate and provide a recommendation to the court as to whether the person meets the statutory definition of a sexually violent predator under Laws of 1990, chapter 3, section 1002.

(2) Annually or more often, the department shall provide the committing court an evaluation determining if a committed person continues meeting the definition of a sexually violent predator under this chapter.

[99-21-001, recodified as § 388-880-030, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-030, filed 8/21/90, effective 9/21/90.]

WAC 388-880-040 Individual treatment. (1) When the court commits a person to the SPP as a sexually violent predator, SPP staff persons shall develop an individual treatment plan (ITP). The ITP shall include, but not be limited to:

(a) A description of a person's specific treatment needs;

(b) An outline of intermediate and long-range treatment goals, with a projected timetable for reaching the goals;

(c) The treatment strategies for achieving the treatment goals;

(d) A description of SPP staff persons' responsibility; and

(e) Criteria for recommending to the court whether a person should be released from the SPP.

(2) The SPP staff persons shall review a committed person's ITP every six months or more often.

[99-21-001, recodified as § 388-880-040, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-040, filed 8/21/90, effective 9/21/90.]

WAC 388-880-050 Rights of a person committed to the sexual predator program. (1) During a person's commitment to the SPP, the department shall apprise the committed person of the person's right to an attorney and to retain a professionally qualified person to perform an evaluation on the committed person's behalf.

(2) Upon request, the department shall provide to the following persons access to a committed person for an evaluation and all records and reports related to the person's commitment, control, care, and treatment:

(a) The committed person's attorney;

(b) The committed person's professionally qualified person, if any;

(c) The prosecuting attorney, or the attorney general, if requested by the prosecuting attorney; and

(d) The professionally qualified person approved by the prosecuting attorney or the attorney general.

(3) A person the court commits to the SPP shall:

(a) Receive adequate care and individualized treatment;

(b) Be permitted to wear the committed person's own clothes and keep and use the person's personal possessions, except when deprivation of possessions is necessary for the person's protection and safety, the protection and safety of others, or the protection of property within the SPP;

(c) Be permitted to accumulate and spend a reasonable amount of money in the person's SPP account;

(d) Have access to reasonable personal storage space within SPP limitations;

(e) Be permitted to have approved visitors within reasonable limitations;

(f) Have reasonable access to a telephone to make and receive confidential calls within SPP limitations; and

(g) Have reasonable access to letter writing material and to:

(i) Receive and send correspondence through the mail within SPP limitations; and

(ii) Send written communication regarding the fact of the person's commitment.

(4) A person the court commits to the SPP shall have the following procedural rights to:

(a) Have reasonable access to an attorney and be informed of the name and address of the person's designated attorney;

(b) Petition the court for release from the SPP; and

(c) Receive annual written notice of the person's right to petition the committing court for release. The department's written notice and waiver shall:

(i) Include the option to voluntarily waive the right to petition the committing court for release; and

(ii) Annually be forwarded to the committing court by the department.

[99-21-001, recodified as § 388-880-050, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050. 93-17-027 (Order 3609), § 275-155-050, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-050, filed 8/21/90, effective 9/21/90.]

WAC 388-880-060 Sexual predator program reimbursement. (1) The department shall obtain reimbursement under RCW 43.20B.330, 43.20B.335, 43.20B.340, 43.20B.345, 43.20B.350, 43.20B.355, 43.20B.360, and 43.20B.370 for the cost of care of a person committed to a SPP to the extent of the person's ability to pay.

(2) The department shall calculate ability to pay and assess liability under chapter 275-16 WAC.

[99-21-001, recodified as § 388-880-060, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-060, filed 8/21/90, effective 9/21/90.]

WAC 388-880-070 Escorted leave—Purpose. The purpose of WAC 275-155-070 through 275-155-140 is:

(1) To set forth the conditions under which residents will be granted leaves of absence;

(2) To provide for safeguards to prevent escape, the obtaining of contraband, and the commission of new crimes, while on leaves of absence; and

(3) To outline the process for the reimbursement of the state by the resident and the resident's family for the costs of the leave of absence.

[99-21-001, recodified as § 388-880-070, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-070, filed 12/1/97, effective 1/1/98.]

WAC 388-880-080 Reasons allowed. An escorted leave of absence may be granted by the superintendent, or designee, subject to the approval of the secretary, to residents to:

(1) Go to the bedside of a member of the resident's immediate family as defined in WAC 275-155-010, who is seriously ill;

(2) Attend the funeral of a member of the resident's immediate family as defined in WAC 275-155-010; and

(3) Receive necessary medical or dental care which is not available in the institution.

[99-21-001, recodified as § 388-880-080, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-080, filed 12/1/97, effective 1/1/98.]

WAC 388-880-090 Conditions. (1) An escorted leave shall be authorized only for trips within the boundaries of the state of Washington.

(2) The duration of an escorted leave to the bedside of a seriously ill member of the resident's immediate family or attendance at a funeral shall not exceed forty-eight hours unless otherwise approved by the superintendent, or designee.

(3) Other than when housed in a city or county jail or state institution the resident shall be in the visual or auditory contact of an approved escort at all times.

(4) The resident shall be housed in a city or county jail or state institution at all times when not in transit or actually engaged in the activity for which the escorted leave was granted.

(5) Unless indigent, the resident and immediate family member shall, in writing, make arrangements to reimburse the state for the cost of the leave prior to the date of the leave.

(6) The superintendent, or designee, shall notify county and city law enforcement agencies with jurisdiction in the area of the resident's destination before allowing any escorted leave of absence.

[99-21-001, recodified as § 388-880-090, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-090, filed 12/1/97, effective 1/1/98.]

WAC 388-880-100 Application requests and approval for escorted leave. The superintendent, or designee, shall establish a policy and procedures governing the method of handling the requests by individual residents. The superintendent, or designee, shall evaluate each leave request and, in writing, approve or deny the request within forty-eight hours of receiving the request based on:

(1) The nature and length of the escorted leave;

(2) The community risk associated with granting the request based on the resident's history of security or escape risk;

(3) The resident's overall history of stability, cooperative or disruptive behavior, and violence or other acting out behavior;

(4) The resident's degree of trustworthiness as demonstrated by his/her performance in unit assignments, security level, and general cooperativeness with facility staff;

(5) The resident's family's level of involvement and commitment to the escorted leave planning process;

(6) The rehabilitative or treatment benefits which could be gained by the resident; and

(7) Any other information as may be deemed relevant.

The resident's, and family's, ability to reimburse the state for the cost of the escorted leave shall not be a determining factor in approving or denying a request.

[99-21-001, recodified as § 388-880-100, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-100, filed 12/1/97, effective 1/1/98.]

WAC 388-880-110 Escort procedures. (1) Only persons approved by the superintendent, or designee, will be authorized to serve as escorts. All escorts must be employees of either the department of social and health services or the department of corrections and must have attained permanent employee status. At least one of the escorts must be experienced in the escort procedures.

(2) The superintendent, or designee, shall determine the use and type of restraints necessary for each escorted leave on an individual basis.

(3) Escorted leaves supervised by department of corrections staff shall require the approval of the superintendent of the appropriate facility and be done in accordance with established department of corrections procedures. Correctional officers may wear civilian clothing when escorting a resident to a bedside visit or a funeral.

[99-21-001, recodified as § 388-880-110, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-110, filed 12/1/97, effective 1/1/98.]

WAC 388-880-120 Expenses. (1) Staff assigned escort duties shall be authorized per diem reimbursement for meals, lodging, and transportation at the rate established by the state travel policy.

(2) Staff assigned escort duties shall receive appropriate compensation at regular salary or overtime for all hours spent in actual escort of the resident, but not including hours spent sleeping or not engaged in direct supervision of the resident. The salary shall be paid at the appropriate straight time and overtime rates as provided in the merit system rules.

(3) Cost of housing the resident in a city or county jail shall be charged to the resident in accordance with WAC 275-155-130.

[99-21-001, recodified as § 388-880-120, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-120, filed 12/1/97, effective 1/1/98.]

WAC 388-880-130 Expenses—Paid by resident. (1) The expenses of the escorted leave as enumerated in WAC 275-155-120 shall be reimbursed by the resident or his/her immediate family member unless the superintendent, or designee, has authorized payment at state expense in accordance with WAC 275-155-140.

(2) Payments by the resident, or the resident's immediate family member, shall be made to the facility's business office and applied to the appropriate fund as defined by law, applicable provisions of the Washington Administrative Code, or department policy.

[99-21-001, recodified as § 388-880-130, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-130, filed 12/1/97, effective 1/1/98.]

WAC 388-880-140 Expenses—Paid by department. The expenses of the escorted leave shall be absorbed by the state if:

(1) The resident and his/her immediate family are indigent as defined in WAC 275-155-010; or

(2) The expenses were incurred to secure medical care.

[99-21-001, recodified as § 388-880-140, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-140, filed 12/1/97, effective 1/1/98.]

Chapter 388-885 WAC
CIVIL COMMITMENT COST REIMBURSEMENT
(Formerly chapter 275-156)

WAC

WAC 388-885-005 Purpose. These rules establish the standards and procedures for reimbursing counties for the cost incurred during civil commitment trial, annual evaluation, and review processes and release procedures related to chapter 71.09 RCW. The department's reimbursement to counties is limited to appropriated funds.

[99-21-002, recodified as § 388-885-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-005, filed 10/8/91, effective 11/8/91.]

WAC 388-885-010 Definitions. (1) "Attorney cost" means the fully documented fee directly related to the violent sexual predator civil commitment process for:

(a) A single assigned prosecuting attorney;

(b) When the person is indigent, a single court-appointed attorney; and

(c) Additional counsel, when additional counsel is approved by the trial judge for good cause. Said fee includes the cost of paralegal services.

(2) "Department" means the department of social and health services.

(3) "Evaluation by expert cost" means a county-incurred service fee directly resulting from the completion of a comprehensive examination and/or a records review, by a single examiner selected by the county, of a person:

(a) Investigated for "sexually violent predator" probable cause;

(b) Alleged to be a "sexually violent predator" and who has had a petition filed; or

(c) Committed as a "sexually violent predator" and under review for release.

In the case where the person is indigent, "evaluation by expert cost" includes the fee for a comprehensive examination and/or records review by a single examiner selected by the person examined. When additional examiners are approved by the trial judge for good cause, "evaluation by expert cost" includes the cost of additional examiners.

(4) "Incidental cost" means county-incurred efforts or costs that are not otherwise covered and are exclusively attributable to the trial of a person alleged to be a "sexually violent predator."

(5) "Investigative cost" means a cost incurred by a police agency or other investigative agency in the course of investigating issues specific to:

(a) Filing or responding to a petition alleging a person is a "sexually violent predator;" or

(b) Testifying at a hearing to determine if a person is a "sexually violent predator."

(6) "Medical cost" means a county-incurred extraordinary medical expense beyond the routine services of a jail.

(7) "Secretary" means the secretary of the department of social and health services.

(8) "Transportation cost" means the cost a county incurs when transporting a person alleged to be, or having been

found to be, a "sexually violent predator," to and from a sexual predator program facility.

(9) "Trial cost" means the costs a county incurs as the result of filing a petition for the civil commitment of a person alleged to be a "sexually violent predator" under chapter 71.09 RCW. This cost is limited to fees for:

(a) Judges, including court clerk and bailiff services;

(b) Court reporter services;

(c) Transcript typing and preparation;

(d) Expert and nonexpert witnesses;

(e) Jury; and

(f) Jail facilities.

[99-21-002, recodified as § 388-885-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-010, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-010, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-010, filed 10/8/91, effective 11/8/91.]

WAC 388-885-015 Limitation of funds. The department shall:

(1) Reimburse funds to a county when funds are available;

(2) Limit a county's reimbursement to costs of civil commitment trials or hearings as described under this chapter;

(3) Restrict a county's reimbursement to documented investigation, expert evaluation, attorney, transportation, trial, incidental, and medical costs;

(4) Not pay a county a cost under the rules of this section when said cost is otherwise reimbursable under law;

(5) Pay a county's claim for a trial or hearing occurring during each biennium in the order in which the claim is received at the office of accounting services, special commitment center, until the department's biennial appropriation is expended.

[99-21-002, recodified as § 388-885-015, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-015, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-015, filed 10/8/91, effective 11/8/91.]

WAC 388-885-020 Maximum allowable reimbursement for civil commitment cost. The department shall reimburse a county for actual costs incurred up to the maximum allowable rate as specified:

(1) Attorney cost - Up to forty-nine dollars and forty-one cents per hour;

(2) Evaluation by expert cost - Actual costs, within reasonable limits, plus travel and per diem according to state travel policy;

(3) Trial costs:

(a) Judge - Up to forty-six dollars and five cents per hour;

(b) Court reporters - Up to twenty dollars and seventy-one cents per hour;

(c) Transcript typing and preparation services - Up to four dollars and thirteen cents per page;

(d) Expert witnesses - Actual costs within reasonable limits plus travel and per diem according to state travel policy;

(e) Nonexpert witnesses - Actual compensation, travel and per diem paid to witnesses, provided compensation is in accordance with chapter 2.40 RCW and state travel policy;

(f) Jurors - Actual compensation, travel, and per diem paid to jurors provided compensation is in accordance with chapter 2.36 RCW and state travel policy;

(g) Jail facilities - Thirty dollars per day.

(4) Investigative cost - Up to twenty dollars and sixty-six cents per hour. Medical costs - Up to fifty dollars per day, not to exceed five consecutive days; and

(5) Transportation cost - Actual compensation paid to transport staff, plus mileage and per diem at the rate specified in the state travel policy.

[99-21-002, recodified as § 388-885-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-020, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-020, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-020, filed 10/8/91, effective 11/8/91.]

WAC 388-885-025 Billing procedure. (1) When a county requests the department reimburse a county's cost, the county shall:

(a) Make a claim using the state of Washington invoice voucher, Form A 19 1-A;

(b) Attach to the claim necessary documentation, support, and justification materials;

(c) Report expenses billed by the hour in one-quarter hour increments unless smaller increments are provided to the county by the vendor; and

(d) Include the name of the person for whom the costs were incurred and the cause number when it exists.

(2) The department may subject a county's claim documentation to periodic audit at the department's discretion.

(3) Only an authorized administrator, or the county administrator's designee, may submit to the department a request for a county's cost reimbursement.

(4) A county shall submit a reimbursement claim to the department within thirty days of final costs incurred to assure proper handling of the claim.

(5) When a county submits a reimbursement claim, the county shall submit a reimbursement claim to the special commitment center, offices of accounting services.

(6) If the department's reimbursement appropriation becomes exhausted before the end of a biennium, a county may continue to make a claim for reimbursement. The department may use the reimbursement claim to justify a request for adequate department funding during future biennia.

[99-21-002, recodified as § 388-885-025, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-025, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-025, filed 10/8/91, effective 11/8/91.]

WAC 388-885-030 Exceptions. (1) The secretary may grant exceptions to the rules of this chapter.

(2) A county seeking an exception shall request the exception, in writing from the secretary or secretary's designee.

(3) The department shall deny a claim which does not follow the rules of this chapter unless the secretary or secretary's designee granted an exception before the claim was filed.

[99-21-002, recodified as § 388-885-030, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-030, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-030, filed 10/8/91, effective 11/8/91.]

WAC 388-885-035 Effective date. When a county submits a reimbursement claim according to this chapter, the claim shall be only for costs incurred as defined in this chapter, on or after July 1, 1990.

[99-21-002, recodified as § 388-885-035, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-035, filed 10/8/91, effective 11/8/91.]

WAC 388-885-040 Audits. The department may audit county reimbursement claims at the department's discretion.

[99-21-002, recodified as § 388-885-040, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-040, filed 10/8/91, effective 11/8/91.]

Chapter 388-890 WAC

REHABILITATION SERVICES FOR INDIVIDUALS WITH DISABILITIES

(Formerly chapter 490-500 WAC (part))

WAC

PURPOSE AND DEFINITIONS

WAC 388-890-0005 What is the purpose of this chapter? This chapter explains the types of vocational rehabilitation services (referred to as "VR services" in this chapter) and independent living (IL) services available to individuals who are eligible through the department of social and health services (DSHS), division of vocational rehabilitation (DVR).

VR services are offered to assist individuals with disabilities to prepare for, get and keep jobs that are consistent with their abilities, capabilities, and interests. This chapter is consistent with the laws included under the Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1998 and codified in 34 Code of Federal Regulations, Parts 361, 363 and 364.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0005, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0010 What definitions apply to this chapter? Client assistance program is a program that offers free advice and information about your rights when you are receiving services from DVR.

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

"DVR" means the DSHS division of vocational rehabilitation.

"Family member" means a person:

(1) Who is your relative or legal guardian or someone who lives in the same household as you; and

(2) Who has a substantial interest in your well-being.

"IL counselor" means an independent living counselor employed by the DSHS division of vocational rehabilitation.

"Impediment to employment" means the physical or mental limitations resulting from a disability that hinder your ability to prepare for a job, find a job, or keep a job that matches your abilities and potential.

"Integrated setting":

(1) for the purpose of receiving services, means a setting commonly found in the community where you would interact with nondisabled people, other than people who are providing VR services to you.

(2) for the purpose of employment, means a setting commonly found in the community in which you interact with nondisabled people to the same extent that a nondisabled person in the same type of job interacts with others.

"VR counselor" means a vocational rehabilitation counselor employed by the DSHS division of vocational rehabilitation.

"You," as used in this chapter, includes your representative or guardian, if a representative or guardian is acting on your behalf or assisting you to make informed decisions about VR or IL program services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0010, filed 8/27/99, effective 11/1/99.]

INFORMED CHOICE

WAC 388-890-0015 What is informed choice? Informed choice is a way to make reasonable decisions by comparing the meaningful options available to you and choosing one that matches your strengths, needs, capabilities and interests.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0015, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0020 How does DVR support the informed choice process? DVR supports the informed choice process by:

(1) Helping you understand the options available to you;

(2) Sharing information to help you make decisions that match your strengths, needs, capabilities, and interests; and

(3) Discussing the information provided and offering advice.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0020, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0025 What decisions can I make using informed choice? (1) You have the right to make informed choices throughout the rehabilitation process.

(2) Your informed choices include, but are not limited to:

(a) Your employment goal;

(b) VR services you need to reach your employment goal;

(c) Service provider(s) for each VR service;

(d) Whether to get services in an integrated or nonintegrated setting;

(e) Using DVR's purchasing methods if DVR is responsible to pay for services or using your choice of purchasing methods for services you agree to pay for.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0025, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0030 What if I don't know how to use the informed choice decision making process? DVR explains to you how to make informed choices in the vocational rehabilitation process, including:

(1) Any conditions that limit your choices; and

(2) Support and assistance if the type of disability you have makes it difficult for you to understand and use informed choice to make decisions.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0030, filed 8/27/99, effective 11/1/99.]

ELIGIBILITY FOR VR SERVICES

WAC 388-890-0035 Who is eligible to receive VR services? You are eligible for VR services if you meet all of the following conditions:

(1) You have a physical, mental, or sensory limitation resulting from a disability that hinders your ability to prepare for, get, or keep a job that matches your abilities and potential;

(2) You intend to and can work after receiving VR services; and

(3) You require VR services to prepare for, get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0035, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0040 How does DVR determine whether VR services will enable me to work? (1) In making an eligibility decision, DVR presumes that VR services will enable you to work, unless, because of the significance of your disability, a VR counselor cannot make such a presumption.

(2) If the significance of your disability prevents a VR counselor from presuming that VR services will enable you to work, you may complete a trial work experience as outlined under WAC 388-890-0670 through 388-890-0705 in order for the counselor to make an eligibility decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0040, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0045 Am I eligible for VR services if I receive Social Security disability benefits? (1) If you receive disability benefits under Title II or Title XVI of the Social Security Act and intend to work, DVR presumes that you are eligible, unless, because of the significance of your disability, a VR counselor cannot presume that VR services will enable you to work.

(2) If the significance of your disability prevents a VR counselor from presuming that VR services will enable you to work, you may complete a trial work experience as outlined in WAC 388-890-0670 through 388-890-0705 in order for the counselor to make an eligibility decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0045, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0050 What criteria are not considered in the eligibility decision? DVR does not base an eligibility decision on your:

(1) Type of disability;

(2) Age, gender, race, color, creed, national origin, or sexual orientation;

(3) Rehabilitation needs;

(4) Cost of services; or

(5) Income level.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0050, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0055 What information does DVR use to make an eligibility decision? (1) To determine whether you are eligible for VR services, a VR counselor reviews existing records about the current status of your disability.

(2) Information may be provided to DVR by you, your family, or other service providers who have information about your disability, such as your doctor, schools you attended, or the Social Security Administration.

(3) If existing information does not verify whether you are eligible, DVR explains what additional information is needed and the options for getting the information.

(4) DVR provides or pays for medical evaluations, tests, assistive technology services, technology devices, or other services needed to document that you are eligible for VR services.

(5) When enough information is available, a VR counselor reviews the information and makes an eligibility decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0055, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0060 After I submit my application to DVR, how long does it take DVR to make an eligibility decision? DVR makes an eligibility decision as soon as enough information is available, but no longer than sixty days after you complete the application requirements under WAC 388-890-0105.

(1) If DVR does not have enough information to determine your eligibility within sixty days, you and a VR counselor must:

(a) Discuss the reason for the delay and whether other methods to get the information are needed;

(b) Agree to extend the eligibility period, if you agree; or

(c) If the significance of your disability prevents a VR counselor from presuming that VR services will enable you to work, you may complete a trial work experience as outlined under WAC 388-890-0670 through 388-890-0705 in order for the counselor to make an eligibility decision.

(2) If you do not agree to extend the eligibility determination period, DVR must close your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0060, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0065 What happens if DVR determines that I am not eligible? (1) Before making a decision that you are not eligible for VR services, a VR counselor consults with you and gives you an opportunity to discuss the decision.

(2) DVR sends you a notice of ineligibility in writing, or using another method of communication, if needed. The written notice includes:

(a) An explanation of the reasons you are not eligible;

(b) Your rights to appeal the decision as outlined under WAC 388-890-1180; and

(c) An explanation of the services available from the client assistance program as outlined in WAC 388-890-1185.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0065, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0070 If I am not eligible for DVR services, can DVR help me find other services and programs to meet my needs? If DVR determines that you are not eligible for DVR services, DVR provides you with information and refers you to other agencies or organizations that may provide services to meet your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0070, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0071 If I am eligible for or ineligible for VR services, how will I be notified? A VR counselor sends you written explanation of your eligibility or ineligibility for VR services that includes a description of the client assistance program (CAP) and how to contact CAP.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0071, filed 8/27/99, effective 11/1/99.]

APPLICATION REQUIREMENTS

WAC 388-890-0075 Who can apply for vocational rehabilitation services? Any individual has the right to apply for VR services, including individuals who:

(1) Applied before, were determined eligible and received VR services; or

(2) Were previously determined ineligible or were denied VR services for other reasons.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0075, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0080 Can I receive VR services if I am not a United States citizen? DVR serves individuals who are legally eligible to work in the United States.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0080, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0085 Am I required to provide proof of my identity and work status? If you apply for VR services, you must provide copies of legal documents requested by DVR that verify your identity and that verify you can legally work in the United States before DVR can offer you VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0085, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0090 If I don't live in Washington, can I receive VR or IL program services? (1) The state in which you live has the primary responsibility to provide VR services to you.

(2) You may receive services from DVR if you are present or intend to be present in Washington in a way that you would be counted for census purposes, including but not limited to:

(a) You pay income taxes;

(b) You maintain a home; or

(c) You are registered to vote.

(3) To receive IL program services, you must be able to receive the services in a DVR region where IL program services are offered.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0090, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0095 Can I receive VR services if I am legally blind? The Washington state department of services for the blind, under an agreement with DVR, is the primary agency to provide vocational rehabilitation services to individuals who are blind or have a visual impairment resulting in an impediment to employment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0095, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0100 Can I receive VR or IL program services if I am Native American? DVR serves eligible Native Americans, including Native Americans who belong to an Indian tribe. If you live on an Indian reservation that operates a vocational rehabilitation program, you may apply for VR services from the tribe or from DVR.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0100, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0105 How do I apply for VR services? To complete the application process:

(1) Sign an application form provided by DVR or provide a written request that includes the following information:

(a) Your name and address;

(b) The nature of your disability;

(c) Your age and gender;

(d) The date of application; and

(e) Your Social Security Number (optional).

(2) Meet with a DVR representative to:

(a) Learn about VR services and processes;

(b) Provide information needed to begin an assessment of your eligibility and VR service needs; and

(c) Make sure you are available to complete the assessment process for determining if you are eligible for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0105, filed 8/27/99, effective 11/1/99.]

GENERAL CONDITIONS FOR RECEIVING VOCATIONAL REHABILITATION SERVICES

WAC 388-890-0110 Under what general conditions does DVR provide vocational rehabilitation services to individuals? (1) DVR provides VR services to individuals under the following general conditions.

(a) The services are needed to:

(i) Get and/or keep a job or advance in employment;

(ii) Determine your eligibility for services;

(iii) Identify your vocational rehabilitation needs; or

(iv) Develop or complete your individual plan for employment (IPE).

(b) You have an open case service record and DVR authorizes the services before the services begin;

(c) The services are provided directly by a VR counselor or purchased by DVR from a service provider who meets local, state and/or national standards required to practice in the field and/or do business in the state;

(d) The services are provided in accordance with payment for services requirements under WAC 388-890-1100 through 388-890-1175; and

(e) The services are consistent with your informed choice, including whether to receive services in an integrated or nonintegrated setting.

(2) Unique or additional conditions that apply to a specific service are outlined under WAC 388-890-0150 to 388-890-0450.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0110, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0115 Can I ask for an exception to a rule or a condition relating to VR services? You or a VR counselor may request an exception to any rule or condition relating to VR services in this chapter if the exception is needed to:

(1) Complete an assessment to determine eligibility;

(2) Identify the VR services you need; or

(3) Achieve your employment goal.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0115, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0120 How do I ask for an exception to a rule or condition in this chapter? (1) A request for excep-

tion to a rule or condition in this chapter is submitted to the regional administrator in writing, and must include:

(a) A description of the exception being requested;

(b) The reason for the exception; and

(c) The duration of the exception, if applicable.

(2) An exception requesting a medical service that is otherwise not provided by DVR may only be requested on a trial basis or for a short duration to be specified in the request.

(3) After getting your request for an exception, the regional administrator considers:

(a) The impact of the exception on accountability, efficiency, choice, satisfaction, and quality of services;

(b) The degree to which your request varies from the rule or condition; and

(c) Whether the rule or condition is a federal rule or regulation that cannot be waived.

(4) The regional administrator responds to the request for an exception within ten working days of receipt of the request.

(a) If the request is approved, the regional administrator will provide a written approval that includes:

(i) The specific WAC for which an exception is approved;

(ii) Any conditions of approval; and

(iii) Duration of the exception.

(b) If the request is denied, the regional administrator will provide a written explanation of the reasons for the denial.

(5) If the regional administrator makes a decision that you do not agree with, you have the right to appeal the decision as outlined under WAC 388-890-1180.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0120, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0125 What happens if the service I want exceeds what I need or is more expensive than a similar service? (1) DVR pays for services at the level required to meet your needs at the lowest cost possible.

(2) You may select the following service providers without regard to the fees charged:

(a) Assistive technology service providers;

(b) Community rehabilitation program service providers; and

(c) Independent living service providers.

(3) If you and a VR counselor cannot agree on the type or level of services you need, you may ask for a review of the decision as outlined under WAC 388-890-1180.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0125, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0130 Can a guardian or another representative act on my behalf? (1) You may select another person as your representative during the VR or IL program.

(2) If you have a legal guardian or a court-appointed representative, he or she must act as your representative.

(a) A legal guardian or court-appointed representative must provide DVR with documentation of guardianship.

(b) Your legal guardian or court-appointed representative must sign the application and other documents that require your signature.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0130, filed 8/27/99, effective 11/1/99.]

VOCATIONAL REHABILITATION SERVICES

WAC 388-890-0135 What is the purpose of vocational rehabilitation (VR) services? VR services are services provided to you to meet your specific needs to prepare for, get, and keep a job, or to advance in employment if you are working. Vocational rehabilitation services include services listed in WAC 388-890-0145.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0135, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0140 How do I know which VR services are right for me? DVR explains how the different VR services are used and gives you the information and support you need to make decisions about the services you need.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0140, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0145 What vocational rehabilitation services are available to individuals from DVR? The following VR services are available to individuals from DVR:

(1) Assessment services;
(2) Assistive technology devices;
(3) Assistive technology services;
(4) Counseling and guidance services;
(5) Independent living services;
(6) Interpreter services;
(7) Job placement and job retention services;
(8) Maintenance services;
(9) Occupational licenses;
(10) Other goods and services;
(11) Personal assistance services;
(12) Physical and mental restoration services;
(13) Post-employment services;
(14) Reader services;
(15) Referral services;
(16) Rehabilitation engineering services;
(17) Self-employment services;
(18) Services to family members;
(19) Supported employment services;
(20) Tools, equipment, initial stocks, and supplies;
(21) Training services;
(22) Transition services; and
(23) Transportation services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0145, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0150 What are assessment services? (1) Assessment services are used to collect information about your:

(a) Disability and how it keeps you from working;
(b) Strengths;
(c) Resources;
(d) Priorities;
(e) Concerns,
(f) Abilities;
(g) Capabilities;
(h) Interests; and
(i) Needs, including your need for supported employment.

(2) Assessment services include the VR services listed under WAC 388-890-0145.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0150, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0155 To determine whether I am eligible for VR services, who decides what assessment services I need and where to get the assessment services? If enough information is not available to determine whether you are eligible for VR services:

(1) DVR decides what assessment services are needed; and

(2) You use informed choice to choose service providers for assessment services you need.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0155, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0160 If I need assessment services to help me choose an employment goal and what VR services I need, who decides what assessment services I need and where to get the assessment services? If you need assessment services to determine your vocational rehabilitation needs or to develop your individualized plan for employment (IPE), you use informed choice to select the:

(1) Assessment services; and

(2) Service providers.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0160, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0165 What if I already have assessment information to help me and DVR make the decisions we need to make? No assessment services are needed if the information you already have is complete and current enough:

(1) For a VR counselor to make a decision about your eligibility; and

(2) To help you make decisions about your vocational rehabilitation needs and the VR services you need on your IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0165, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0170 How do I provide needed assessment information to DVR? You may give information needed for an assessment directly to DVR or you may give written consent to DVR to get the information from other sources including, but not limited to:

(1) Doctors or other medical service providers;

(2) Community programs or organizations that have provided services to you;

(3) Schools you attended.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0170, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0175 What is an assistive technology device? An assistive technology device is any item, piece of equipment or product, either commercially available or custom-designed that is used to increase, maintain or improve your functional capacities. Assistive technology devices include, but are not limited to:

(1) Telecommunications devices;

(2) Sensory aids and devices including hearing aids, telephone amplifiers and other hearing devices, real time captioning, captioned videos, taped text;

(3) Eyeglasses, contact lenses, microscopic lenses, Brailled and large print materials; electronic formats; graphics and other special visual aids;

(4) Simple language materials;

(5) Vehicle modifications;

(6) Computer and computer-related hardware and software;

(7) Other technological aids and devices.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0175, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0180 Under what conditions does DVR provide and issue assistive technology devices? (1) DVR provides assistive technology devices to you under conditions specified in WAC 388-890-0110.

(2) DVR issues assistive technology devices to you under conditions specified in WAC 388-890-0455 through 388-890-0480.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0180, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0185 Under what conditions does DVR provide vehicle modifications? DVR provides vehicle modifications to you under conditions specified in WAC 388-890-0110, and:

(1) If a used vehicle is to be modified, an inspection from a certified or journey level auto mechanic must be performed and documented to ensure the vehicle is in good condition and capable of being modified.

(2) You, your spouse, or other family member is the registered and/or legal owner of the vehicle.

(3) You agree to pay for and have driver insurance and vehicle insurance adequate to cover the cost of replacement for loss or damage at the time of modification.

(4) A specialist in evaluation and modification of vehicles for individuals with disabilities prescribes and inspects the modification, except prescriptions are not required for:

(a) Placement of a wheelchair lift, ramp, or scooter lift and tie downs for passenger access only;

(b) Replacement of hand controls;

(c) Wheelchair carriers; and

(d) Other minor driving aids.

(5) If you operate the vehicle:

(a) Your disability must be stable or slowly progressive and not likely to impair your driving ability in the future.

(b) You agree to pay for and have a current driver's license and vehicle license with required endorsements.

(c) Following modification, you are adequately trained to operate the vehicle as modified.

(d) You demonstrate that you can safely operate the vehicle as modified.

(6) If someone else operates the vehicle for you, you agree to pay for and have a current vehicle license with required endorsements.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0185, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0190 What are assistive technology services? Assistive technology services help you to select, get or use an assistive technology device. Assistive technology services include, but are not limited to services that:

(1) Evaluate your needs and how you perform activities in your daily environment;

(2) Select, design, fit, customize, adapt, apply, maintain, repair, or replace an assistive technology device;

(3) Coordinate and use other therapies or services that have assistive technology devices such as existing education and rehabilitation plans and programs;

(4) Train or give technical assistance on the use of assistive technology to you or your family members, guardians, advocates or authorized representatives;

(5) Train or give technical assistance to professionals, employers, or others who provide services to you, hire you, or are involved in your major life activities if they need training on the use of assistive technology to help you get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0190, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0195 Under what conditions does DVR provide assistive technology services? DVR provides assistive technology services under the conditions outlined in WAC 388-890-0110.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0195, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0200 What are counseling and guidance services? Counseling and guidance services are information and support services provided by a VR counselor to assist you to make informed decisions about your VR services. Counseling and guidance services include, but are not limited to:

(1) Explaining your responsibilities in a VR program;

(2) Explaining the nature and scope of VR services;

(3) Explaining the use of services and resources available from other programs as comparable services and benefits;

(4) Explaining information about your strengths, resources, priorities, interests, and rehabilitation needs;

(5) Explaining your opportunities to make informed choices;

(6) Helping you collect and understand information needed to decide on a employment goal;

(7) Providing you information and support to decide which services and activities you need to reach your employment goal;

(8) Providing support and information to you and someone you choose to develop all or part of your individualized plan for employment;

(9) Explaining how to use services to reach your employment goal;

(10) Providing you support and advice when issues arise during your VR program that relate to health, family, finances, interpersonal relationships, appearance, and other issues that could impact your vocational rehabilitation;

(11) Providing information and support, with your permission, to employers, family members, relatives or others to help you get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0200, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0210 Under what conditions does DVR provide counseling and guidance services? A VR counselor provides counseling and guidance services as needed throughout the rehabilitation process.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0210, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0220 What are independent living services? Independent living services help you deal with life issues that may prevent you from getting and keeping a job. Independent living services include, but are not limited to:

(1) An evaluation to help you find out about the:

(a) Issues in your life that may present problems for you in vocational rehabilitation and in work;

(b) Ways to deal with life issues that present problems for you; and

(c) Services you need to help you deal with the issues.

(2) Self-advocacy to help you find out about and manage the services you need to live independently and to help you find out about benefit rights and responsibilities;

(3) Independent living counseling to help you set personal goals, learn how to make decisions that relate to life issues and employment and to help your family with issues related to your disability and independence;

(4) Independent living skills training to help you get skills to manage and balance your life in areas including, but not limited to budgeting, meal preparation and nutrition, shopping, hygiene, time management, recreation, necessary community resources, and attendant management;

(5) Living arrangement counseling, including helping you to:

(a) Find out about housing resources and the qualifications for applying for housing;

(b) Make decisions about the living arrangements you want and need; and

(c) Make decisions about changing to a more independent living arrangement.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0220, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0225 Under what conditions does DVR provide independent living services? DVR provides independent living services under the conditions outlined in WAC 388-890-0110 and DVR does not pay your family members to provide independent living services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0225, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0230 What are interpreter services? Interpreter services are services to assist deaf, deaf-blind, and hard of hearing individuals who use sign language or another form of communication to express and receive information with other individuals who use speech and hearing to communicate. An example of interpreter services is the use of an interpreter by a deaf person who communicates in American Sign Language to express and receive information with a person who speaks English. Interpreter services include:

(1) Oral interpreting, in which the interpreter mouths (without voice) what the speaker says, using some natural facial expressions;

(2) Sign interpreting, in which the interpreter signs what the speaker says;

(3) Tactile interpreting, in which a hands-on interpreting method is used with people who are deaf-blind. The interpreter communicates what the speaker says by signing and/or fingerspelling into the hands of the deaf-blind person; and

(4) Voice interpreting, in which the interpreter speaks what a deaf person is mouthing or signing.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0230, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0235 Under what conditions can I receive interpreter services? DVR provides interpreter services under the conditions outlined in WAC 388-890-0110.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0235, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0240 What are job placement and job retention services? Job placement and job retention services help you get or keep a job that meets your employment goal.

(1) Job placement includes job search to help you look for and find a job.

(2) Job retention includes follow-up services to help you keep a job once you are working.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0240, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0245 Under what conditions can I receive job placement and job retention services? DVR provides job placement and job retention services to you under the conditions listed in WAC 388-890-0110, and:

(1) A VR counselor provides job placement services to help you conduct a self-directed job search; or

(2) DVR purchases job placement services only if:

(a) You and your VR counselor agree that you are unable to conduct a self-directed job search because of the significance of your disability; or

(b) You have tried to conduct a self-directed job search without success.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0245, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0250 What are maintenance services? Maintenance services include financial assistance for food, shelter, and/or clothing expenses that occur in excess of your usual living expenses in order for you to participate in another VR service. The following examples include, but are not limited to, the ways maintenance may be used:

(1) A uniform or other suitable clothing required to look for or get a job;

(2) Short-term lodging and meals required to participate in assessment or training services not within commuting distance of your home;

(3) A security deposit or utility hook-ups on housing you need to relocate for a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0250, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0255 Under what conditions does DVR provide maintenance services? DVR provides maintenance services under the conditions in WAC 388-890-0110, and if you and your VR counselor agree that you need maintenance services to participate in another VR service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0255, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0260 What are occupational licenses? Occupational licenses are licenses, permits or certificates showing you meet certain standards or have accomplished certain achievements and/or have paid dues, fees or otherwise qualify to engage in a business, a specific occupation or trade, or other work related activity.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0260, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0265 Under what conditions can I get an occupational license? DVR pays fees for occupational licenses under the conditions listed in WAC 388-890-0110 and if you meet the requirements to hold the occupational license as established by the licenser.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0265, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0270 What other goods and services does DVR provide? DVR provides other miscellaneous goods and services to meet your specific needs for vocational rehabilitation and employment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0270, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0275 Under what conditions does DVR provide and issue other goods and services? (1) DVR provides other goods and services to you under conditions specified in WAC 388-890-0110.

(2) DVR issues other goods and services to you as outlined under WAC 388-890-0455 through 388-890-0480.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0275, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0280 What are personal assistance services? Personal assistance services increase your ability to perform daily living activities on or off the job to help you get or keep a job. Personal assistance services include, but are not limited to, bathing, dressing, cooking, eating, and helping you move around.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0280, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0285 Under what conditions does DVR provide or pay for personal assistance services? DVR provides personal assistance services under the conditions listed in WAC 388-890-0110, and:

(1) If needed to help you participate in another VR service.

(2) Your family members cannot be paid to provide personal assistance services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0285, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0290 What are the physical and mental restoration services DVR provides? Physical and mental restoration services are used to diagnose and treat physical and mental impairments for the purposes of correcting, improving, modifying or accommodating a physical or mental condition. Physical and mental restoration services include:

(1) Cognitive rehabilitation services;

(2) Corrective surgery or therapy;

(3) Diagnosis and treatment of mental or emotional disorders by licensed individuals;

(4) Dental treatment if the treatment is directly related to an employment outcome, or in emergency situations involving pain, acute infections, or injury;

(5) Nursing services;

(6) Hospitalization, including surgery or treatment, and clinic services;

(7) Drugs and supplies;

(8) Prosthetic and orthotic devices;

(9) Visual examinations and visual treatment;

(10) Podiatry;

(11) Physical therapy;

(12) Occupational therapy;

(13) Speech or hearing therapy;

(14) Treatment of acute or chronic medical conditions and emergencies that occur when providing physical and mental restoration services, or that are related to the condition being treated;

(15) Special services for the treatment of end-stage renal disease; and

(16) Other medical or medically-related rehabilitation services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0290, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0295 Under what conditions does DVR provide physical and mental restoration services? DVR provides physical and mental restoration services under the conditions in WAC 388-890-0110, and if:

(1) Your disabling condition is stable or slowly progressive; and

(2) The service is expected to substantially modify, correct, or improve a physical or mental impairment that is a substantial impediment to employment for you within a reasonable length of time.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0295, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0300 What are the medical treatments DVR does not pay for? DVR does not pay for the following medical treatments:

(1) Maintenance of your general health including, but not limited to, vitamins, in-patient hospital based weight loss programs or for-profit weight loss programs, exercise programs, health spas, swim programs and athletic fitness clubs;

(2) Facelifts, liposuction, cellulite removal;

(3) Maternity care;

(4) Hysterectomies, elective abortions, sterilization, and contraceptive services as independent procedures;

(5) Drugs not approved by the Federal Drug Administration for general use or by state law;

(6) Life support systems, services, and hospice care;

(7) Transgender services including surgery and medication management;

(8) Homeopathic and herbalist services, Christian Science practitioners or theological healers; and

(9) Treatment that is experimental, obsolete, investigational, or otherwise not established as effective medical treatment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0300, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0305 What are post-employment services? Post employment services are one or more of the vocational rehabilitation services listed in WAC 388-890-0145, provided after DVR determines you have achieved an employment outcome or a supported employment outcome,

your case service record is closed, and you need additional services to help you keep, regain or advance in employment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0305, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0310 Under what conditions does DVR provide post-employment services? DVR provides post-employment services under the conditions listed in WAC 388-890-0110, and if:

(1) Your VR case service record was closed because you achieved an employment outcome;

(2) Your VR case service record has been closed less than three years; and

(3) The impediments to employment related to your disability have not changed to the extent that you require more than short term intervention to keep, regain, or advance in employment within the same or closely related occupation.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0310, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0315 What are reader services? Reader services help you get information from printed text if your disability impairs or prevents you from getting information from printed text. An example of reader services is the use of a person to read print materials such as job announcements and letters from possible employers to an individual with dyslexia or an individual who is blind.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0315, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0320 Under what conditions does DVR provide reader services? DVR provides reader services under the conditions listed in WAC 388-890-0110.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0320, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0325 What are referral services? Referral services help you find and get services or benefits from other programs or agencies.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0325, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0330 Under what conditions does DVR provide referral services? DVR provides referral services under the conditions listed in WAC 388-890-0110, and if:

(1) A VR counselor determines you are not eligible for DVR services; or

(2) You and a VR counselor identify services or benefits available to you from another agency or organization and you agree to be referred.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0330, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0335 What is rehabilitation engineering? Rehabilitation engineering is a type of rehabilitation technology service. Rehabilitation engineering uses engineering sciences to design, develop, adapt, test, evaluate, and implement new and unique products to help you maintain or improve your ability to move around, communicate, hear, see, and understand things.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0335, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0340 Under what conditions does DVR provide rehabilitation engineering? DVR provides rehabilitation engineering services under the conditions listed in WAC 388-890-0110.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0340, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0345 What are self-employment services? Self-employment services include:

(1) Consultation and technical assistance to help you conduct market analyses, develop business plans, and use other resources to pursue self-employment or to establish a small business to become self-employed;

(2) All services required to help you in self-employment including, but not limited to:

(a) Planning;

(b) Consultation;

(c) Initial stocks and supplies;

(d) Tools;

(e) Equipment;

(f) Business licenses;

(g) Fees.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0345, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0350 Under what conditions does DVR provide self-employment services and issue items for self-employment? (1) DVR provides self-employment services under the conditions listed in WAC 388-890-0110.

(2) DVR issues items for self employment under WAC 388-890-0455 through 388-890-0480.

(3) Before DVR supports a self-employment goal, you must complete a business plan that demonstrates that the self-employment you are considering is feasible, sustainable, and results in employment.

(4) DVR does not support hobbies or activities that do not result in an income-producing self-employment outcome.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0350, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0355 What are services to family members? Services to family members are provided to a family member, guardian, or household member with whom you have a close interpersonal relationship. Services to family members include, but are not limited to:

(1) Family or marital counseling;

(2) Information and referral services to family members as appropriate;

(3) Child care.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0355, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0360 Under what conditions does DVR provide services to my family members? DVR provides services to family members under the conditions listed in WAC 388-890-0110 and the following additional conditions for child care:

(1) DVR pays for the following types of licensed child care and child care exempt from licensing in conformance with DSHS children's administration regulations and licensing or certification requirements:

(a) Child day care centers as outlined in WAC 388-150-020 (1)(2) and (4) through (8)(a);

(b) Family child day care homes as outlined in WAC 388-155-020 (1) through (6)(a); and

(c) School-age child care centers as outlined in WAC 388-151-010 and 388-151-020.

(2) DVR pays for in-home or relative child care including:

(a) Child care provided to your child(ren) in your home by a relative or other person; and

(b) Child care provided to your child(ren) by a relative outside of your home.

(3) For in-home or relative child care, you assume full responsibility for the qualifications of the child care provider and the quality of child care services.

(4) DVR pays the child care provider's usual rates for child care services directly to the child care provider.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0360, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0365 What are supported employment services? See WAC 388-890-0570 through 388-890-0665 for supported employment program and services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0365, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0370 What are tools, equipment, initial stocks and supplies? Tools, equipment, initial stocks and supplies are materials and hardware required to carry out the duties of a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0370, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0375 Under what conditions does DVR provide and issue tools, equipment, initial stocks and supplies? (1) DVR provides tools, equipment, initial stocks and supplies under the conditions listed in WAC 388-890-0110.

(2) DVR issues tools, equipment, initial stocks and supplies under WAC 388-890-0455 through 388-890-0480.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0375, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0380 What are training services? Training services assist you to gain knowledge, skills and abilities needed for employment. Training services, include, but are not limited to:

(1) Training to develop work habits, work behaviors, and work skills;

(2) On-the-job training;

(3) Vocational, technical, trade or business training;

(4) Post-secondary academic training;

(5) Books, tools, fees, and other training supplies;

(6) Independent living training;

(7) Tutoring that supports another training service you are receiving;

(8) Other types of training that strengthen your knowledge, skills and abilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0380, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0385 What is on-the-job training? On-the-job training is a way to gain work skills needed for a specific job after being placed in that job. After you start a job, the employer or the employer's designee provides individualized training to teach you the skills you need to perform the job. DVR may reimburse an employer for training costs that exceed the employer's usual costs to train a new employee.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0385, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0390 Under what conditions does DVR provide on-the-job training? DVR provides on-the-job training as a training service under the conditions in WAC 388-890-0110 and if:

(1) An employer has hired you;

(2) The employer or employer's designee has the skills to provide the training you need to learn the job; and

(3) The employer signs an agreement to include at a minimum:

(a) Training to be provided by the employer or designee;

(b) Duration or number of hours of training to be provided;

(c) How the employer will evaluate and report your progress to DVR;

(d) Employer's cost to provide the training; and

(e) Agreed-upon fee, including payment criteria.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0390, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0395 Under what conditions does DVR provide training services and issue items for training? (1) DVR provides training services under the conditions listed in WAC 388-890-0110.

(2) DVR issues devices, tools, equipment or other items used for training under WAC 388-890-0455 through 388-890-0480.

(3) Training at an institution of higher education (universities, colleges, community or junior colleges, vocational schools, technical institutes, or hospital schools of nursing) is provided only after you and a VR counselor have made maximum efforts to get and use grant funding, in whole or in part, from other sources to pay for the training.

(4) You must give DVR a copy of your grant funding award or denial form when it is available.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0395, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0400 Do I have to apply for a student loan to pay for training services? You are not required to apply for a student loan to pay for training services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0400, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0405 Can I receive training services from a private school, an out-of-state training agency or an out-of-state college? If you choose training services from a private school, an out-of-state training agency or an out-of-state college when an in-state or public program is available and adequate to meet your needs, the following conditions apply:

(1) The private school, out-of-state training agency or out-of-state college must meet DVR standards; and

(2) You are responsible for any costs related to the training in excess of what DVR would pay for the training service from a public school or in-state training agency.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0405, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0410 What are transition services? (1) Transition services are work-related activities you begin while you are in high school that are coordinated with VR services to help you prepare for and go to work in the community after you leave high school.

(2) Transition services may include any of the VR services listed under WAC 388-890-0145.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0410, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0415 Under what conditions does DVR provide transition services? DVR provides transition services under the conditions listed in WAC 388-890-0110, and if you:

(1) Are a high school student with a disability; and

(2) Will complete high school during the next twelve months.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0415, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0420 How does DVR coordinate with public high schools to provide transition services? VR counselors work with teachers and other staff in public high schools to coordinate and provide transition services as outlined under an interagency agreement between DVR and the office of superintendent of public instruction.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0420, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0425 How does DVR help me plan transition services? DVR offers counseling and guidance to help you to make informed choices about what VR services and activities you need to:

(1) Assess your rehabilitation needs, including your need to move to a more independent living arrangement;

(2) Decide on an employment goal; and

(3) Decide what VR services are needed to reach your employment goal.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0425, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0430 Who decides what transition services I get from DVR? With support from a VR counselor, you use informed choice to make decisions about which activities and VR services to use based on your individual needs, preferences, interests, and employment goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0430, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0435 What activities does DVR support after I leave high school? DVR supports activities that help you select and reach your employment goal, including but not limited to:

(1) Employment, including supported employment;

(2) Training at a vocational school, technical school, on-the-job training, or other training agency;

(3) Continuing education at a college, community college, or other post-secondary school;

(4) Referral to other community services or organizations that offer services to adults to live more independently and to get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0435, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0440 What are transportation services? Transportation services help you get around in the community to participate in VR services or to get or keep a job. Transportation services include, but are not limited to:

(1) Public transportation fares or passes;

(2) Estimated cost of gasoline;

(3) Vehicle repair and maintenance;

(4) Attendant fees and travel costs while in travel status;

(5) Purchase of vehicles.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0440, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0445 Under what conditions does DVR provide transportation services? DVR provides transportation services to you under conditions specified in WAC 388-890-0110 and if provided in connection with another VR service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0445, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0450 Under what conditions does DVR provide and issue a vehicle? (1) DVR provides a vehicle under the conditions outlined under WAC 388-890-0110 and 388-890-0125, and:

(a) Your disability is stable or slowly progressive, and is not likely to impair your ability to drive in the future.

(b) You and a VR counselor agree it is a necessary service under your individualized plan for employment (IPE) because:

(i) No other transportation options are available and it is not feasible for you to relocate to live closer to employment or other transportation options; or

(ii) A vehicle is required as a condition of employment before you can get or keep a job.

(c) The vehicle is provided in support of another VR service.

(d) You do not have a vehicle or your vehicle cannot be modified or repaired to the extent that you can drive it.

(e) You agree to:

(i) Be the registered owner of the vehicle; and

(ii) Pay for and have a current driver's license, vehicle license, and vehicle registration.

(f) Pay for and have driver insurance and vehicle insurance adequate to cover the cost of replacement for loss or damage at the time the vehicle is issued to you.

(2) DVR issues a vehicle as outlined under WAC 388-890-0455 through 388-890-0480.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0450, filed 8/27/99, effective 11/1/99.]

ISSUING AND RETURNING EQUIPMENT AND DEVICES FOR PARTICIPANT USE

WAC 388-890-0455 Under what conditions does DVR issue a device, tool, piece of equipment or other item I need to participate in VR services or to get a job? If you need a device, tool, piece of equipment or other item to participate in VR services or to go to work, DVR provides the item under the conditions listed in WAC 388-890-0110 and if the item meets applicable local, state and national engineering safety, and, health standards.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0455, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0460 What conditions apply to the use of a device, tool, piece of equipment or other item that is issued to me? If DVR determines an item may be re-used by another person if it is returned, you must sign a statement agreeing to the following before DVR issues the item to you:

(1) DVR has ownership of the item issued to you, and you understand permission for use may be taken away by DVR at any time;

(2) You agree to immediately return the item if DVR requests you to do so and you understand you are responsible to pay for the item if you do not immediately return it to DVR;

(3) You agree to maintain the item according to manufacturer's guidelines, if applicable, and keep it secure from damage, loss or theft; and

(4) You agree to engrave an identification number on all or part of the item, if requested to do so by DVR.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0460, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0465 What types of devices, tools, pieces of equipment or other items can DVR issue to me? DVR issues devices, tools, equipment, or other items that you need to participate in VR services or to get a job, including but not limited to:

(1) Assistive technology devices as outlined under WAC 388-890-0175;

(2) Equipment, supplies or other items needed for self-employment as outlined under WAC 388-890-0345;

(3) Tools, equipment, initial stocks or supplies as outlined under WAC 388-890-0370;

(4) A vehicle as outlined under WAC 388-890-0440;

(5) Tools and other training supplies as outlined under WAC 388-890-0380.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0465, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0470 Does DVR issue new or used devices, tools, pieces of equipment, or other items? (1) If an item is readily available from DVR's inventory that is appropriate and adequate to meet your specific needs, DVR issues the item to you.

(2) If the item is not available from DVR's inventory, DVR locates the item for issue to you from another source.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0470, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0475 What happens if I fail to return a device, tool, piece of equipment or other item if requested by DVR? If DVR directs you to return any item issued to you but owned by DVR and you do not immediately return it, DVR reports the loss to the DSHS office of financial recovery (OFR). The OFR attempts to recover the item or payment for the item from you. If the OFR cannot recover the item(s) or payment for the item(s) from you, the OFR report may the loss to the local county prosecutor for legal action.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0475, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0480 What happens to a device, tool, piece of equipment or other item if I need it when my

DVR case service record is closed? DVR transfers ownership of the device, tool, piece of equipment or other item to you at the time DVR closes your case if you:

(1) Are working in a job that requires the item;

(2) Do not need additional VR services; and

(3) A VR counselor determines you have achieved an employment outcome.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0480, filed 8/27/99, effective 11/1/99.]

INDIVIDUALIZED PLAN FOR EMPLOYMENT (IPE)

WAC 388-890-0485 What is an individualized plan for employment (IPE)? (1) An individualized plan for employment (IPE) is a written document prepared on forms provided by DVR.

(2) An IPE is an agreement that records the decisions and commitments you and a VR counselor make about VR services and activities.

(3) The IPE documents the VR services you will use to prepare for, get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0485, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0490 How do I develop an IPE? (1) You have the following options for developing an IPE. You may use each option separately or in combination with the other options to develop all or part of the IPE:

(a) Develop the IPE with assistance and support from a VR counselor;

(b) Develop the IPE on your own; and

(c) Develop the IPE with a representative, family member, advocate, or other individual of your choice.

(2) If you choose to develop the IPE with someone other than a VR counselor, DVR helps you identify sources external to DVR that may help you develop your IPE. DVR does not pay for any related costs or fees charged by other parties to develop the IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0490, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0495 What information does DVR give me to develop my IPE? DVR gives you the following information in writing about how to develop an IPE:

(1) A description of the information that must be included on an IPE;

(2) Financial conditions or restrictions that relate to the IPE;

(3) Other information you request;

(4) Where to get help to fill out forms required by DVR;

(5) Your rights if you disagree with DVR about a decision relating to the IPE;

(6) Information about the client assistance program (CAP) and how to contact the program.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0495, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0500 Who makes decisions about what to include on my IPE? You use informed choice to make decisions about what to include on your IPE. You have the right to make decisions that are consistent with your strengths, abilities, capabilities, and interests, including but not limited to:

(1) The type of job you want;

(2) What VR services you need to help you reach your employment goal;

(3) What service provider to use.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0500, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0505 Can I include any VR services I want on my IPE? DVR provides only those VR services that you and a VR counselor agree are:

(1) Consistent with your strengths, abilities, capabilities, and interests; and

(2) Needed to achieve the employment goal listed on your IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0505, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0510 What if the employment goal I choose is religious in nature? DVR is prohibited from supporting an employment goal that is religious in nature under the Washington State Constitution, Article 1, subsection 11.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0510, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0515 What must be included on my IPE? An IPE must include all of the following items, at a minimum:

(1) Your employment goal;

(2) The VR services you plan to use;

(3) The date VR services included on the plan begin;

(4) When you expect to begin working;

(5) The name of the person or organization providing each service included on the IPE;

(6) What criteria you will use to evaluate whether you are making progress toward your employment goal;

(7) Terms and conditions, including:

(a) A description of what DVR has agreed to do to support your IPE; and

(b) A description of what you have agreed to do to reach your employment goal, including:

(i) Steps you will take to achieve your employment goal;

(ii) What services you agree to help pay for, and how much you will pay; and

(iii) What services you agree to apply for as comparable services and benefits.

(8) What services will be provided by another organization as a comparable service or benefit;

(9) The expected need for post-employment services;

(10) The process used to provide or procure services;

(11) The basis on which DVR determines you have achieved an employment outcome as outlined in WAC 388-890-0535;

(12) Your rights under the IPE and your options to appeal a decision your DVR counselor makes that you do not agree with as outlined in WAC 388-890-1180;

(13) Your rights and procedures to file a complaint to report and resolve any dissatisfaction; and

(14) The availability of the client assistance program as outlined in WAC 388-890-1185.

(15) An IPE that includes a supported employment outcome must also document:

(a) The extended services or natural supports you need;

(b) The name of the person or organization paying for the extended services, if extended services are used;

(c) If it is not known who will pay for extended services or natural supports when the IPE is developed, the IPE includes a statement explaining the expected source of extended service or a plan to identify a source of extended services;

(d) A goal for the number of hours per week you are going to work based on your strengths, abilities, capabilities, interest and informed choice;

(e) A description of how the services on your IPE are coordinated with other federal or state services you get under another individualized plan; and

(f) The basis on which DVR determines you have achieved a supported employment outcome as outlined in WAC 388-890-0535 (1) through (4), 388-890-0650 and 388-890-0660.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0515, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0520 Who signs the IPE? You and a VR counselor must agree to and sign your IPE. DVR gives you a copy of the signed IPE, in writing or in another method of communication, if needed.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0520, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0525 Is the IPE reviewed and updated? You and a VR counselor review the IPE at least once a year, or more often if needed.

(1) You and a VR counselor amend the IPE if there are major changes in the employment goal, the VR services to be used, or the service provider to be used.

(2) Changes to an IPE take effect when you and a VR counselor sign the updated IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0525, filed 8/27/99, effective 11/1/99.]

CLOSING A CASE SERVICE RECORD AND ANNUAL REVIEWS

WAC 388-890-0530 Why does DVR close a case service record? A VR counselor closes your case service record for any of the following reasons:

(1) You are working and no longer need VR services;

(2) You decline VR services;

(3) Anytime DVR determines that you are not eligible or no longer eligible;

(4) You are no longer available to participate in services;

(5) You cannot be located;

(6) You ask DVR to close your case service record; or

(7) You refuse to cooperate in required or agreed upon services

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0530, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0535 Under what conditions does DVR determine that I am working and no longer need VR services? DVR determines that you have achieved an employment outcome and no longer need VR services if:

(1) You received services under an IPE that helped you get a job;

(2) Your job matches your strengths, needs, abilities, interests and choices;

(3) You have been working for at least ninety days; and

(4) You and a VR counselor agree the job is satisfactory and that you are performing the job well; and

(5) You are working in an integrated setting or in a nonintegrated setting of your choice.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0535, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0540 Am I involved in the decision to close my case? (1) Before closing your case service record, a VR counselor gives you an opportunity to discuss the decision.

(2) DVR notifies you in writing, or another method of communication, if needed, about the reason your case service record is being closed and your rights if you disagree with the decision as outlined under WAC 388-890-1180.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0540, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0545 What is competitive employment? Competitive employment is work in the competitive labor market that you perform on a full-time or part-time basis in an integrated setting for which you earn a wage at or above the minimum wage, but not less than the usual wage and level of benefits your employer pays to nondisabled employees who do the same or similar work as you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0545, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0550 What is extended employment? Extended employment is:

(1) Work in a nonintegrated setting for a public or nonprofit agency or organization which provides support services to you to continue to train or prepare for competitive employment unless you choose to remain in extended employment; and

(2) Work for which you earn a wage according to special certificate provisions of 14(c) of the U.S. Department of Labor Fair Labor Standards Act (29 U.S.C. 214 (c)).

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0550, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0555 If the job I get is in extended employment, what follow-up does DVR provide? (1) If you go to work in extended employment, DVR reviews your status annually to:

(a) Determine your interest and need to move to competitive employment;

(b) Determine your interest and need to receive training for competitive employment; and

(c) Evaluate whether there are VR services or other services that would assist you to move to competitive employment.

(2) DVR provides an opportunity for you to give input during the annual review.

(3) DVR reviews your status annually for two years following the date you go to work.

(4) After two years, you may request that DVR continue to review your status annually.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0555, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0560 Under what conditions does DVR follow up with me if I am determined ineligible for VR services? (1) If DVR determines you are ineligible because you are too significantly disabled to benefit from VR services in terms of employment under any of the following conditions, DVR contacts you within twelve months of the date determined ineligible to review whether anything has changed to affect your eligibility:

(a) You are too significantly disabled to participate in a trial work experience;

(b) You decline a trial work experience and you and your VR counselor agree that you are too significantly disabled to benefit from VR services in terms of employment;

(c) You participate in a trial work experience as outlined under WAC 388-890-0670 through 388-890-0705 and are determined too significantly disabled to benefit from services in terms of employment; or

(d) You and your VR counselor cannot find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for supported employment.

(2) After DVR completes the initial twelve month review, you or your representative may request additional annual reviews.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0560, filed 8/27/99, effective 11/1/99.]

SUPPORTED EMPLOYMENT PROGRAM

WAC 388-890-0570 What is supported employment? (1) Supported employment is:

(a) Competitive work; or

(b) Work in an integrated setting while you work toward competitive work consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; or

(c) Transitional employment for an individual with a most significant disability due to chronic mental illness.

(2) Supported employment is for an individual with a most significant disability who:

(a) Has not traditionally worked in competitive employment; or

(b) Has worked in competitive employment, but the disability has caused the individual to stop working, or work off and on; and

(c) Needs intensive supported employment services and extended services to work because of the nature and significance of the disability.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0570, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0575 Who is eligible for supported employment? You are eligible for supported employment services if:

(1) You are eligible for vocational rehabilitation services under WAC 388-890-0035;

(2) You are an individual with a most significant disability under WAC 388-890-0755 category one; and

(3) Supported employment is appropriate for you based on a comprehensive assessment of your needs, including an evaluation of your rehabilitation, career and job needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0575, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0580 Who decides if I am eligible for supported employment? DVR decides if you are eligible for supported employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0580, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0585 What is competitive work in supported employment? Competitive work, as used in supported employment, is:

(1) Work in the competitive labor market that you perform on a full-time or part-time basis in an integrated setting; and

(2) Work for which you are paid at or above the minimum wage, but not less than the usual wage your employer pays to nondisabled employees who do the same or similar work as you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0585, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0590 What is an integrated setting in supported employment? An integrated setting in supported employment is a work setting commonly found in the community in which you interact with nondisabled people to the

same extent that a nondisabled person in the same type of job interacts with other persons.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0590, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0595 Is my work setting integrated if my interactions at the work site are with nondisabled supported employment service providers? Interactions at your work site between you and a nondisabled supported employment service provider do not meet the requirement for an integrated setting.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0595, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0600 What is transitional employment? Transitional employment is a work model using a series of consecutive jobs in competitive employment for individuals with the most significant disabilities due to mental illness.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0600, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0605 What are supported employment services? Supported employment services are:

(1) Ongoing support services as described in WAC 388-890-0610; and

(2) Vocational rehabilitation services listed in WAC 388-890-0145.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0605, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0610 What are ongoing support services? Ongoing support is a type of supported employment service to help you get and keep a job. Ongoing support services include:

(1) An assessment of your employment situation at least twice a month, or under special circumstances and especially at your request, an assessment regarding your employment situation that takes place away from your worksite at least twice a month to:

(a) Determine what is needed to maintain job stability; and

(b) Coordinate services or provide specific intensive services that are needed at or away from your worksite to help you maintain job stability.

(2) Intensive job skill training for you at your job site by skilled job trainers.

(3) Job development, job placement and job retention services.

(4) Social skills training.

(5) Regular observation or supervision.

(6) Follow-up services such as regular contact with your employer, you, your representatives, and other appropriate individuals to help strengthen and stabilize the job placement.

(7) Facilitation of natural supports at the worksite.

(8) Other services similar to services described in subsections (1) through (7) above.

(9) Any other vocational rehabilitation service described in WAC 388-890-0145 through 388-890-0450.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0610, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0615 Under what conditions does DVR provide supported employment services? DVR provides supported employment services under the conditions in WAC 388-890-0110 and if you are an individual with a most significant disability as described in category one, WAC 388-890-0755.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0615, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0620 What is included on my individualized plan for supported employment? Your individualized plan for supported employment includes the information specified in WAC 388-890-0515.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0620, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0625 What are extended services? Extended services help you keep your job after DVR stops providing supported employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0625, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0630 Does DVR provide extended services? DVR does not provide extended services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0630, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0635 Who provides the extended services I need? Extended services are provided by nonprofit private organizations such as community rehabilitation programs, state and local public agencies, employers, or any other appropriate resources.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0635, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0640 What is natural support? Natural support is a method used to help you keep your job after DVR stops providing supported employment services. Natural support uses the people who you ordinarily come into contact with at work and/or at home to help you with work routines and social interactions at the work site.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0640, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0645 Are supported employment services time-limited? DVR provides supported employment

services as part of your individualized plan for employment for a period not to exceed eighteen months, unless under special circumstances you and your VR counselor jointly agree to extend the time in order to achieve the employment goals in your individualized plan for employment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0645, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0650 What is required for me to change from supported employment services to extended services? Prior to helping you change from supported employment services to extended services, a VR counselor must ensure the following:

(1) You have made substantial progress toward meeting the number of work hours per week you want to work as documented on your individualized plan for employment;

(2) You are stabilized in the job; and

(3) Extended services are readily available and can be provided to you without an interruption in services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0650, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0655 What happens if my VR counselor and I do not find a source for extended services and/or we cannot establish natural supports during the initial eighteen months of my individualized plan for employment? If you and your VR counselor do not find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for employment, DVR must determine that you are no longer eligible for VR services under WAC 388-890-0065.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0655, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0660 Under what conditions does DVR close my case service record for supported employment? A VR counselor closes your case service record for supported employment under WAC 388-890-0530 through 388-890-0540, except if you have achieved a supported employment outcome, DVR must wait at least ninety days after helping you change from supported employment services to extended services before closing your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0660, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0665 Under what conditions does DVR provide supported employment services as post-employment services? DVR provides supported employment services to you as post-employment services following the change from supported employment services to extended services if:

(1) Your extended service provider cannot provide the services; and

(2) You need such services as job station redesign, repair and maintenance of assistive technology devices and replacement of prosthetic and orthotic devices to keep your job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0665, filed 8/27/99, effective 11/1/99.]

TRIAL WORK EXPERIENCE

WAC 388-890-0670 What is a trial work experience? A trial work experience is a method of assessment used by DVR to determine eligibility for VR services:

(1) Only if a VR counselor cannot presume that VR services will enable you to work because of the significance of your disability; and

(2) After you have applied for VR services and before an individualized plan for employment is developed.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0670, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0675 What happens during a trial work experience? (1) During a trial work experience, you are placed in a sufficient variety of realistic integrated employment settings and provided with VR services to assess how you perform.

(2) The trial work experience continues long enough to provide sufficient information for a VR counselor to determine whether:

(a) VR services will enable you to work and that you are eligible for VR services; or

(b) VR services will not enable you to work, because of the significance of your disability; and/or

(c) Service providers are able to meet your VR service needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0675, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0680 Who decides if a trial work experience is needed to determine if I am eligible for DVR services? DVR determines whether a trial work experience is needed to determine your eligibility for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0680, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0685 What services does DVR provide during a trial work experience? DVR may use the individual VR services listed under WAC 388-890-0145 through 388-890-0450 during a trial work experience.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0685, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0690 What if I am too significantly disabled to participate in a trial work experience? If DVR is unable to identify VR services or service providers that would enable you to perform a trial work experience because of the significance of your disability, DVR follows the proce-

dures outlined under WAC 388-890-0065 to determine that you are not eligible for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0690, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0695 What choices can I make about the trial work experience? If a trial work experience is needed to decide if you are eligible for VR services, DVR provides information and support to help you make informed choices that include, but are not limited to:

(1) What type of work setting to use;

(2) What service providers to use.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0695, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0700 Am I evaluated during the trial work experience? DVR evaluates your progress in a trial work experience as often as needed, but at least every ninety days.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0700, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0705 When does DVR make an eligibility decision when I am in a trial work experience? There is no time limit for a trial work experience. As soon as DVR has enough information to decide whether VR services will enable you to get or keep a job, DVR must:

(1) Make an eligibility decision;

(2) Document the basis for eligibility or ineligibility; and

(3) Discontinue trial work experience.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0705, filed 8/27/99, effective 11/1/99.]

VOCATIONAL REHABILITATION SERVICES FOR GROUPS OF INDIVIDUALS

WAC 388-890-0710 Are there any vocational rehabilitation services that can be provided to a group of individuals with disabilities? The following vocational rehabilitation services may be provided to a group of individuals with disabilities:

(1) Services to establish, develop, or improve a community rehabilitation program may be provided to a group of individuals with disabilities who are currently not being served or whose service needs are not being met by DVR.

(2) Services may be provided to an identified group of individuals with disabilities if the VR services:

(a) Are likely to contribute to the rehabilitation of those in the group; and

(b) Cannot be purchased on an individual basis.

(3) Consulting and/or technical assistance services may be provided to support planning the development of school programs to meet the long-term employment needs of a group of students with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0710, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0715 Under what conditions does DVR provide services to a group of individuals with disabilities to establish, develop or improve a community rehabilitation program? (1) DVR may provide services to a group of individuals with disabilities to establish, develop, or improve a community rehabilitation program if:

(a) DVR has identified a group of individuals with disabilities who are not being served or whose service needs are not being met by DVR because of limited staff resources.

(b) Services of a community rehabilitation are needed in a geographic area.

(c) DVR has evaluated the community rehabilitation program services and determined that VR services to groups are needed and are likely to meet the service needs of the group.

(2) DVR does not pay for the cost of construction related to establishing or developing a community rehabilitation program.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0715, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0720 Under what conditions does DVR provide services to a group of individuals with disabilities that cannot be purchased under an individual IPE? (1) DVR may provide services to a group of individuals with disabilities if the services are likely to contribute to the rehabilitation of those in the group, but cannot be purchased under an individualized plan for employment of any one person within the group because:

(a) The services are needed by the individuals in the group to apply for DVR services when a barrier exists that hinders access to VR services for a group of individuals with disabilities.

(b) The services needed by the group are not designated by a unit or per person cost and/or cannot be prorated equitably to the IPE's of those in the group.

(2) DVR does not purchase equipment in excess of five thousand dollars as a service to groups of individuals with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0720, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0725 Under what conditions does DVR provide consulting and/or technical assistance to plan for the transition of students with disabilities? (1) DVR may purchase consulting and/or technical assistance for schools to plan for the transition of students with disabilities if:

(a) DVR has determined that the school needs consulting or technical assistance services to plan for the transition of students with disabilities;

(b) The school has expressed a commitment to provide the resources needed to implement a plan for the transition of students with disabilities;

(c) DVR has determined the services are likely to result in increased capacity within the school system to assist students with disabilities to transition from school to work; and

(d) DVR does not have adequate staff resources to provide the needed consulting or technical assistance.

(2) DVR does not pay for:

(a) The cost to implement a plan; or

(b) Individual VR services to students with disabilities as a service to groups.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0725, filed 8/27/99, effective 11/1/99.]

ORDER OF SELECTION

WAC 388-890-0730 What if DVR does not have funding to serve all eligible individuals? (1) When funds or other resources are not available to serve all eligible individuals, DVR establishes an order to select eligible individuals to develop and carry out an individualized plan for employment (IPE).

(2) When the selection order is in effect and you are eligible for services, DVR assigns your name to one of three selection categories.

(3) You can develop and carry out an IPE based on:

(a) The priority of the selection category you are in; and

(b) The order in which you applied for DVR services as indicated by the date on your application. If you are a public safety officer with a disability that was acquired while acting in the line of duty you are placed first within a category, regardless of the date on your application.

(4) If the category you are in is one that DVR does not have funds or other resources for you to develop and carry out an IPE, DVR provides you with vocational rehabilitation information, guidance, and referral services to access other federal and state programs suited to address specific employment needs of individuals with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0730, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0745 If DVR has to decide in what category to place me, who decides what assessment services I need and where to get the assessment services? If DVR has to decide in what category to place you because funds or other resources are not available to all eligible individuals:

(1) DVR decides what assessment services are needed; and

(2) You choose the service providers for the assessment services you need based on informed choice.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0745, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0750 What categories are used by DVR to determine the priority by which eligible individuals are served and in what order are the categories prioritized? (1) DVR uses the following categories to determine the priority by which to serve you if you are eligible for VR services:

(a) Category one—First priority, individuals with the most significant disabilities;

(b) Category two—Second priority, individuals with significant disabilities; and

(c) Category three—Third priority, individuals with disabilities.

(2) The categories are prioritized for eligible individuals to develop and carry out an IPE in the following order:

(a) Individuals with the most significant disabilities first;

(b) Individuals with significant disabilities second; and

(c) Individuals with disabilities third.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0750, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0755 What information does DVR use to determine whether I am in category one? DVR determines you are in category one-first priority, eligible individuals with the **most** significant disabilities if you are an individual with a significant disability as outlined in WAC 388-890-760 except:

(1) You have one or more physical, mental, or sensory impairments that constitute or result in a substantial impediment to employment for you and cause you to experience serious limitations in **four** or more of the following areas in terms of an employment outcome:

(a) Mobility;

(b) Communication;

(c) Self-care;

(d) Self-direction;

(e) Interpersonal skills;

(f) Work tolerance;

(g) Work skills in terms of an employment outcome; and

(2) You require extended services in order to work.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0755, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0760 What information does DVR use to determine whether I am in category two? DVR determines you are in category two—second priority, eligible individuals with significant disabilities if you meet all of the following criteria:

(1) You are receiving disability benefits under Title II or Title XVI of the Social Security Act; or you have one or more physical, mental, or sensory impairments including:

(a) Amputation;

(b) Arthritis;

(c) Autism;

(d) Blindness;

(e) Burn injury;

(f) Cancer;

(g) Cerebral palsy;

(h) Cystic fibrosis;

(i) Deafness;

(j) Head injury;

(k) Heart disease;

(l) Hemiplegia;

(m) Hemophilia;
(n) Respiratory or pulmonary dysfunction;
(o) Mental retardation;
(p) Mental illness;
(q) Multiple sclerosis;
(r) Muscular dystrophy;
(s) Musculo-skeletal disorders;
(t) Neurological disorders (including stroke and epilepsy);
(u) Paraplegia;
(v) Quadriplegia;
(w) Other spinal cord conditions;
(x) Sickle cell anemia;
(y) Specific learning disability;
(z) End stage renal disease; or
(aa) Other disability or combination of disabilities to cause comparable substantial functional limitation as identified by an assessment for determining eligibility and vocational rehabilitation needs.

(2) You have one or more physical, mental, or sensory impairments that constitute or result in a substantial impediment to employment for you and cause you to experience serious limitations in **one** or more of the following areas in terms of an employment outcome:
(a) Mobility,
(b) Communication,
(c) Self-care,
(d) Self-direction,
(e) Interpersonal skills,
(f) Work tolerance,
(g) Work skills in terms of an employment outcome.

(3) Your vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0760, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0765 What information does DVR use to determine whether I am in category three? DVR determines you are in category three—third priority, eligible individuals with disabilities if you are eligible for VR services and you do not meet the criteria to qualify as an individual with a **most** significant disability as outlined in WAC 388-890-755, or an individual with a significant disability as outlined in WAC 388-890-760.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0765, filed 8/27/99, effective 11/1/99.]

INDEPENDENT LIVING PROGRAM — TITLE VII

WAC 388-890-0780 What is the independent living (IL) program? (1) The independent living (IL) program is authorized by the department of social and health services, division of vocational rehabilitation under Title VII of the Rehabilitation Act, as amended.

(2) Independent living (IL) is a program of services that assists adults and emancipated minors with significant disabilities to live more independently in their families and communities. IL program services are not offered in all DVR offices. Individuals interested in IL program services must be able to receive services in a region where IL program services are offered.

(3) In addition to the rules in sections WAC 388-890-0780 through 388-890-1095 covering independent living program services, the following vocational rehabilitation rules apply:

(a) Payment for VR and IL program services, WAC 388-890-1100 through 388-890-1175;

(b) Confidentiality of personal information, WAC 388-890-1265 through 388-890-1295; and

(c) How to contact DVR if you don't speak English, WAC 388-890-1300 through 388-890-1310.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0780, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0785 What types of services does the IL program offer? If you are eligible, the IL program can help you get the following types of services, as needed, to reach your IL goals:
(1) Advocacy services;
(2) Rehabilitation technology services;
(3) Communications services;
(4) IL counseling services;
(5) Housing services;
(6) IL skills training;
(7) Information and referral services;
(8) Mobility training;
(9) Peer counseling services;
(10) Personal assistance services;
(11) Physical rehabilitation services;
(12) Preventative services;
(13) Recreational services;
(14) Services to family members;
(15) Therapeutic treatment services;
(16) Transportation services; and
(17) Other IL program services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0785, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0790 Who is eligible for Title VII IL program services? (1) You are eligible for IL program services under Title VII if you are an adult or emancipated minor and you:

(a) Have a significant disability, as defined under WAC 388-890-0795;

(b) Are not currently eligible for VR services; and

(c) Can receive IL program services in a region that offers the services.

(2) Eligibility is not based on your age, color, creed, gender, sexual orientation, national origin, race, religion, or type of disability.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0790, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0795 What is a significant disability? In the Title VII IL program, you have a significant disability if:

(1) You have a physical, mental, cognitive or sensory impairment that greatly limits your level of independence in your family or community; and

(2) IL program services are likely to improve or maintain your level of independence in any of these areas.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0795, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0800 Who provides IL program services? (1) An IL counselor provides IL program services; or

(2) The IL counselor may refer you to a service provider who meets standards established by the IL program.

(3) When a service provider is used, the service provider must provide IL program services that you, the IL counselor, and the service provider have agreed to in advance of starting the service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0800, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0805 What are my responsibilities in the IL program? To receive independent living services, you must:

(1) Complete tasks that you have agreed to complete to reach your IL goals;

(2) Be willing to learn new skills and try new things; and

(3) Accept responsibility for your decisions and actions related to your IL goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0805, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0810 How do I apply for IL program services? To apply for IL program services you:

(1) Fill out and sign an IL program services application form; or

(2) Submit the following information:

(a) Your name, address and the county where you live;

(b) Your birthdate and gender;

(c) Your Social Security Number (optional);

(d) A short description of the type of disability; and

(e) The date of your application.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0810, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0815 What happens after I submit my application for IL program services? After you apply for IL program services, you meet with an IL counselor to:

(1) Fill out other forms and releases needed by the IL program to collect the information needed to decide if you are eligible for services;

(2) Complete an assessment to:

(a) Verify whether you have a significant disability that greatly limits your level of independence in your family or community;

(b) Identify your IL needs; and

(c) Decide if IL program services can help you to improve or maintain your level of independence in your family or community.

(3) The assessment may include, but is not limited to, the following areas:

(a) Your home and living environment, including housing, ability to get around, and safety;

(b) Financial issues, such as budgeting, paying bills, and managing money;

(c) Your basic skills in cooking, cleaning, shopping and general home and family care;

(d) How you relate to your family or others socially, and how you spend your free time;

(e) How you manage your own personal care;

(f) School or work interests.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0815, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0820 Who decides if I am eligible for IL program services? (1) An IL counselor determines whether you meet the eligibility requirements as outlined under WAC 388-890-0790; or

(2) If an individual or organization has a contract with the IL program to offer IL program services, the individual or organization may determine whether you meet the eligibility requirements under WAC 388-890-0790.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0820, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0825 Where does the IL program get the information needed to decide if I am eligible? The IL program uses information that you, your family, your doctor, or other organizations submit to decide if you are eligible.

(1) If the information does not verify whether you are eligible for IL program services, you may need to get additional assessments, exams, or tests to get the information.

(2) The IL program pays for services needed to verify whether you are eligible.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0825, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0830 How do I find out if I am eligible for IL program services? (1) If the IL program verifies you are eligible, the IL program notifies you of the decision.

(2) If the IL program determines you are not eligible, the IL program must:

(a) Talk with you about the decision;

(b) Send you, or your representative, a notice of the decision in writing, including information about the services offered by the client assistance program and how to ask for services; and

(c) When possible, refer you to other agencies or programs that offer services to meet your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0830, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0835 What if I disagree with a decision about my eligibility for IL or a decision about IL program services? If an IL counselor makes a decision about your IL program services that you don't agree with, you have the following options:

(1) Try to resolve the disagreement by talking to the IL counselor, his or her supervisor, or regional administrator;

(2) Contact the client assistance program as outlined under WAC 388-890-1185; and/or

(3) Request mediation as outlined under WAC 388-890-1190 through 388-890-1215.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0835, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0840 Under what conditions can I get IL program services? (1) The IL program offers services as needed to:

(a) Establish your eligibility;

(b) Assess your IL needs;

(c) Develop an IL plan; and

(d) Reach your IL goals.

(2) The IL program provides services only if you are not eligible to receive a comparable service from another organization or program.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0840, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0845 How are my IL program services planned? (1) If you are eligible for IL program services, you work with an IL counselor to develop a written IL plan or a verbal IL plan.

(a) You can get the same IL program services under a written IL plan and a verbal IL plan.

(b) If you choose a verbal IL plan, you must sign a waiver declining a written IL plan.

(2) Before the IL program purchases services under a written IL plan or verbal IL plan, you must complete a financial statement as outlined under WAC 388-890-1145, unless you receive public assistance or support from another program as outlined under WAC 388-890-1150.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0845, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0850 What is included on a written or verbal IL plan? The written or verbal IL plan includes:

(1) Your goals for addressing the barriers that limit your level of independence in your family or community;

(2) The IL program services you are using to achieve each goal; and

(3) How long you expect to use each service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0850, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0855 Who signs and keeps a written IL plan? (1) You and an IL counselor sign the written IL plan.

(2) The IL counselor gives you a copy of the written IL plan in a format that you can understand and use.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0855, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0860 How often is my IL plan reviewed? (1) You and an IL counselor review your IL plan at least once a year, and more often if needed to decide whether:

(a) IL program services should continue, change or stop;

(b) You can and want to be referred to DVR to apply for vocational rehabilitation services as outlined under WAC 388-890-105; and

(c) You should be referred to another program or service.

(2) You may develop a new plan, if changes are needed.

(3) When you develop a new plan, the new plan is developed as outlined in WAC 388-890-0845 through 388-890-0855.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0860, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0870 What are IL advocacy services? IL advocacy services support and assist you to express your interests or concerns to others to:

(1) Reach your IL goals; or

(2) Get other benefits and services you need.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0870, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0875 What are IL rehabilitation technology services? IL rehabilitation technology services assist you to use devices, equipment, or technology services that enable you to reach your IL goals. IL rehabilitation technology services assist you to:

(1) Assess your technology needs;

(2) Try out different types of devices, equipment, and services;

(3) Obtain devices; and/or

(4) Receive training on the use of devices or equipment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0875, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0880 What are IL communication services? IL communication services assist you to learn skills or use services that enable you to understand and share information. Examples of communication services include, but are not limited to:

(1) How to get and use interpreter services, including tactile interpreter services;

(2) Training in the use of equipment that helps you communicate;

(3) Braille training;

(4) How to get and use reader services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0880, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0885 What are IL counseling services? (1) IL counseling services include support and advice from an IL counselor to help you reach your IL goals by finding out about issues that get in the way of your independence.

(2) IL counseling services also includes therapeutic counseling services purchased from a qualified therapist on a short-term basis to help you:

(a) Adjust to your disabling condition; and

(b) Deal with issues about being more independent.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0885, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0890 What are IL housing services? IL housing services assist you to find or keep a suitable living arrangement and take steps needed to move, if needed. Housing services include, but are not limited to, assisting you to:

(1) Find out about low-income housing resources and different types of housing;

(2) Find housing that accommodates your disability;

(3) Assess what is needed in your current housing to accommodate your disability;

(4) Find out about ways to make your home accessible.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0890, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0895 Are IL program payments for home modifications limited? (1) The IL program pays for home modifications if:

(a) The modifications are related to a disability and will improve or maintain independence or safety.

(b) You and/or a family member with whom you live:

(i) Own the place where you live; and

(ii) Complete a financial statement based on the family income to determine whether you must pay, in whole or in part, for home modifications.

(c) The housing construction complies with appropriate building codes and permit requirements.

(2) The IL program does not pay for the cost of labor to construct home modifications.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0895, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1000 What is IL skills training? IL skills training teaches you skills to manage and balance your life in areas including, but not limited to:

(1) Budgeting;

(2) Meal planning and/or preparation;

(3) Consumer skills;

(4) Personal care;

(5) Social interaction.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1000, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1005 What are IL information and referral services? IL information and referral services help you to find out about and get help from other community programs and services. IL information and referral services include, but are not limited to:

(1) Information about a variety of disability issues;

(2) Information about health insurance and where it is available;

(3) Help with contacting other programs and services in the community.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1005, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1010 What is IL peer counseling? IL peer counseling is support, advice, teaching, and information sharing with people with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1010, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1015 What is IL mobility training? IL mobility training improves your ability to get around in your home or your community, including but not limited to:

(1) How to use a wheelchair;

(2) How to make transfers;

(3) Training on the use of public transportation.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1015, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1020 What is IL personal assistance training? IL personal assistance training helps you develop the skills to get or keep the services of an attendant or assistant to meet your personal assistance needs. Personal assistance training includes, but is not limited to:

(1) How to find an attendant or assistant;

(2) How to manage services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1020, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1025 Does the IL program pay for attendant services as part of personal assistance training? The IL program does not pay for attendant services as part of personal assistance training.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1025, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1030 What are IL physical rehabilitation services? IL physical rehabilitation services include medical assessments or short-term services to assist you to identify or reach your IL goals. Physical rehabilitation services include, but are not limited to:

(1) Occupational therapy;

(2) Speech therapy;

(3) Physical therapy.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1030, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1035 What are IL preventative services? IL preventative services enable you to prevent or limit conditions that result from your disability. IL preventative services enable you to reduce the risk that conditions or limitations worsen. IL preventative services may include, but are not limited to, the purchase of items used to prevent decubitus ulcers.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1035, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1040 What are IL recreational services? IL recreational services assist you to find ways to enjoy activities or hobbies of personal interest to you. IL recreational services may include but are not limited to:

(1) Assisting you to find information and contact local programs or organizations that offer activities you are interested in;

(2) Getting short-term instruction in an area of interest to you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1040, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1045 What are IL program services to family members? (1) IL program services to family members assist you and your family members with issues related to your disability or independence. Services to family members may include, but are not limited to:

(a) Giving your family training to understand disability issues;

(b) Assisting you to get child care needed to allow you to use IL program services.

(2) Family member means:

(a) Your legal guardian;

(b) Someone related to you; or

(c) Someone you live with who has a strong interest in your well being and who needs IL program services for you to achieve your IL goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1045, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1050 What are IL therapeutic services? IL therapeutic services include evaluations to assist you to get specific information from a medical professional, such as a psychologist or neuropsychologist, to help you:

(1) Identify your IL goals; and/or

(2) Decide best methods for you to receive services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1050, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1055 What are IL transportation services? (1) IL transportation services help you participate in other IL program services and include, but are not limited to:

(a) Public transportation fares or passes,

(b) Estimated cost of gasoline,

(c) Parking fees.

(2) IL transportation services do not include the purchase of vehicles.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1055, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1060 What other services does the IL program offer? The IL program may offer other services needed to help you to understand IL program services and options or achieve your IL goals. Other IL program services may include, but are not limited to support to attend a class, and support to find volunteer work.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1060, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1065 How long can I receive independent living services? There is no limit on how long IL program services may be provided.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1065, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1070 Why does the IL program stop providing or paying for IL program services? (1) The IL program stops providing or paying for IL program services if you:

(a) Agree with an IL counselor that you have completed the goals and objectives in your IL plan.

(b) Are no longer available to receive services at a DVR office where IL program services are offered.

(c) Choose to quit using IL program services.

(d) Are eligible and plan to use vocational rehabilitation services.

(2) The IL program stops providing or paying for IL program services if an IL counselor:

(a) Determines you no longer need IL program services.

(b) Determines you are not progressing in your IL plan.

(c) Determines that you are no longer eligible for IL program services.

(d) Refers you to another service or program that offers services that are more likely to meet your needs.

(e) Cannot locate you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1070, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1075 Am I involved in the decision to stop receiving IL program services? Before the IL program decides to stop providing or paying for your IL program services, an IL counselor must give you an opportunity to discuss the reasons for the decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1075, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1080 How does the IL program notify me that my services are stopping? (1) If an IL counselor decides that you are no longer eligible for IL program ser-

vices, the IL counselor must follow the procedures in WAC 388-890-0065 to notify you about the decision.

(2) If you and an IL counselor have decided to stop IL program services for another reason, the IL program must send you a written notice. The written notice must explain:

(a) The reason the IL program has decided to stop providing or paying for IL program services; and

(b) The services offered by the client assistance program as outlined under WAC 388-890-1185 and how to ask for those services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1080, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1085 If the IL program decides I am not eligible for IL program services, is the decision reviewed? (1) If the IL program decides that you are not eligible for IL program services, an IL counselor must contact you to review the decision within twelve months.

(2) If you have a change in your life that affects your eligibility for IL program services, you may ask the IL program to review the decision.

(3) The IL program is not required to review your eligibility if you:

(a) Refuse or decline a review;

(b) Are no longer available to receive services at a DVR office that provides IL program services; or

(c) Cannot be located.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1085, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1090 Does the IL program keep a record of my IL program services? The IL program keeps a record of your services, either electronically or in writing for three years after you stop receiving IL program services. The record includes, but is not limited to:

(1) Records that verify your eligibility or ineligibility;

(2) IL goals and objectives that are:

(a) Established with your input, whether on a written IL plan or not; and

(b) Achieved by you.

(3) Services you requested and received;

(4) A written IL plan or a written form signed by you declining a plan.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1090, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1095 Does the IL program keep personal information confidential? (1) The IL program protects your personal information as outlined in WAC 388-890-1255 through 388-890-1295.

(2) When a service provider is used, the service provider must have and follow policies and procedures that are consistent with WAC 388-890-1255 through 388-890-1295.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1095, filed 8/27/99, effective 11/1/99.]

PAYMENT FOR VR AND IL PROGRAM SERVICES

WAC 388-890-1100 How are costs for VR and IL program services paid? DVR may only pay for VR and IL program services after you and a counselor have looked for other resources available to pay for the services, including:

(1) Comparable services and benefits; and

(2) Your own financial resources.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1100, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1110 What are comparable services and benefits? Comparable services and benefits are services or benefits that are similar to services DVR would provide that are available to you from another public program, under a health insurance program, or as an employee benefit. For example, if you need a mental health service and it is available to you at no cost from a local mental health center, DVR will not pay another organization or service provider for that service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1110, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1115 What VR or IL program services are provided without a determination of comparable services or benefits? (1) The following VR services are provided without a determination of comparable services and benefits:

(a) Assessment services, as outlined under WAC 388-890-0150;

(b) Assistive technology services, as outlined under WAC 388-890-0190;

(c) Assistive technology devices, as outlined under WAC 388-890-0175;

(d) Counseling and guidance services, as outlined under WAC 388-890-0200;

(e) Independent living services, including assessments, when provided directly by a VR or IL counselor, as outlined under WAC 388-890-0220;

(f) Referral services, as outlined under WAC 388-890-0325;

(g) Job placement and job retention services, as outlined under WAC 388-890-0240;

(h) Training services, as outlined under WAC 388-890-380 except training at an institution of higher education as outlined under 388-890-0395;

(i) Rehabilitation engineering services, as outlined under WAC 388-890-0335; and

(j) Post-employment services as outlined under WAC 388-890-0305 that include any of the services listed in subsections (a) through (i) above.

(2) The IL program does not pay for IL program services as outlined under WAC 388-890-870 through 388-890-1060 that you can get at no cost from another public program or as an employee or insurance benefit.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1115, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1120 What if determining the availability of comparable services and benefits would result in a delay or interrupt my progress? (1) A determination of comparable services and benefits is not required before you begin receiving VR services if you and a VR or IL counselor agree the determination would delay or interrupt:

(a) A service you need when you are at extreme medical risk;

(b) An immediate job placement; or

(c) Your progress toward achieving the employment outcome identified on your individual plan for employment or toward achieving your IL goals.

(2) A VR or IL counselor may complete the determination of comparable services and benefits while you receive VR or IL program services if it is expected that services and benefits exist and could be used at a later time without resulting in a delay.

(3) If comparable services and benefits are available, you must apply for and use comparable services and benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1120, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1125 What is extreme medical risk? Extreme medical risk means a likelihood of death or a functional impairment will substantially worsen if medical services, including mental health services, are not provided quickly.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1125, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1130 Does DVR pay for a service if comparable services and benefits are available, but I don't want to use them? DVR does not pay for a service that is available to you as a comparable service or benefit. If you choose not to apply for or use comparable services or benefits that a VR or IL counselor determines are adequate to meet your needs, you are responsible to pay for the services or benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1130, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1135 Are awards and scholarships based on merit considered comparable services and benefits? Awards and scholarships you earn based on merit are not considered comparable services and benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1135, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1140 How do I get comparable services and benefits? (1) You apply for comparable services and benefits from the organization or agency from which the service or benefit is available.

(2) If you need assistance to apply for comparable services and benefits, a VR or IL counselor helps you apply for the services or benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1140, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1145 How does DVR determine whether I pay for all or part of my VR or IL services using my own financial resources? To determine whether you must pay for all or part of your VR or IL program services using your own financial resources:

(1) You must complete a DVR financial statement to document your financial status before DVR purchases services under an IPE or IL Plan, except the services outlined in WAC 388-890-1175.

(2) You must provide copies of financial records requested by DVR to establish your financial status.

(3) Depending on your income tax filing status for the previous year, you must provide financial information based on your own individual resources or based on your family resources.

(a) If your income tax status was reported as married filing jointly, married filing separately, or as a dependent of another person, complete the financial statement based on family resources.

(b) If your income tax status was reported as single, complete the financial statement based on your own financial resources.

(4) If you fail to report your financial status accurately or provide the required information, DVR may deny or suspend services at any time in the rehabilitation process, except the services listed under WAC 388-890-1175.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1145, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1150 Do I have to report my financial status if I receive public assistance or income support from another public program? You meet DVR's financial need criteria if you qualify for one of the programs listed below, regardless of whether you are married, are a dependent, or receive financial support from another family member. If you give DVR proof that you receive benefits from one of these programs, you do not need to give DVR any other information about your financial status:

(1) DSHS income assistance,

(2) Medicaid, or

(3) Supplemental Security Income.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1150, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1155 What financial information does DVR use to decide if I need to help pay for VR services? The following information is used to determine whether you must pay any part of the cost of VR or IL program services:

(1) Your income from all sources;

(2) Your assets and property, including but not limited to bank accounts, vehicles, personal property, stocks, bonds and trusts; and

(3) Your living expenses, including household expenses, credit payments, disability-related expenses and other financial obligations.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1155, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1160 Are any of my resources not counted in the decision about whether I have to help pay for services? DVR does not count the following resources when deciding whether you need to help pay for VR or IL program services:

(1) The value of your primary home and furnishings;

(2) The value of items that you keep because of personal attachment or hobby interest, rather than because of monetary value;

(3) The value of one vehicle per household member if the vehicle is needed for work, school, or to participate in VR or IL program services;

(4) Retirement, insurance, or trust accounts that do not pay a current benefit to you or your family;

(5) If a retirement, insurance or trust account pays a current benefit, only the monthly benefit is counted as income. The balance of the account is excluded;

(6) Up to five thousand dollars of your total assets are excluded as exempt;

(7) Equipment or machinery used to produce income;

(8) Livestock used to produce income; and

(9) Disability-related items.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1160, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1165 How does DVR decide whether I have resources to help pay for VR services? (1) You must complete a financial statement that compares your total income and assets to your total living expenses and obligations, unless you meet the conditions listed under WAC 388-890-1150.

(2) DVR allows you to deduct five thousand dollars from your total assets as an exemption.

(3) DVR pays for your VR or IL program services if the results of the financial statement show that you do not have resources available to help pay for your VR or IL program services.

(4) You must help pay for VR or IL program services if the results of the financial statement show that you have resources available to help pay for your VR or IL program services.

(5) DVR does not pay for VR or IL program services under an IPE or IL plan when the financial statement shows that you have resources available and choose not to use them to pay for VR or IL program services, except for the services listed under WAC 388-890-1150.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1165, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1170 How is the amount I pay for VR or IL program services determined? (1) After completing the financial statement, you and a VR or IL counselor must agree how to use the resources identified on the financial statement to help pay for VR or IL program services.

(2) The costs you agree to pay are documented on the IPE or IL plan.

(3) If your financial status changes, report the change to a VR or IL counselor.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1170, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1175 What VR or IL program services am I not required to help pay for? You are not required to help pay for the following VR or IL program services, regardless of your financial status:

(1) Assessment services needed to determine eligibility or rehabilitation needs, including independent living assessment services;

(2) Counseling, guidance, and referral services provided by DVR staff;

(3) Job placement and job retention services;

(4) Independent living services provided directly by DVR staff or for which there is no cost; and

(5) Post-employment services that include any of the services listed in subsections (1) through (4) of this section.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1175, filed 8/27/99, effective 11/1/99.]

YOUR RIGHTS WHEN YOU DISAGREE WITH A DECISION MADE BY DVR

WAC 388-890-1180 What if a VR counselor makes a decision about my VR services that I don't agree with? (1) If a VR counselor makes a decision relating to your VR services that you don't agree with, you have the following options:

(a) Try to resolve the disagreement by talking to the VR counselor, a VR supervisor, or regional administrator;

(b) Contact the Client Assistance Program as outlined under WAC 388-890-1185;

(c) Request mediation; and/or

(d) Request a formal hearing.

(2) You have the right to use one or more of these options at any time.

(3) Your efforts to reach an agreement with the VR counselor, VR supervisor, or regional administrator are not used to deny or delay your right to mediation or a formal hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1180, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1185 What is the client assistance program (CAP)? (1) The client assistance program (CAP) is a program that offers advice and information at no cost to you about your rights as a DVR participant and to help you understand and receive services available.

(2) You may ask for help or information from CAP at any time during the rehabilitation process by:

(a) Asking a DVR staff person for information about how to contact CAP; or

(b) Calling CAP at the toll-free number 1-800-544-2121 voice/TTY.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1185, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1190 What is mediation? (1) Mediation is a method used when you and a VR counselor cannot resolve a disagreement about your VR services.

(2) A trained mediator who knows the laws and rules about VR services conducts a meeting with you and a representative from DVR.

(3) The mediator does not work for DVR.

(4) The mediator does not make decisions about the disagreement between you and a VR counselor.

(5) During a mediation meeting, the mediator:

(a) Allows each party to present information or evidence;

(b) Helps each party listen to and understand the other party's position;

(c) Reviews and explains any laws that apply; and

(d) Facilitates an agreement, if possible, between the parties.

(6) You may be represented by another person of your choice at the mediation meeting.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1190, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1195 When can I ask for mediation? (1) Mediation is an option any time you disagree with a decision DVR makes about your VR services.

(2) All parties involved in the issue, including DVR, must agree to mediation.

(3) Mediation is not used to deny or delay your right to a formal hearing. You may request both mediation and a formal hearing at the same time. If an agreement is:

(a) Reached during mediation, the formal hearing is canceled.

(b) Not reached during mediation, the formal hearing is held as scheduled.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1195, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1200 Who arranges and pays for mediation? (1) DSHS schedules and holds mediation sessions in a timely manner at a location that is convenient to all parties.

(2) DSHS pays for costs related to mediation, except costs related to a representative or attorney you ask to attend.

(3) DVR may pay for VR services you require to participate in mediation, such as transportation or child care.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1200, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1205 Is information discussed during mediation confidential? Information discussed during mediation is kept confidential and may not be used in a later hearing or civil proceeding, if one is held. Before beginning a mediation session, all parties must sign a statement of confidentiality.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1205, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1210 How do I request mediation? For more information or to request mediation, ask a VR counselor, supervisor or regional administrator or call DVR's statewide toll free number 1-800-637-5627.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1210, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1215 After the mediation session, do I receive a written statement of the results? (1) When you and the DVR representative reach an agreement during the mediation meeting, DSHS provides you with a written statement of the agreement.

(2) Agreements you and DVR make through mediation are not legally binding.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1215, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1220 What is a formal hearing? (1) A formal hearing is a proceeding conducted as outlined under the Administrative Procedure Act, chapter 388-08 WAC.

(2) A formal hearing is similar to a trial and is held by an administrative law judge who does not work for DSHS.

(3) During the formal hearing, both you and DVR may present information, witnesses, and/or documents to support your position.

(4) You may be represented by an attorney, a friend, a relative, or someone else if you choose.

(5) The administrative law judge makes a decision after:

(a) Hearing all of the information presented;

(b) Reviewing any documents submitted; and

(c) Reviewing relevant federal and state laws and regulations.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1220, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1225 When is a formal hearing available? (1) You have the right to a formal hearing when you disagree with a decision made by DVR about your eligibility for VR services or a decision about VR services.

(2) You must ask for a formal hearing in writing within twenty days of the decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1225, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1230 How do I request a formal hearing? (1) To ask for a formal hearing, you must send a written request to the Office of Administrative Hearings, P.O. Box 2465, Olympia, Washington 98507-2465.

(2) You must include the following information in your written request:

(a) Your name, address, and telephone number;

(b) A written statement about the decision and the reasons you disagree; and

(c) Any other information that supports your position.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1230, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1235 After I submit a request for a formal hearing, when is it held? The office of administrative hearings must hold a formal hearing within forty-five days of receipt of your written request for a hearing, unless:

(1) You or DVR ask for a delay; and

(2) There is a reasonable cause for the delay.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1235, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1240 Do I receive a written formal hearing decision? The office of administrative hearings sends you a written report of the findings and decisions within thirty days of the formal hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1240, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1245 Is the decision after a formal hearing final? (1) The office of administrative hearings decision is final and DVR must implement the decision.

(2) If you do not agree with the office of administrative hearings decision, you may pursue civil action through superior court to review that decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1245, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1250 Can DVR suspend, reduce or terminate my services while waiting for a formal hearing decision? DVR must not suspend, reduce, or terminate services while a decision is waiting for a formal hearing decision, unless you:

(1) Provide false information to obtain VR services; or

(2) Commit fraud or other criminal action to obtain VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1250, filed 8/27/99, effective 11/1/99.]

CONFIDENTIALITY OF PERSONAL INFORMATION

WAC 388-890-1255 How do I know what personal information I must give DVR and how it is used? When you apply for services, DVR must explain:

(1) What types of personal information you must share;

(2) What information DVR must get and what information is optional;

(3) How DVR uses personal information;

(4) What laws allow DVR to use personal information; and

(5) Your options if you decline to give DVR required information.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1255, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1260 Does DVR keep a record of my VR services on file? DVR keeps a record of VR services for three years after your case is closed. The VR case service record includes, but is not limited to:

(1) The application form or request for VR services.

(2) Records that verify the type and severity of your disability.

(3) A summary of how your disability limits your ability to get or keep a job.

(4) Records that explain and support:

(a) The eligibility or ineligibility decision; and

(b) Your rehabilitation needs.

(5) Records that support the need for a trial work experience, if needed, and summaries of trial work progress reviews.

(6) Financial statement or proof that you qualify for income assistance as outlined under WAC 388-890-1150.

(7) Information collected to develop an individualized plan for employment (IPE), including:

(a) A summary of how your job goal matches your strengths, abilities, and interests;

(b) Each step needed to reach your job goal; and

(c) VR services to be used and how the services address the impediment to employment.

(8) If VR services are provided in a setting that is not integrated, a written explanation of reasons for using a nonintegrated setting.

(9) IPE, IPE amendments, and IPE progress reports.

(10) Records that verify you are paid at or above the minimum wage, but not less than the usual wage your employer pays to nondisabled individuals doing the same or similar work, if you achieve a competitive employment outcome.

(11) Summary of annual reviews, if done.

(12) Written results of mediation sessions or formal hearings, if held.

(13) Written summary of the need for post-employment services after getting a job, including a description of what services are needed.

(14) Notification of case closure and appeal rights.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1260, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1265 Under what conditions does DVR share personal information in my record with another service provider or organization? DVR shares personal information with another service provider or organization only when:

(1) You sign a written consent giving DVR permission to release the information; and

(2) The information is needed to help you meet your rehabilitation goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1265, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1270 When DVR gets personal information about me from another agency or service provider, is it kept confidential? If DVR gets personal information about you from another agency or service provider, DVR only releases the information to others following rules established by the agency or service provider that provided the information and with your written consent.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1270, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1275 Does DVR change incorrect information in my record? (1) You may ask DVR to correct information in your record that you believe is incorrect.

(2) DVR corrects the information, unless there is a disagreement about whether the information is correct. If there is a disagreement about whether the information is correct, you may:

(a) Write a summary describing why the information is not correct; or

(b) Ask DVR to write a summary describing your concerns about the information.

(3) DVR puts the written summary in your record.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1275, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1280 How do I receive copies of information from my DVR record? (1) You may ask DVR for information contained in your record. A request for records must be in writing.

(2) DVR gives you copies of the records in a timely manner, unless DVR determines the information may be harmful to you.

(3) If DVR determines the records may be harmful to you, DVR releases the records to your representative, parent, legal guardian, another person you choose, or to a qualified medical professional.

(4) If a representative has been appointed by a court to represent you, the information must be released to the representative.

(5) If previously existing records are given to DVR by another organization or service provider, you must ask the organization or service provider for the records.

(6) If DVR requested or paid an organization or service provider to create records, such as an assessment to determine eligibility, DVR may release the records to you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1280, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1285 Can DVR release personal information without my written consent? DVR releases personal information without your written consent only under the following conditions:

(1) When required by federal or state law;

(2) When asked by a law enforcement agency to investigate criminal acts, unless prohibited by federal or state law;

(3) When given an order signed by a judge, magistrate, or authorized court official;

(4) When DVR decides you may be a danger to yourself or others;

(5) When asked by the division of child support of the department of social and health services; or

(6) To an organization, agency or person(s) for audit, evaluation or research.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1285, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1290 Under what conditions does DVR release personal information for audit, evaluation or research? DVR may release personal information for audit, evaluation or research when the results would improve the quality of life or DVR services for people with disabilities. Before any personal information is shared, the organization, agency, authority or individual must agree to the following conditions:

(1) The information must only be used by people directly involved in the audit, evaluation or research;

(2) The information must only be used for the reasons approved by DVR in advance;

(3) The information must be kept secure and confidential;

(4) The information must not be shared with any other parties, including you or your representative; and

(5) The final product or report must not contain any personal information that would identify you without your written consent.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1290, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1295 How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases? (1) DVR uses special protections when you share personal information about drug or alcohol abuse or about HIV/AIDS and sexually transmitted diseases.

(2) DVR asks for your specific permission to copy information of this nature before sharing it with a service provider or organization that is helping you reach your employment goals.

(3) Information about drug and alcohol abuse must be handled in accordance with RCW 70.96A.150 and applicable federal and state laws and regulations.

(4) Information about HIV/AIDS or other sexually transmitted diseases must be handled in accordance with RCW 70.24.105 and applicable federal and state laws and regulations.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1295, filed 8/27/99, effective 11/1/99.]

HOW TO CONTACT DVR IF YOU DON'T SPEAK ENGLISH

WAC 388-890-1300 How do I contact DVR if I don't speak English? If you don't speak English, you may request another type of communication to meet with DVR. DVR arranges and pays for services you need to communicate with DVR to learn about or apply for DVR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1300, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1305 What other methods of communication does DVR use? DVR uses equipment, devices or other services you need to understand and respond to information. Methods we can use to communicate with you include, but are not limited to, the use of:

(1) Interpreters;
(2) Readers;
(3) Captioned videos;
(4) Telecommunications devices and services;
(5) Taped text;
(6) Braille and large print materials;
(7) Electronic formats;
(8) Graphics;
(9) Simple language materials.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1305, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1310 When does DVR communicate with me using methods other than English? DVR uses a method of communication that enables you to understand information and ask questions about the following, at a minimum:

(1) How DVR keeps personal information confidential;

(2) Your right to make informed choices throughout the rehabilitation process;

(3) DVR's decision about whether you are eligible for VR or IL program services;

(4) The options you have to develop an individualized plan for employment (IPE);

(5) Other essential information relating to VR or IL program services and programs and answer your questions.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1310, filed 8/27/99, effective 11/1/99.]