substantive policies to condition a project. For example, an agency may condition a project to reduce neighborhood traffic or traffic impacts, which could have the effect of reducing the level of development otherwise permitted by zoning ordinance.

[Statutory Authority: RCW 36.70B.040. 01-13-039, § 365-197-070, filed 6/13/01, effective 7/14/01.]

WAC 365-197-080 An agency may deny a project based upon consistency analysis. (1) An agency has the authority to deny a project if it:

(a) Is inconsistent and does not comply with the applicable development regulations, or in their absence, the adopted comprehensive plan;

(b) Will result in significant adverse environmental impacts which cannot be mitigated per RCW 43.21C.060 and WAC 197-11-660; or

(c) Does not comply with other local, state, or federal law and rules, and the local jurisdiction has the authority to deny based upon these other laws and rules.

(2) This rule is not intended to modify any criteria developed by a GMA county/city for denying a project.

[Statutory Authority: RCW 36.70B.040. 01-13-039, § 365-197-080, filed 6/13/01, effective 7/14/01.]

Title 388 WAC

SOCIAL AND HEALTH SERVICES, DEPARTMENT OF

Chapters

Chapter 388-05 WAC
CONTRACTOR BILLING REQUIREMENTS—GENERAL

WAC 388-05-0001 What is the purpose of this chapter? The purpose of this chapter is to establish general procedures for contractors to follow when submitting claims for payment to the department of social and health services. Additional requirements may also apply.

[Statutory Authority: RCW 43.17.060. 01-12-071, § 388-05-0001, filed 6/4/01, effective 7/5/01.]

WAC 388-05-0005 What contracts does this chapter apply to? This chapter applies to all contracts for personal or client services as defined in chapter 39.29 RCW and to all interlocal agreements governed by chapter 39.34 RCW. This chapter does not supersede WAC 388-502-0150 titled Time limits for providers to bill medical assistance administration (MAA).

[Statutory Authority: RCW 43.17.060. 01-12-071, § 388-05-0005, filed 6/4/01, effective 7/5/01.]

WAC 388-05-0010 How soon does a contractor have to submit claims for payment to the department after the services are rendered? Each contractor who is rendering authorized services to the department or its clients shall submit claims for payment, as agreed upon between the department and the contractor, no later than twelve months after the date of service. If the claims for payment are not presented within the twelve-month period there shall not be a charge against the state. The twelve-month period may be shortened by contract or regulation. The twelve-month period may be extended by contract or regulation, but only if required by applicable state or federal law or regulation. The department may grant exceptions to the twelve-month period for initial claims when billing delays are caused by either of the following:

(a) The department's certification or authorization of services for a client for a retroactive period; or

(b) The provider proves to the department's satisfaction that there are other extenuating circumstances.

This provision shall apply to all claims for payment submitted on or after the effective date.

[Statutory Authority: RCW 43.17.060. 01-12-071, § 388-05-0010, filed 6/4/01, effective 7/5/01.]

Chapter 388-06 WAC
BACKGROUND CHECKS

WAC 388-06-0010 What is the purpose of this chapter? (1) The purpose of this chapter is to establish rules for background checks conducted by children's administration (CA), and the division of developmental disabilities (DDD) at the department of social and health services (DSHS). The department does background checks on individuals who are licensed, certified, contracted, or authorized to care for or have unsupervised access to children and to individuals with a developmental disability. Background checks are conducted to find and evaluate any history of criminal convictions and child abuse or neglect.

(2) This chapter also defines when the one hundred twenty-day provisional hire is allowed by DSHS. WAC 388-06-0500 through 388-06-0540 apply to all DSHS administrations.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0010, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0020 What definitions apply to WAC 388-06-0100 through 388-06-0260 of this chapter? The following definitions apply to WAC 388-06-0100 through 388-06-0260 of this chapter:

"Authorized" or **"authorization"** means not disqualified by the department to have unsupervised access to children and individuals with a developmental disability. This includes persons who are certified, contracted, allowed to receive payments from department funded programs, or volunteer.

"CA" means children's administration, department of social and health services. Children's administration is the cluster of programs within DSHS responsible for the provision of licensing of foster homes, group facilities/programs and child-placing agencies, child protective services, child welfare services, and other services to children and their families.

"CAMIS" means case and management information system. This data system is used by children's administration.

"Certification" means:

(1) Department approval of a person, home, or facility that does not legally need to be licensed, but wishes to have evidence that they met the minimum licensing requirements.

(2) Department licensing of a of a child-placing agency to certify and supervise foster home and group care programs.

"Children" or **"youth"** means individuals who are under parental or department care including:

(1) Individuals under eighteen years old; or

(2) Foster children up to twenty-one years of age and enrolled in high school or a vocational school program; or

(3) Developmentally disabled individuals up to twenty-one years of age for whom there are no issues of child abuse and neglect; or

(4) JRA youth up to twenty-one years of age and who are under the jurisdiction of JRA or a youthful offender under the jurisdiction of the department of corrections who is placed in a JRA facility.

(5) These two terms are used interchangeably in this chapter.

"DCFS" means division of children and family services and is a division within children's administration that provides child welfare, child protective services, and support services to children in need of protection and their families.

"DDD" means the division of developmental disabilities, department of social and health services (DSHS).

"DLR" means the division of licensed resources that is a division within children's administration, the department of social and health services.

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

"I" and **"you"** refers to anyone who has unsupervised access to children or to persons with developmental disabilities in a home, facility, or program. This includes, but is not limited to, persons seeking employment, a volunteer opportunity, an internship, a contract, certification, or a license for a home
or facility.

"JRA" means the juvenile rehabilitation administration, department of social and health services.

"Licensor" means an employee of DLR or of a child placing agency licensed or certified under chapter 74.15 RCW to approve and monitor licenses for homes or facilities that offer care to children. Licenses require that the homes and facilities meet the department's health and safety standards.

"Individuals with developmental disability" means individuals who meet eligibility requirements in Title 71A RCW, WAC 388-825-030, for services. A developmental disability is any of the following: Mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition described in WAC 388-825-030; originates before the age of eighteen years; is expected to continue indefinitely; and results in a substantial handicap.

"Spousal abuse" includes any crime of domestic violence as defined in RCW 10.99.020 when committed against a spouse, former spouse, person with whom the perpetrator has a child regardless of whether the parents have been married or lived together at any time, or an adult with whom the perpetrator is presently residing or has resided in the past.

"Unsupervised" means not in the presence of:

(1) The licensee, another employee or volunteer from the same business or organization as the applicant who has not been disqualified by the background check.

(2) Any relative or guardian of the child or developmentally disabled individual or vulnerable adult to whom the applicant has access during the course of his or her employment or involvement with the business or organization (RCW 43.43.080(9)).

"Unsupervised access" means that an individual will or may be left alone with a child or vulnerable adult (individual with developmental disability) at any time for any length of time.

"We" refers to the department, including licensors and social workers.

"WSP" refers to the Washington State Patrol.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0020, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0100 Why are background checks done? The department does background checks to help safeguard the health, safety and well being of children and of individuals with a developmental disability in licensed homes and facilities and in day treatment programs. By doing background checks, the department reduces the risk of harm to children and individuals with a developmental disability from caregivers that have been convicted of certain crimes. The department's regulations require the evaluation of your background to determine your character, suitability and competence before you are issued a license, contract, certificate, or authorized to have unsupervised access to children or to individuals with a developmental disability.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0100, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0110 Who must have background checks? The department requires background checks on individuals who will have unsupervised access to children or to individuals with a developmental disability in homes, facilities, or operations licensed, relicensed, or contracted by the department to provide care as required under chapter 74.15 RCW. The department requires background checks on the following people:

(1) A person licensed, certified, or contracted by us to care for children (chapter 74.15 RCW and RCW 43.43.832);

(2) A prospective or current employee for a licensed care provider or a person or entity contracting with us;

(3) A volunteer or intern with regular or unsupervised access to children who is in a home or facility that offers licensed care to children;

(4) A person who is at least sixteen years old, is residing in a foster home, relatives home, or child care home and is not a foster child;

(5) A relative other than a parent who may be caring for a child or an individual with a developmental disability;

(6) A person who regularly has unsupervised access to a child or an individual with a developmental disability;

(7) A provider who has unsupervised access to a child or individual with a developmental disability in the home of the child or individual with a developmental disability; and

(8) Prospective adoptive parents as defined in RCW 26.33.020.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0110, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0120 Who is not affected by this chapter? This chapter does not apply to schools, hospitals, or other facilities where the primary focus is not custodial.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0120, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0130 Does the background check process apply to new and renewal licenses, certification, contracts, and authorizations to have unsupervised access to children or individuals with a developmental disability? These regulations apply to all applications for new and renewal licenses, contracts, certifications, and authorizations to have unsupervised access to children and individuals with a developmental disability that are processed by the department after the effective date of this chapter.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0130, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0140 What happens if I don't comply with the background check requirement? The department will deny, suspend or revoke your license, contract, certification, or authorization to care for children or for individuals with a developmental disability, if you or someone on the premises of your home or facility having unsupervised access does not comply with the department's requirement for a background check.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0140, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0150 What does the background check cover? (1) The department must review the following records:

(a) Criminal convictions and pending charges.

(b) For children's administration, child protective service case file information (CAMIS) for founded reports of child abuse or neglect; and

(c) For children's administration, administrative hearing decisions related to any DLR license that has been revoked, suspended or denied.

(2) The department may also review any civil judgment, determination or disciplinary board final decisions of child abuse or neglect.

(3) The department may review law enforcement records of convictions and pending charges in other states or locations if:

(a) You have lived in another state; and

(b) Reports from credible community sources indicate a need to investigate another state's records.

(4) If you have lived in Washington state less than three years immediately prior to your application to have unsupervised access to children or to individuals with a developmental disability, the department requires that you be fingerprinted for a background check with the Washington state patrol (WSP) and the Federal Bureau of Investigation (FBI), as mandated by chapter 74.15 RCW.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0150, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0160 Who pays for the background check? (1) Children's administration (CA) pays for the general administrative costs for background checks for foster home applicants, relative, and CA adoptive home applicants.

(2) Children's administration pays for fingerprinting expenses for those foster home applicants and relatives who require fingerprinting.

(3) Children's administration does not pay for fingerprinting for employees, contractors, or volunteers associated with any other type of home or facility.

(4) The division of developmental disabilities pays for background checks for individuals seeking authorization to provide services to their clients.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0160, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0170 Will a criminal conviction permanently prohibit me from being licensed, contracted, or authorized to have unsupervised access to children or to individuals with developmental disability? (1) There are convictions for certain crimes that will permanently prohibit you from being licensed, contracted, or authorized to have unsupervised access to children or to individuals with developmental disability. Those felony convictions are as follows:

(a) Child abuse and/or neglect;

(b) Spousal abuse;

(c) A crime against a child (including child pornography);

(d) A crime involving violence (including rape, sexual assault, or homicide but not including other physical assault); or

(e) Any federal or out-of-state conviction for an offense that under the laws of this state would disqualify you from having unsupervised access to children or individuals with developmental disabilities in any home or facility.

(2) If you are convicted of one of the crimes listed in WAC 388-06-0170 (1)(a) through (e) you will not be able to:

(a) Receive a license to provide care to children;

(b) Be approved for adoption of a child;

(c) Be a contractor;

(d) Be employed by a licensed agency or contractor, if you will have unsupervised access to children or to individuals with a developmental disability;

(e) Volunteer or participate as an intern in a home or facility that offers care to children or to individuals with a developmental disability; or

(f) Provide any type of care to children or to individuals with a developmental disability, if the care is funded by the state.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0170, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0180 Are there other criminal convictions that will prohibit me from working with children or individuals with a developmental disability? The department must disqualify you from licensing, contracting, certification, or from having unsupervised access to children or to individuals with a developmental disability if it has been less than five years from a conviction for the following crimes:

(1) Any physical assault not included in WAC 388-06-0170;

(2) Any sex offense not included in WAC 388-06-0170;

(3) Any felony conviction not included in WAC 388-06-0170; or

(4) Felony violation of the following drug-related crimes:

(a) The Imitation Controlled Substances Act (for substances that are falsely represented as controlled substances (see chapter 69.52 RCW));

(b) The Legend Drug Act (prescription drugs, see chapter 69.41 RCW);

(c) The Precursor Drug Act (substances used in making controlled substances, see chapter 69.43 RCW);

(d) The Uniform Controlled Substances Act (illegal drugs or substances, see chapter 69.50 RCW);or

(e) Unlawfully manufacturing, delivering or possessing a controlled substance with intent to deliver, or unlawfully using a building for drug purposes.

(5) Any federal or out-of-state conviction for an offense that under the laws of this state would disqualify you from having unsupervised access to children or individuals with developmental disabilities in your home or facility no less than five years from a conviction listed in this section.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0180, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0190 If I have a conviction, may I ever have unsupervised access to children or individuals with a developmental disability? (1) In two situations, DSHS may find a person with convictions able to have unsupervised access to children or individuals with a developmental disability:

(a) If the conviction for any crime listed in WAC 388-06-0180 occurred more than five years ago; or

(b) If the conviction was for a crime other than those listed in WAC 388-06-0170 or 388-06-0180.

(2) In both of these situations, DSHS must review your background to determine your character, suitability, and competence to have unsupervised access to children or individuals with a developmental disability. In this review, DSHS must consider the following factors:

(a) The amount of time that has passed since you were convicted;

(b) The seriousness of the crime that led to the conviction;

(c) The number and types of other convictions in your background;

(d) The amount of time that has passed since you were convicted;

(e) Your age at the time of conviction;

(f) Documentation indicating you have successfully completed all court-ordered programs and restitution;

(g) Your behavior since the conviction; and

(h) The vulnerability of those that would be under your care.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0190, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0200 Will I be disqualified if there are pending criminal charges on my background check? (1) The department will not license, contract, certify, or authorize a person to have unsupervised access to children or individuals with a developmental disability who have a criminal charge pending.

(2) You may reapply for a license, contract, certification, or approval to have unsupervised access to children or to individuals with a developmental disability by providing

proof to the department that the charge against you has been dropped or that you were acquitted.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0200, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0210 Will you license, contract, or authorize me to have unsupervised access to children or individuals with a developmental disability if my conviction has been expunged, or vacated from my record or I have been pardoned for a crime? If you receive a pardon or a court of law acts to expunge or vacate a conviction on your record, the crime will not be considered a conviction for the purposes of licensing, contracting, certification, or authorization for unsupervised access to children or to individuals with a developmental disability.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0210, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0220 How will I know if I have not been disqualified by the background check? (1) If you have not been disqualified by the background check and are applying for a license or certification to care for children, the department will not directly notify you. Instead, the department continues the process for approving your application.

(2) If you have requested a contract or approval for unsupervised access to children or to individuals with a developmental disability, the department will notify you, and your prospective employer or your supervisor.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0220, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0230 How will I know if I have been disqualified by the background check? (1) The department will notify you, and the care provider, the employer, or the licensor if you have been disqualified by the background check. The notice will be in writing and will include any laws and rules that require disqualification.

(2) If the department sends you a notice of disqualification, you will not receive a license, contract, certification, or be authorized to have unsupervised access to children or to individuals with a developmental disability.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0230, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0240 What may I do if I disagree with the department's decision to deny me a license, certification, contract, or authorization based on the results of the background check? (1) If you are seeking a license, or employment with a licensed home or facility you may request an administrative hearing to disagree with the department's decision process to deny authorization for unsupervised access to children or to individuals with a developmental disability (chapter 34.05 RCW). You cannot contest the conviction in the administrative hearing.

(2) Prospective volunteers, interns, contractors, or those seeking certification do not have the right to appeal the department's decision to deny authorization for unsupervised access to children and to individuals with a developmental disability.

(3) The employer or prospective employer cannot contest the department's decision on your behalf.

(4) The administrative hearing will take place before an administrative law judge employed by the office of administrative hearings (chapter 34.05 RCW).

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0240, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0250 Is the background check information released to my employer or prospective employer? (1) The department will share with employers or approved care providers only that:

(a) You are disqualified; or

(b) You have not been disqualified by the background check.

(2) The department will follow laws related to the release of criminal history records (chapter 10.97 and 43.43 RCW) and public disclosure (chapter 42.17 RCW) when releasing any information.

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0250, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0260 May I receive a copy of my criminal background check results? (1) The department will provide you a copy of your criminal background check results if you:

(a) Make the request in writing to the department; and

(b) Offer proof of identity, such as picture identification.

(2) A copy of your WSP criminal background check results may also be obtained from the Washington state patrol (chapter 10.97 RCW).

[Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0260, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0500 What is the purpose of the one hundred twenty-day provisional hire? The one hundred twenty day provisional hire allows an employee to have unsupervised access to children, juveniles and vulnerable adults on a provisional basis pending the results of their Federal Bureau of Investigation (FBI) background check.

[Statutory Authority: Chapter 43.20A RCW, RCW 72.05.440 and 74.15.030. 01-15-019, § 388-06-0500, filed 7/10/01, effective 8/10/01.]

WAC 388-06-0510 What definitions apply to one hundred twenty-day provisional hires? "Agency" means any agency of the state or any private agency providing services to children, juveniles, and vulnerable adults.

"Background check central unit (BCCU)" means the DSHS program responsible for conducting background checks for DSHS administrations.

"Disqualified" means the results of an individual's background check disqualifies them from a position which will or may provide unsupervised access to children, juveniles, and vulnerable adults.

"Entity" means, but is not limited to, a licensed facility, a corporation, a partnership, a sole proprietorship, or a contracted or certified service provider.

"Hire" means engagement by an agency, entity or a hiring individual to perform specific agreed duties as a paid

employee, a contract employee, a volunteer, or a student intern.

"Hiring individual" means a DSHS client who is eligible to hire an individual to provide in-home service with state funding.

"Individual" means an employee, a contract employee, a volunteer, or a student intern.

"Qualified" means an individual can be hired into a position that includes unsupervised access to children, juveniles, and vulnerable adults because the results of their background check are not disqualifying.

"Unsupervised access" means that:

(1) An individual will or may have the opportunity to be alone with a child, juvenile, or a vulnerable adult; and

(2) Neither a qualified employee, contract employee, volunteer, or student intern of the agency, or entity nor a relative or guardian of the child, juvenile or vulnerable adult is present.

[Statutory Authority: Chapter 43.20A RCW, RCW 72.05.440 and 74.15.030. 01-15-019, § 388-06-0510, filed 7/10/01, effective 8/10/01.]

WAC 388-06-0520 Who is responsible for approving the one hundred twenty-day provisional hire? The agency, entity or hiring individual is responsible for approving individuals for the one hundred twenty-day provisional hire.

[Statutory Authority: Chapter 43.20A RCW, RCW 72.05.440 and 74.15.030. 01-15-019, § 388-06-0520, filed 7/10/01, effective 8/10/01.]

WAC 388-06-0525 When are individuals eligible for the one hundred twenty-day provisional hire? Individuals are eligible for the one hundred twenty-day provisional hire immediately. The signed background check application and two FBI fingerprint cards must be sent to the BCCU within forty-eight hours by the agency, entity or hiring individual.

[Statutory Authority: Chapter 43.20A RCW, RCW 72.05.440 and 74.15.030. 01-15-019, § 388-06-0525, filed 7/10/01, effective 8/10/01.]

WAC 388-06-0530 When does the one hundred twenty-day provisional hire begin? The one hundred twenty-day provisional hire may begin from either:

(1) The date of hire of an individual; or

(2) After completion of a state background check on an individual.

The agency, entity, or hiring individual makes this decision.

[Statutory Authority: Chapter 43.20A RCW, RCW 72.05.440 and 74.15.030. 01-15-019, § 388-06-0530, filed 7/10/01, effective 8/10/01.]

WAC 388-06-0535 Who approves one hundred twenty-day provisional hire extensions? The agency, entity or hiring individual approves one hundred twenty-day provisional hire extensions. An extension is approved when the agency, entity or hiring individual does not receive the FBI result within one hundred twenty days from:

(1) The date of hire; or

(2) Completion of the state background check.

[Statutory Authority: Chapter 43.20A RCW, RCW 72.05.440 and 74.15.030. 01-15-019, § 388-06-0535, filed 7/10/01, effective 8/10/01.]

WAC 388-06-0540 Are there instances when the one hundred twenty-day provisional hire is not available? The one hundred twenty-day provisional hire is not available to an agency, entity, or hiring individual requesting:

(1) An initial license;

(2) An initial contract; or

(3) Approval as a family child day care home provider, foster parent or adoptive parent (see 42 U.S.C. Sec 671 (a)(20)).

[Statutory Authority: Chapter 43.20A RCW, RCW 72.05.440 and 74.15.030. 01-15-019, § 388-06-0540, filed 7/10/01, effective 8/10/01.]

Chapter 388-11 WAC
CHILD SUPPORT—OBLIGATIONS

WAC

388-11-011 through 388-11-340 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-11-011 Definitions. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 00-15-016 and 00-20-022, § 388-11-011, filed 7/10/00 and 9/25/00, effective 11/6/00. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-011, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-11-011, filed 2/10/93, effective 3/13/93. Statutory Authority: 1990 1st ex.s. c 2. 90-20-072 (Order 3081), § 388-11-011, filed 9/28/90, effective 10/29/90. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-011, filed 8/30/88. Statutory Authority: RCW 74.08.090. 85-23-019 (Order 2304), § 388-11-011, filed 11/13/85; 83-21-014 (Order 2036), § 388-11-011, filed 10/6/83; 81-05-021 (Order 1605), § 388-11-011, filed 2/11/81; 80-01-026 (Order 1465), § 388-11-011, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1020.

388-11-015 Credits allowed—Debt satisfaction. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-015, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and 45 CFR 302-33 (a)(5). 93-17-060 (Order 3622), § 388-11-015, filed 8/16/93, effective 9/16/93. Statutory Authority: 1990 1st ex.s. c 2. 90-20-072 (Order 3081), § 388-11-015, filed 9/28/90, effective 10/29/90. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-015, filed 8/30/88. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-11-015, filed 12/14/79; 78-07-015 (Order 1305), § 388-11-015, filed 6/15/78; Order 1054, § 388-11-015, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3375

388-11-045 Service requirements—Tolling. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-045, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-11-045, filed 2/10/93, effective 3/13/93. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-045, filed 8/30/88. Statutory Authority: RCW 74.08.090. 83-17-007 (Order 1997), § 388-11-045, filed 8/5/83; 80-06-088 (Order 1507), § 388-11-045, filed 5/28/80; 80-01-026 (Order 1465), § 388-11-045, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3350.

388-11-048 Request for paternity tests—Liability for costs. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-048, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.20A.056. 92-13-026 (Order 3403), § 388-11-048, filed 6/9/92, effective 7/10/92.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority:

RCW 74.08.090. Later promulgation, see WAC 388-14A-8300.

388-11-065 Defenses to liability. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-065, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 94-10-033 (Order 3731), § 388-11-065, filed 4/28/94, effective 5/29/94. Statutory Authority: RCW 74.20A.056. 92-13-026 (Order 3403), § 388-11-065, filed 6/9/92, effective 7/10/92. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-065, filed 8/30/88. Statutory Authority: RCW 74.08.090. 86-05-009 (Order 2340), § 388-11-065, filed 2/12/86; 83-21-014 (Order 2036), § 388-11-065, filed 10/6/83; 80-01-026 (Order 1465), § 388-11-065, filed 12/14/79; 78-07-015 (Order 1305), § 388-11-065, filed 6/15/78; Order 1054, § 388-11-065, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3370.

388-11-067 Equitable estoppel. [Statutory Authority: RCW 74.08.090. 94-10-033 (Order 3731), § 388-11-067, filed 4/28/94, effective 5/29/94.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6500.

388-11-100 Duty of the administrative law judge in a hearing to determine the amount of a support obligation. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 00-15-016 and 00-20-022, § 388-11-100, filed 7/10/00 and 9/25/00, effective 11/6/00. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-11-100, filed 2/5/90, effective 3/1/90. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-100, filed 8/30/88. Statutory Authority: RCW 74.08.090. 86-05-009 (Order 2340), § 388-11-100, filed 2/12/86; 80-01-026 (Order 1465), § 388-11-100, filed 12/14/79; 78-07-015 (Order 1305), § 388-11-100, filed 6/15/78; Order 1054, § 388-11-100, filed 9/25/75; Order 875, § 388-11-100, filed 11/16/73.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6300.

388-11-120 When is it appropriate to vacate a default order? [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 00-15-016 and 00-20-022, § 388-11-120, filed 7/10/00 and 9/25/00, effective 11/6/00. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-120, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and 45 CFR 302-33 (a)(5). 93-17-060 (Order 3622), § 388-11-120, filed 8/16/93, effective 9/16/93. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-11-120, filed 2/10/93, effective 3/13/93. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-120, filed 8/30/88. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-11-120, filed 12/14/79; 78-07-015 (Order 1305), § 388-11-120, filed 6/15/78; Order 1054, § 388-11-120, filed 9/25/75; Order 875, § 388-11-120, filed 11/16/73.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3700.

388-11-135 Service. [Statutory Authority: RCW 74.08.090 and 45 CFR 302-33 (a)(5). 93-17-060 (Order 3622), § 388-11-135, filed 8/16/93, effective 9/16/93. Statutory Authority: RCW 74.08.090. 81-05-021 (Order 1605), § 388-11-135, filed 2/11/81; 78-07-015 (Order 1305), § 388-11-135, filed 6/15/78.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3130.

388-11-140 Modification. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-140, filed 4/10/96, effective 5/11/96. Statutory Authority: Chapters 74.20A and 26.19 RCW, RCW 74.20A.059 and 26.23.050 and E2SSB 5120 and ESSB 5996. 92-08-034 (Order 3344), § 388-11-140, filed 3/24/92, effective 4/24/92. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-140, filed 8/30/88. Statutory Authority: RCW 74.08.090. 81-05-021 (Order 1605), § 388-11-140, filed 2/11/81; 80-01-026 (Order 1465), § 388-11-140, filed 12/14/79; 78-07-015 (Order 1305), § 388-11-140, filed 6/15/78; Order 1054, § 388-11-140, filed 9/25/75; Order 875, § 388-11-140, filed 11/16/73.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3800 and 388-14A-3925.

388-11-143 Department review of support orders. [Statutory Authority: RCW 74.08.090 and 45 CFR 302.70, 303.7 and 303.8. 93-24-014 (Order 3671), § 388-11-143, filed 11/19/93, effective 12/20/93.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3900 through 388-14A-3907.

388-11-145 Notice to parties. [Statutory Authority: RCW 74.08.090 and 45 CFR 302-33 (a)(5). 93-17-060 (Order 3622), § 388-11-145, filed 8/16/93, effective 9/16/93. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-11-145, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090.

388-11-150 The parties may resolve any child support case by entering a consent order or an agreed settlement. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 00-15-016 and 00-20-022, § 388-11-150, filed 7/10/00 and 9/25/00, effective 11/6/00. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-150, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-11-150, filed 2/10/93, effective 3/13/93. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-150, filed 8/30/88. Statutory Authority: RCW 74.08.090. 86-05-009 (Order 2340), § 388-11-150, filed 2/12/86; 82-17-068 (Order 1864), § 388-11-150, filed 8/18/82; 81-05-021 (Order 1605), § 388-11-150, filed 2/11/81; 80-01-026 (Order 1465), § 388-11-150, filed 12/14/79; Order 875, § 388-11-150, filed 11/16/73.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3600.

388-11-155 Duration of obligation. [Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-11-155, filed 6/9/92, effective 7/10/92. Statutory Authority: 1990 1st ex.s. c 2. 90-20-072 (Order 3081), § 388-11-155, filed 9/28/90, effective 10/29/90. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-155, filed 8/30/88. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-11-155, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3810.

388-11-170 Collection of debts determined. [Statutory Authority: RCW 74.08.090 and 45 CFR 302-33 (a)(5). 93-17-060 (Order 3622), § 388-11-170, filed 8/16/93, effective 9/16/93. Statutory Authority: 1990 1st ex.s. c 2. 90-20-072 (Order 3081), § 388-11-170, filed 9/28/90, effective 10/29/90. Statutory Authority: RCW 74.08.090. 78-07-015 (Order 1305), § 388-11-170, filed 6/15/78; Order 1054, § 388-11-170, filed 9/25/75; Order 875, § 388-11-170, filed 11/16/73.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4000 and 388-14A-4030.

388-11-180 Procedural reference. [Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-11-180, filed 2/5/90, effective 3/1/90. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-180, filed 8/30/88. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-11-180, filed 12/14/79; 78-07-015 (Order 1305), § 388-11-180, filed 6/15/78; Order 1054, § 388-11-180, filed 9/25/75; Order 875, § 388-11-180, filed 11/16/73.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6000.

388-11-205 Assessing support. [Statutory Authority: RCW 74.08.090 and N.R. vs. Soliz, U.S. District Court Docket #C93-5338B. 94-10-064 (Order 3733), § 388-11-205, filed 5/3/94, effective 6/3/94. Statutory Authority: Chapters 74.20A and 26.19 RCW, RCW 74.20A.059 and 26.23.050 and E2SSB 5120 and ESSB 5996. 92-08-034 (Order 3344), § 388-11-205, filed 3/24/92, effective 4/24/92. Statutory Authority: 1990 1st ex.s. c 2. 90-20-072 (Order 3081), § 388-11-205, filed 9/28/90, effective 10/29/90. 88-18-031 (Order 2689), § 388-11-205, filed 8/30/88.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090.

Later promulgation, see WAC 388-14A-3200, 388-14A-3205, and 388-14A-3400.

388-11-210 Administrative orders. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-210, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and 45 CFR 303.11 and 45 CFR 303.100. 93-05-020 (Order 3512), § 388-11-210, filed 2/10/93, effective 3/13/93. Statutory Authority: Chapters 74.20A and 26.19 RCW, RCW 74.20A.059 and 26.23.050 and E2SSB 5120 and ESSB 5996. 92-08-034 (Order 3344), § 388-11-210, filed 3/24/92, effective 4/24/92. Statutory Authority: 1990 1st ex.s. c 2. 90-20-072 (Order 3081), § 388-11-210, filed 9/28/90, effective 10/29/90. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-210, filed 8/30/88.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3110, 388-14A-3850, and 388-14A-6300.

388-11-215 Health insurance. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-215, filed 4/10/96, effective 5/11/96. Statutory Authority: 1990 1st ex.s. c 2. 90-20-072 (Order 3081), § 388-11-215, filed 9/28/90, effective 10/29/90. Statutory Authority: 1988 c 275. 88-18-031 (Order 2689), § 388-11-215, filed 8/30/88.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3125 and 388-14A-4100 through 388-14A-4130.

388-11-220 Liability for birth costs. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-220, filed 4/10/96, effective 5/11/96. Statutory Authority: 1990 1st ex.s. c 2. 91-10-027 (Order 3163), § 388-11-220, filed 4/23/91, effective 5/24/91; 90-20-072 (Order 3081), § 388-11-220, filed 9/28/90, effective 10/29/90.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-8300.

388-11-280 Credit for dependent benefits. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-280, filed 4/10/96, effective 5/11/96.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4200.

388-11-300 Amending notices. [Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-300, filed 4/10/96, effective 5/11/96.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3275.

388-11-305 Uniform Interstate Family Support Act—Notices served in another state. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 00-15-016 and 00-20-022, § 388-11-305, filed 7/10/00 and 9/25/00, effective 11/6/00. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-305, filed 4/10/96, effective 5/11/96.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-7200.

388-11-310 Request for late hearing—Good cause. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 00-15-016 and 00-20-022, § 388-11-310, filed 7/10/00 and 9/25/00, effective 11/6/00. Statutory Authority: RCW 74.20A.055 and 74.08.090. 96-09-036 (Order 3964), § 388-11-310, filed 4/10/96, effective 5/11/96.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3500.

388-11-320 What is the division of child support's DCS most wanted internet site? [Statutory Authority: RCW 26.23.120(2). 99-01-057, § 388-11-320, filed 12/11/98, effective 1/11/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4600.

388-11-325 Whose picture can go on the division of child support's DCS most wanted internet site? [Statutory Authority: RCW 26.23.120(2). 99-01-057, § 388-11-325, filed 12/11/98, effective 1/11/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4605.

388-11-330 How does a noncustodial parent avoid being posted on the DCS most wanted internet site? [Statutory Authority: RCW 26.23.120(2). 99-01-057, § 388-11-330, filed 12/11/98, effective 1/11/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4610.

388-11-335 When does DCS remove a noncustodial parent from the DCS most wanted internet site? [Statutory Authority: RCW 26.23.120(2). 99-01-057, § 388-11-335, filed 12/11/98, effective 1/11/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4615.

388-11-340 What information does the division of child support post to the DCS most wanted internet site? [Statutory Authority: RCW 26.23.120(2). 99-01-057, § 388-11-340, filed 12/11/98, effective 1/11/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4620.

WAC 388-11-011 through 388-11-340 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-13 WAC
RECOVERY OF SUPPORT PAYMENTS

WAC

388-13-010 through 388-13-120 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-13-010 Debt, assignment, recoupment, set-off. [Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-010, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090.

388-13-020 Notice of support debt. [Statutory Authority: RCW 74.08.090. 86-05-009 (Order 2340), § 388-13-020, filed 2/12/86; 80-01-026 (Order 1465), § 388-13-020, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090.

388-13-030 Service of notice of support debt. [Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-030, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5510.

388-13-040 Failure to make answer or request for hearing. [Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-040, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5515.

388-13-050 Petition for hearing after twenty days—Stay. [Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-13-050, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-050, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5530.

388-13-060 Timely application for hearing. [Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-13-060, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-060, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5520.

388-13-070 Hearing—Initial decision. [Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-13-070, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 86-05-009 (Order 2340), § 388-13-070, filed 2/12/86; 80-01-026 (Order 1465), § 388-13-070, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory

Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5525.

388-13-085 Collection action. [Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-085, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5535.

388-13-090 Limitation on proceeding. [Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-090, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5505(9).

388-13-100 Acknowledgment of debt. [Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-100, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5540.

388-13-110 Default. [Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-13-110, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-110, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5515 and 388-14A-5525.

388-13-120 Procedural reference. [Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-13-120, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-13-120, filed 12/14/79.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6000.

WAC 388-13-010 through 388-13-120 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-14 WAC
SUPPORT ENFORCEMENT

WAC

388-14-010 through 388-14-570 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-14-010 Office of support enforcement as the Title IV-D agency. [Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-010, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-010, filed 2/12/86; Order 1054, § 388-14-010, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1000.

388-14-020 Definitions. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-020, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 26.23.035. 92-13-026 (Order 3403), § 388-14-020, filed 6/9/92, effective 7/10/92. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-020, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-020, filed 2/12/86; 83-21-014 (Order 2036), § 388-14-020, filed 10/6/83; 80-01-026 (Order 1465), § 388-14-020, filed 12/14/79; Order 1054, § 388-14-020, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1020.

388-14-030 Confidentiality. [Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-030, filed 9/2/97, effective 10/3/97. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-14-030, filed 2/10/93, effective 3/13/93; 91-17-063 (Order 3234), § 388-14-030, filed 8/20/91, effective 9/20/91. Statutory Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-030, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-030, filed 3/4/88; Order 1054, § 388-14-030, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2105 through 388-14A-2160.

388-14-035 Requests for address disclosure—Form of request. [Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-035, filed 9/2/97, effective 10/3/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2110 and 388-14A-2115.

388-14-040 Authorization for address release. [Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-040, filed 9/2/97, effective 10/3/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2125.

388-14-045 Requests for address disclosure—Notice of request—Standards for nonrelease. [Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-045, filed 9/2/97, effective 10/3/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2115.

388-14-050 Requests for address disclosure—Hearings. [Statutory Authority: RCW 26.23.120, as amended by 1997 c 58 § 908 and Section 303 of Public Law 104-193 (Federal Personal Responsibility and Work Opportunity Reconciliation Act). 97-18-075, § 388-14-050, filed 9/2/97, effective 10/3/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2120.

388-14-100 Absent parent's responsibility—Liability. [Order 1054, § 388-14-100, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090.

388-14-200 Families accepting assistance must assign certain support rights to the state. [Statutory Authority: RCW 74.20A.310 and 26.23.035. 98-10-042, § 388-14-200, filed 4/28/98, effective 5/29/98. Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-14-200, filed 6/9/92, effective 7/10/92. Statutory Authority: RCW 74.20A.270. 90-05-022 (Order 2942), § 388-14-200, filed 2/13/90, effective 3/16/90. Statutory Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-200, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-200, filed 3/4/88. Statutory Authority: RCW 74.20A.270. 85-20-085 (Order 2288), § 388-14-200, filed 10/1/85. Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-14-200, filed 12/14/79; 78-09-053 (Order 1330), § 388-14-200, filed 8/22/78; Order 1054, § 388-14-200, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2030, 388-14A-2035, and 388-14A-2036.

388-14-201 Cooperation with division of child support. [Statutory Authority: RCW 74.20A.310 and 26.23.035. 98-10-042, § 388-14-201, filed 4/28/98, effective 5/29/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2040.

388-14-202 Effects of noncooperation. [Statutory Authority: RCW 74.20A.310 and 26.23.035. 98-10-042, § 388-14-202, filed 4/28/98, effective 5/29/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2041 and 388-14A-2075.

388-14-203 Medical assistance only—Assignment of support rights—Cooperation. [Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-14-203, filed 6/9/92, effective 7/10/92.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090.

388-14-205 Responsibilities of the office. [Statutory Authority: RCW 74.08.090 and 45 CFR 303.106. 94-15-046 (Order 3754), § 388-14-205, filed 7/15/94, effective

8/15/94. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-14-205, filed 2/10/93, effective 3/13/93; 92-13-026 (Order 3403), § 388-14-205, filed 6/9/92, effective 7/10/92. Statutory Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-205, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-205, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-205, filed 2/12/86; 79-06-032 (Order 1400), § 388-14-205, filed 5/16/79; 78-09-053 (Order 1330), § 388-14-205, filed 8/22/78.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1025, 388-14A-1030, 388-14A-2000, and 388-14A-2005.

388-14-210 Support payments to office of support enforcement. [Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-210, filed 3/4/88; 80-01-026 (Order 1465), § 388-14-210, filed 12/14/79; Order 1054, § 388-14-210, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1000 and 388-14A-3375.

388-14-220 Subpoena power. [Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-220, filed 3/4/88; 81-05-021 (Order 1605), § 388-14-220, filed 2/11/81; 78-07-015 (Order 1305), § 388-14-220, filed 6/15/78; Order 1054, § 388-14-220, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-8500.

388-14-250 Payments to the family. [Order 1054, § 388-14-250, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5000.

388-14-260 Interstate cases. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-260, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-14-260, filed 2/5/90, effective 3/1/90. Statutory Authority: 74.08.090. 85-23-019 (Order 2304), § 388-14-260, filed 11/13/85; Order 1054, § 388-14-260, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-7100 and 388-14A-7200.

388-14-270 Distribution of support payments. [Statutory Authority: RCW 74.20A.310 and 26.23.035. 98-10-042, § 388-14-270, filed 4/28/98, effective 5/29/98. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-270, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 26.23.035. 92-13-026 (Order 3403), § 388-14-270, filed 6/9/92, effective 7/10/92. Statutory Authority: RCW 74.08.090. 90-17-001 (Order 2979), § 388-14-270, filed 8/2/90, effective 9/2/90. Statutory Authority: RCW 74.04.057. 89-10-070 (Order 2794), § 388-14-270, filed 5/3/89. Statutory Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-270, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-270, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-270, filed 2/12/86; 85-01-004 (Order 2174), § 388-14-270, filed 12/6/84; 80-01-026 (Order 1465), § 388-14-270, filed 12/14/79; Order 1054, § 388-14-270, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5000 through 388-14A-5100.

388-14-271 Notice of intent to distribute support money. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-271, filed 6/18/97, effective 7/19/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5050.

388-14-272 Notice to recover a support payment. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-272, filed 6/18/97, effective 7/19/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5300.

388-14-273 Payment distribution payment services only cases. [Statutory Authority: RCW 26.23.035. 92-13-026 (Order 3403), § 388-14-273, filed 6/9/92, effective 7/10/92.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5000 and 388-14A-5001.

388-14-274 Distribution notice. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-274, filed 6/18/97, effective 7/19/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5100.

388-14-276 Total versus total notice. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-276, filed 6/18/97, effective 7/19/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5200.

388-14-300 Nonassistance support enforcement services—Persons eligible for services. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-300, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090 and 45 CFR 303.106. 94-15-046 (Order 3754), § 388-14-300, filed 7/15/94, effective 8/15/94. Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-14-300, filed 6/9/92, effective 7/10/92; 90-16-041 (Order 3043), § 388-14-300, filed 7/24/90, effective 8/24/90; Order 1054, § 388-14-300, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2000.

388-14-310 Nonassistance support enforcement application. [Statutory Authority: RCW 74.08.090 and 45 CFR 303.106. 94-15-046 (Order 3754), § 388-14-310, filed 7/15/94, effective 8/15/94. Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-14-310, filed 6/9/92, effective 7/10/92; 90-16-041 (Order 3043), § 388-14-310, filed 7/24/90, effective 8/24/90; 88-07-012 (Order 2606), § 388-14-310, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-310, filed 2/12/86; 80-01-026 (Order 1465), § 388-14-310, filed 12/14/79; Order 1054, § 388-14-310, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2000, 388-14A-2010, and 388-14A-2015.

388-14-350 Location of absent parents. [Statutory Authority: RCW 74.08.090. 83-21-014 (Order 2036), § 388-14-350, filed 10/6/83; Order 1054, § 388-14-350, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1035.

388-14-360 Cooperation with other states. [Order 1054, § 388-14-360, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1050.

388-14-365 Reassignment by state administering an approved plan. [Statutory Authority: RCW 74.08.090. 80-01-026 (Order 1465), § 388-14-365, filed 12/14/79; Order 1054, § 388-14-365, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1055.

388-14-370 Cooperative arrangements with courts and law enforcement officials. [Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-370, filed 3/4/88; 80-01-026 (Order 1465), § 388-14-370, filed 12/14/79; 78-07-015 (Order 1305), § 388-14-370, filed 6/15/78; Order 1054, § 388-14-370, filed 9/25/75.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-1060.

388-14-376 Recovery of excess daycare and special child rearing expense payments. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-376, filed 6/18/97, effective 7/19/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4300 through 388-14A-4304.

388-14-385 The division of child support's grievance and dispute resolution method is called a conference board. [Statutory Authority: RCW 74.20A.310, 26.23.035 and 74.08.090. 98-17-033, § 388-14-385, filed 8/11/98,

effective 9/11/98. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-385, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 94-15-045 (Order 3753), § 388-14-385, filed 7/15/94, effective 8/15/94; 93-05-020 (Order 3512), § 388-14-385, filed 2/10/93, effective 3/13/93; 91-09-018 (Order 3133), § 388-14-385, filed 4/9/91, effective 5/10/91. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-14-385, filed 2/5/90, effective 3/1/90. Statutory Authority: 1988 c 275. 89-01-049 (Order 2738), § 388-14-385, filed 12/14/88. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-385, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-385, filed 2/12/86; 81-05-021 (Order 1605), § 388-14-385, filed 2/11/81; 80-01-026 (Order 1465), § 388-14-385, filed 12/14/79; 78-07-015 (Order 1305), § 388-14-385, filed 6/15/78.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6400.

388-14-386 How to apply for a conference board. [Statutory Authority: RCW 74.20A.310, 26.23.035 and 74.08.090. 98-17-033, § 388-14-386, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6405.

388-14-387 Explanation of the conference board process. [Statutory Authority: RCW 74.20A.310, 26.23.035 and 74.08.090. 98-17-033, § 388-14-387, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6410.

388-14-388 Scope of authority of conference board chair defined. [Statutory Authority: RCW 74.20A.310, 26.23.035 and 74.08.090. 98-17-033, § 388-14-388, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6415.

388-14-390 Hearing when collection action is initiated against a bank account—Exemptions—Burden of proof. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-390, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090 and 45 CFR 303.106. 94-15-046 (Order 3754), § 388-14-390, filed 7/15/94, effective 8/15/94. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-14-390, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 83-21-014 (Order 2036), § 388-14-390, filed 10/6/83.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6200.

388-14-395 Limitation on collection of support payments from head of household—Request for conference board—Burden of proof. [Statutory Authority: RCW 74.08.090. 83-21-014 (Order 2036), § 388-14-395, filed 10/6/83.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-8120.

388-14-410 Release of information to consumer reporting agency. [Statutory Authority: RCW 74.08.090. 86-05-009 (Order 2340), § 388-14-410, filed 2/12/86.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2160.

388-14-415 Notice of support owed. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-415, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 92-13-026 (Order 3403), § 388-14-415, filed 6/9/92, effective 7/10/92; 91-09-018 (Order 3133), § 388-14-415, filed 4/9/91, effective 5/10/91. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.090. 90-04-077 (Order 3005), § 388-14-415, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.08.090. 88-07-012 (Order 2606), § 388-14-415, filed 3/4/88; 86-05-009 (Order 2340), § 388-14-415, filed 2/12/86.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3310.

388-14-420 Once a support enforcement case is opened, under what circumstances can it be closed? [Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-420, filed 9/24/99, effective 10/25/99. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-420, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090, 45 CFR 303.11 and 45 CFR 303.100. 93-05-020 (Order 3512), § 388-14-420, filed 2/10/93, effective 3/13/93. Statutory Authority: RCW 74.08.090. 90-16-041 (Order 3043), § 388-14-420, filed 7/24/90, effective 8/24/90; 88-07-012 (Order 2606), § 388-14-420, filed 3/4/88.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2080.

388-14-421 Under what circumstances may DCS deny a request to close a support enforcement case? [Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-421, filed 9/24/99, effective 10/25/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2085.

388-14-422 Who is mailed notice of DCS' intent to close a case? [Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-422, filed 9/24/99, effective 10/25/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2090.

388-14-423 What if I don't agree with the case closure notice? [Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-423, filed 9/24/99, effective 10/25/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2095.

388-14-424 What happens to payments that come in after a case is closed? [Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-424, filed 9/24/99, effective 10/25/99.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-2097.

388-14-427 Payroll deduction notice—Order to withhold and deliver—Wage assignments—Agreements for electronic service. [Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-14-427, filed 2/10/93, effective 3/13/93.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4040.

388-14-435 Notice of support debt. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-435, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 93-05-020 (Order 3512), § 388-14-435, filed 2/10/93, effective 3/13/93; 91-09-018 (Order 3133), § 388-14-435, filed 4/9/91, effective 5/10/91.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3304.

388-14-440 Notice to payee. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-440, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 91-09-018 (Order 3133), § 388-14-440, filed 4/9/91, effective 5/10/91.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-3315.

388-14-450 Debt adjustment notice. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-450, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090. 91-09-018 (Order 3133), § 388-14-450, filed 4/9/91, effective 5/10/91.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-5400.

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

Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4100.

388-14-480 Notice of enrollment—Health insurance coverage—Issuance and termination. [Statutory Authority: RCW 26.18.170 and 26.18.180. 92-13-026 (Order 3403), § 388-14-480, filed 6/9/92, effective 7/10/92.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4120.

388-14-490 All Washington employers must report new hires to the Washington state support registry. [Statutory Authority: RCW 26.23.040. 99-20-011, § 388-14-490, filed 9/24/99, effective 10/25/99; 92-13-026 (Order 3403), § 388-14-490, filed 6/9/92, effective 7/10/92.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-8200.

388-14-495 Registering an order from another state for enforcement or modification. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-495, filed 6/18/97, effective 7/19/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-7100.

388-14-496 Uniform Interstate Family Support Act—Notices served in another state. [Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-496, filed 6/18/97, effective 7/19/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090.

388-14-500 The division of child support will accept oral requests for hearing or conference board. [Statutory Authority: RCW 34.05.220(1) and 74.08.090. 98-17-032, § 388-14-500, filed 8/11/98, effective 9/11/98. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-500, filed 6/18/97, effective 7/19/97.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-6100.

388-14-510 What is the division of child support's license suspension program? [Statutory Authority: RCW 74.20A.320(10). 98-17-031, § 388-14-510, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4500.

388-14-520 The notice of noncompliance and intent to suspend licenses. [Statutory Authority: RCW 74.20A.320(10). 98-17-031, § 388-14-520, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4505.

388-14-530 Who is subject to the DCS license suspension program? [Statutory Authority: RCW 74.20A.320(10). 98-17-031, § 388-14-530, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4510.

388-14-540 How do I avoid having my license suspended for failure to pay child support? [Statutory Authority: RCW 74.20A.320(10). 98-17-031, § 388-14-540, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4515.

388-14-550 Signing a repayment agreement will avoid certification for noncompliance. [Statutory Authority: RCW 74.20A.320(10). 98-17-031, § 388-14-550, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4520.

388-14-560 How to obtain a release of certification for noncompliance. [Statutory Authority: RCW 74.20A.320(10). 98-17-031, § 388-14-560, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4525.

388-14-570 Administrative hearings regarding license suspension are limited in scope. [Statutory Authority: RCW 74.20A.320(10). 98-17-031, § 388-14-570, filed 8/11/98, effective 9/11/98.] Repealed by 01-03-089, filed 1/17/01, effective 2/17/01. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-14A-4530.

WAC 388-14-010 through 388-14-570 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-14A WAC
DIVISION OF CHILD SUPPORT RULES

WAC

WAC 388-14A-1000 The DSHS division of child support is the Title IV-D child support enforcement agency for the state of Washington. (1) The division of child support (DCS) is the part of the department of social and health services that provides child support enforcement services for the state of Washington under Title IV-D of the federal Social Security Act. DCS acts as the Washington state support registry (WSSR) under chapter 26.23 RCW.

(2) If your support order requires you to make payments to DCS or to WSSR, send payments to: WSSR, PO Box 45868, Olympia WA 98504-5868.

(3) If you want to call DCS, you can call 1-800-442-KIDS, or call the local DCS field office.

(4) If you want to write to DCS, you can write to P.O. Box 9162, Olympia WA 98507-9162 or to the local DCS field office.

(5) DCS is responsible for the statewide administration of wage withholding under Title IV-D.

(6) DCS is the agency referred to in federal law as "the Title IV-D agency," and performs all duties assigned to the Title IV-D agency.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1000, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-010 and 388-14-210.]

WAC 388-14A-1005 What is Washington's state plan under Title IV-D? (1) The division of child support (DCS), on behalf of the department of social and health services of the state of Washington, has established the following provisions as the state plan (the "plan") for its child support enforcement program. This plan is authorized by Title IV-D of the Social Security Act and chapters 74.20 and 74.20A RCW. This plan covers the entire state of Washington.

(2) DCS is the organization within the state of Washington that administers the plan.

(3) DCS enters into contracts for child support enforcement and related services with:

(a) Other state agencies;

(b) Indian tribes, county prosecutors and court clerks in the state of Washington;

(c) Other states or foreign countries for action under the Uniform Interstate Family Support Act (UIFSA) and other laws to enforce or collect child support, locate noncustodial parents, or establish paternity. These contracts may include procedures for:

(i) Making referrals;

(ii) Assigning debts;

(iii) Reporting actions and activities; and

(iv) Coordinating activities under and ensuring compliance with UIFSA.

(d) Private parties;

(e) The secretary of the Department of Health and Human Services to refer and certify cases:

(i) To the federal parent locator service (FPLS);

(ii) To the secretary of the treasury for action to collect support debts; and

(iii) For action in the United States district courts to enforce support debts.

(4) DCS manages the Title IV-D plan for the state of Washington and:

(a) Oversees all activities under the plan to ensure that the program meets the standards for an efficient and effective program;

(b) Evaluates the quality and scope of services provided under the plan;

(c) Ensures that federal and state requirements for records management, accounting and fiscal control are met;

(d) Provides all services under the plan in appropriate cases, including action to locate parents, to establish paternity, and to establish, enforce and collect child support; and

(e) Assures that referrals and other communications with the Title IV-A agency (which operates the public assistance programs) and the Title IV-E agency (which operates the foster care program) meet the requirements of the Title IV-D and Title IV-A state plans.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1005, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-1010 What are the other names that the division of child support has used? (1) The division of child support (DCS) has been known by many names including:

(a) The office of support enforcement (OSE);

(b) The support enforcement division (SED);

(c) The state's Title IV-D agency; and

(d) The Washington State Support Registry (WSSR).

(2) Some statutes and forms use one of these other names, but they all mean the division of child support.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1010, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-1015 What laws regulate the actions of the division of child support? (1) The following are the primary state and federal laws which apply to the division of child support (DCS):

(a) Title IV-D of the Social Security Act sets out the federal requirements for a state's support enforcement program.

(b) Title 45 of the Code of Federal Regulations contains the federal regulations regarding support enforcement programs.

(c) Chapter 26.23 RCW establishes the Washington state support enforcement program.

(2) Most state statutes governing DCS are found in Title 26 RCW and chapters 74.20 and 74.20A RCW.

(3) The Washington Administrative Code (WAC) contains the state regulations regarding the Washington state support enforcement program.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1015, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-1020 What definitions apply to the rules regarding child support enforcement? For purposes of this chapter, the following definitions apply:

"Absence of a court order" means that there is no court order setting a support obligation for the noncustodial parent (NCP), or specifically relieving the NCP of a support obligation, for a particular child.

"Absent parent" is a term used for a noncustodial parent.

"Accrued debt" means past-due child support which has not been paid.

"Administrative order" means a determination, finding, decree or order for support issued under RCW 74.20A.055, 74.20A.056, or 74.20A.059 or by another state's agency under an administrative process, establishing the existence of a support obligation (including medical support) and ordering the payment of a set or determinable amount of money for current support and/or a support debt. Administrative orders include:

(1) An order entered under chapter 34.05 RCW;

(2) An agreed settlement or consent order entered under WAC 388-14A-3600; and

(3) A support establishment notice which has become final by operation of law.

"Agency" means the Title IV-D provider of a state. In Washington, this is DCS.

"Agreed settlement" is an administrative order that reflects the agreement of the noncustodial parent, the custodial parent and the division of child support. An agreed settlement does not require the approval of an administrative law judge.

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

"Applicant/custodian" means a person who applies for nonassistance support enforcement services on behalf of a child or children residing in their household.

"Applicant/recipient," "applicant," and **"recipient"** means a person who receives public assistance on behalf of a child or children residing in their household.

"Arrears" means the debt amount owed for a period of time before the current month.

"Assistance" means cash assistance under the state program funded under Title IV-A of the federal Social Security Act.

"Birth costs" means medical expenses incurred by the custodial parent or the state for the birth of a child.

"Conference board" means a method used by the division of child support for resolving complaints regarding DCS cases and for granting exceptional or extraordinary relief from debt.

"Consent order" means a support order that reflects the agreement of the noncustodial parent, the custodial parent and the division of child support. A consent order requires the approval of an administrative law judge.

"Court order" means a judgment, decree or order of a Washington state superior court, another state's court of comparable jurisdiction, or a tribal court.

"Current support" or **"current and future support"** means the amount of child support which is owed for each month.

"Custodial parent" means the person, whether a parent or not, with whom a dependent child resides the majority of the time period for which the division of child support seeks to establish or enforce a support obligation.

"Date the state assumes responsibility for the support of a dependent child on whose behalf support is sought" means the date that the TANF or AFDC program grant is effective. For purposes of this chapter, the state remains responsible for the support of a dependent child until public assistance terminates, or support enforcement services end, whichever occurs later.

"Delinquency" means failure to pay current child support when due.

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

"Dependent child" means a person:

(1) Seventeen years of age or younger who is not self-supporting, married, or a member of the united states armed forces;

(2) Eighteen years of age or older for whom a court order requires support payments past age eighteen;

(3) Eighteen years of age or older, but under nineteen years of age, for whom an administrative support order exists if the child is:

(a) A full-time student; and

(b) Reasonably expected to complete secondary school or the equivalent level of vocational or technical training before the end of the month in which the child turns nineteen.

"Disposable earnings" means the amount of earnings remaining after the deduction of amounts required by law to be withheld.

"Earnings" means compensation paid or payable for personal service. Earnings include:

(1) Wages or salary;

(2) Commissions and bonuses;

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

(4) Disability payments under Title 51 RCW;

(5) Unemployment compensation under RCW 50.40.020, 50.40.050 and Title 74 RCW;

(6) Gains from capital, labor, or a combination of the two; and

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

"Employee" means a person to whom an employer is paying, owes, or anticipates paying earnings in exchange for services performed for the employer.

"Employer" means any person or organization having an employment relationship with any person. This includes:

(1) Partnerships and associations;

(2) Trusts and estates;

(3) Joint stock companies and insurance companies;

(4) Domestic and foreign corporations;

(5) The receiver or trustee in bankruptcy; and

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

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

"Family" means the person or persons on whose behalf support is sought, which may include a custodial parent and one or more children, or a child or children in foster care placement. The family is sometimes called the assistance unit.

"Family member" means the caretaker relative, the child(ren), and any other person whose needs are considered in determining eligibility for assistance.

"Foreign order" means a court or administrative order entered by a tribunal other than one in the state of Washington.

"Foster care case" means a case referred to the Title IV-D agency by the Title IV-E agency, which is the state division of child and family services (DCFS).

"Fraud," for the purposes of vacating an agreed settlement or consent order, means:

(1) The representation of the existence or the nonexistence of a fact;

(2) The representation's materiality;

(3) The representation's falsity;

(4) The speaker's knowledge that the representation is false;

(5) The speaker's intent that the representation should be acted on by the person to whom it is made;

(6) Ignorance of the falsity on the part of the person to whom it is made;

(7) The latter's:

(a) Reliance on the truth of the representation;

(b) Right to rely on it; and

(c) Subsequent damage.

"Full support enforcement services" means the entire range of services available in a Title IV-D case.

"Good cause" for the purposes of late hearing requests and petitions to vacate orders on default means a substantial reason or legal justification for delay, including but not limited to the grounds listed in civil rule 60. The time periods used in civil rule 60 apply to good cause determinations in this chapter.

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

"Health care costs":

(1) For the purpose of establishing support obligations under RCW 74.20A.055 and 74.20A.056, means medical, dental and optometrical expenses; and,

(2) For the purpose of enforcement action under chapters 26.23, 74.20 and 74.20A RCW, including the notice of support debt and the notice of support owed, means medical, dental and optometrical costs stated as a fixed dollar amount by a support order.

"Hearing" means an adjudicative proceeding authorized by this chapter, or chapters 26.23, 74.20 and 74.20A RCW, conducted under chapter 388-02 WAC and chapter 34.05 RCW.

"I/Me" means the person asking the question which appears as the title of a rule.

"Income" includes:

(1) All gains in real or personal property;

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

(3) Earnings;

(4) Interest and dividends;

(5) Proceeds of insurance policies;

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

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

"Income withholding action" includes all withholding actions which DCS is authorized to take, and includes but is not limited to the following actions:

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

(2) Serving and enforcing liens under chapter 74.20A RCW;

(3) Issuing orders to withhold and deliver under chapter 74.20A RCW;

(4) Issuing notices of payroll deduction under chapter 26.23 RCW; and

(5) Obtaining wage assignment orders under RCW 26.18.080.

"Locate" can mean efforts to obtain service of a support establishment notice in the manner prescribed by WAC 388-14A-3105.

"Medical support" means either or both:

(1) Health care costs stated as a fixed dollar amount in a support order; and

(2) Health insurance coverage for a dependent child.

"Noncustodial parent" means the natural parent, adoptive parent, responsible stepparent or person who signed and filed an affidavit acknowledging paternity, from whom the state seeks support for a dependent child. Also called the NCP. A parent is considered to be an NCP when for the majority of the time during the period for which support is sought, the dependent child resided somewhere other than with that parent.

"Other ordinary expense" means an expense incurred by a parent which:

(1) Directly benefits the dependent child; and

(2) Relates to the parent's residential time or visitation with the child.

"Past support" means support arrears.

"Paternity testing" means blood testing or genetic tests of blood, tissue or bodily fluids. This is also called genetic testing.

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

"Permanently assigned arrearages" means those arrears which the state may collect and retain up to the amount of unreimbursed assistance.

"Physical custodian" means custodial parent (CP).

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

"Reasonable efforts to locate" means any of the following actions performed by the division of child support:

(1) Mailing a support establishment notice to the noncustodial parent in the manner described in WAC 388-14A-3105;

(2) Referral to a sheriff or other server of process, or to a locate service or department employee for locate activities;

(3) Tracing activity such as:

(a) Checking local telephone directories and attempts by telephone or mail to contact the custodial parent, relatives of the noncustodial parent, past or present employers, or the post office;

(b) Contacting state agencies, unions, financial institutions or fraternal organizations;

(c) Searching periodically for identification information recorded by other state agencies, federal agencies, credit bureaus, or other record-keeping agencies or entities; or

(d) Maintaining a case in the division of child support's automated locate program, which is a continuous search process.

(4) Referral to the state or federal parent locator service;

(5) Referral to the attorney general, prosecuting attorney, the IV-D agency of another state, or the Department of the Treasury for specific legal or collection action;

(6) Attempting to confirm the existence of and to obtain a copy of a paternity acknowledgment; or

(7) Conducting other actions reasonably calculated to produce information regarding the NCP's whereabouts.

"Required support obligation for the current month" means the amount set by a superior court order, tribal court order, or administrative order for support which is due in the month in question.

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

"Residential care" means foster care, either state or federally funded.

"Residential parent" means the custodial parent (CP), or the person with whom the child resides that majority of the time.

"Responsible parent" is a term sometimes used for a noncustodial parent.

"Responsible stepparent" means a stepparent who has established an in loco parentis relationship with the dependent child.

"Retained support" means a debt owed to the division of child support by anyone other than a noncustodial parent.

"Satisfaction of judgment" means payment in full of a court-ordered support obligation, or a determination that such an obligation is no longer enforceable.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"State" means a state or political subdivision, territory, or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, a federally recognized Indian tribe or a foreign country.

"Superior court order" means a judgment, decree or order of a Washington state superior court, or of another state's court of comparable jurisdiction.

"Support debt" means support which was due under a support order but has not been paid. This includes:

(1) Delinquent support;

(2) A debt for the payment of expenses for the reasonable or necessary care, support and maintenance including health care costs, birth costs, child care costs, and special child rearing expenses of a dependent child or other person;

(3) A debt under RCW 74.20A.100 or 74.20A.270; or

(4) Accrued interest, fees, or penalties charged on a support debt, and attorney's fees and other litigation costs awarded in an action under Title IV-D to establish or enforce a support obligation.

"Support enforcement services" means all actions the Title IV-D agency is required to perform under Title IV-D of the Social Security Act and state law.

"Support establishment notice" means a notice and finding of financial responsibility under WAC 388-14A-3115, a notice and finding of parental responsibility under WAC 388-14A-3120, or a notice and finding of medical responsibility under WAC 388-14A-3125.

"Support money" means money paid to satisfy a support obligation, whether it is called child support, spousal support, alimony, maintenance, medical support, or birth costs.

"Support obligation" means the obligation to provide for the necessary care, support and maintenance of a dependent child or other person as required by law, including health insurance coverage, health care costs, birth costs, and child care or special child rearing expenses.

"Temporarily assigned arrearages" means those arrears which accrue prior to the family receiving assistance, for assistance applications dated on or after October 1, 1997.

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

"Title IV-A agency" means the part of the department of social and health services which carries out the state's responsibilities under the temporary assistance for needy families (TANF) program (and the aid for dependent children (AFDC) program when it existed).

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

"Title IV-D agency" or **"IV-D agency"** means the division of child support, which is the agency responsible for carrying out the Title IV-D plan in the state of Washington. Also refers to the Washington state support registry (WSSR).

"Title IV-D case" is a case in which the division of child support provides services which qualifies for funding under the Title IV-D plan.

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

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

"Title IV-E case" means a foster care case

"Tribunal" means a state court, tribal court, administrative agency, or quasi-judicial entity authorized to establish, enforce or modify support orders or to determine parentage.

"Unreimbursed assistance" means the cumulative amount of assistance which was paid to the family and which has not been reimbursed by assigned support collections.

"We" means the division of child support, part of the department of social and health services of the state of Washington.

"WSSR" is the Washington state support registry.

"You" means the reader of the rules, a member of the public, or a recipient of support enforcement services.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-1020, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-011 and 388-14-020.]

WAC 388-14A-1025 What are the responsibilities of the division of child support? (1) The division of child support (DCS) provides support enforcement services when:

(a) The department of social and health services pays public assistance or provides foster care services;

(b) A former recipient of public assistance is eligible for services, as provided in WAC 388-14A-2000 (2)(c);

(c) A custodial parent (CP) or noncustodial parent (NCP) requests nonassistance support enforcement services under RCW 74.20.040 and WAC 388-14A-2000;

(d) A support order or wage assignment order under chapter 26.18 RCW directs the NCP to make support payments through the Washington state support registry (WSSR);

(e) A support order under which there is a current support obligation for dependent children is submitted to the WSSR;

(f) A former custodial parent (CP) requests services to collect a support debt accrued under a court or administrative support order while the child(ren) resided with the CP;

(g) A child support enforcement agency in another state or foreign country requests support enforcement services; or

(h) A child support agency of an Indian tribe requests support enforcement services.

(2) DCS takes action under chapters 26.23 and 74.20A RCW to establish, enforce and collect child support obligations.

(a) DCS refers cases to the county prosecuting attorney or attorney general's office when judicial action is required.

(b) If DCS has referred a case to the county prosecuting attorney or attorney general's office and the CP has been granted good cause level A, DCS does not share funding under Title IV-D for any actions taken by the prosecutor or attorney general's office once DCS advises them of the good cause finding.

(3) DCS does not take action on cases where the community services office (CSO) has granted the CP good cause not to cooperate under WAC 388-422-0020, when the CSO grants "level A good cause." If the CSO grants "level B good cause," DCS proceeds to establish and/or enforce support obligations but does not require the CP to cooperate with DCS. WAC 388-14A-2065 and 388-14A-2070 describe the way DCS handles cases with good cause issues.

(4) DCS establishes, maintains, retains and disposes of case records in accordance with the department's records management and retention policies and procedures adopted under chapter 40.14 RCW.

(5) DCS establishes, maintains, and monitors support payment records.

(6) DCS receives, accounts for and distributes child support payments required under court or administrative orders for support.

(7) DCS files a satisfaction of judgment when we determine that a support obligation is either paid in full or no longer legally enforceable. WAC 388-14A-2099 describes the procedures for filing a satisfaction of judgment. WAC 388-14A-2099(4) describes how DCS determines a support obligation is satisfied or no longer legally enforceable.

[Statutory Authority: RCW 74.08.090, 74.20A.310. 01-24-080, § 388-14A-1025, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 45 CFR 303.106. 01-03-089, § 388-14A-1025, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-205.]

WAC 388-14A-1030 What kinds of services can the division of child support provide? The services provided by the division of child support include, but are not limited to the following:

(1) Receiving payments and distributing the payments (see WAC 388-14A-5000);

(2) Establishing or modifying administrative child support orders (see WAC 388-14A-3100);

(3) Enforcing and modifying court orders for child support or maintenance (see WAC 388-14A-3305 and 388-14A-3310);

(4) Referral to the prosecuting attorney for establishment of paternity;

(5) Providing locate services as provided in WAC 388-14A-1035;

(6) Referral for welfare to work services in conjunction with other parts of DSHS, the employment security department (ESD) and private contractors;

(7) Cooperation with the IV-D agencies of other states and Indian tribes (see WAC 388-14A-1060); and

(8) Providing any other services allowed by the state plan and applicable state and federal law.

[Statutory Authority: RCW 74.08.090, 45 CFR 303.106. 01-03-089, § 388-14A-1030, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-205.]

WAC 388-14A-1035 What kinds of locate services does the division of child support provide? The division of child support (DCS) maintains a service to locate noncustodial parents, using:

(1) All sources of information and available records in Washington or other states; and

(2) The federal parent locator service (FPLS) maintained by the federal Department of Health and Human Services.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1035, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-350.]

WAC 388-14A-1036 Who can request DCS locate services? DCS provides locate services for:

(1) Persons receiving public assistance for the benefit of dependent children;

(2) Any agency or attorney of another state seeking to collect support obligations under an agreement entered into with DCS;

(3) A court which has the authority to issue an order against a noncustodial parent (NCP) for the support and maintenance of a child;

(4) The custodial parent (CP), legal guardian, attorney or agent of a child who does not receive public assistance, and has not applied for full support enforcement services;

(5) The IV-D agency of another state;

(6) The child support agency of an Indian tribe; and

(7) Those persons authorized by 45 C.F.R. 303.15 to use the FPLS in connection with parental kidnaping or child custody cases.

[Statutory Authority: RCW 74.08.090. 01-03-089, § WAC 388-14A-1036, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-1040 What must a request for locate services contain? A request or referral asking the division of child support (DCS) to provide locate services must contain the following information:

(1) The name of the noncustodial parent (NCP);

(2) The NCP's Social Security Number, if known;

(3) Whether NCP is now or has been a member of the armed services;

(4) Whether NCP is now receiving or has received any federal benefits;

(5) A request for a referral to the federal parent locator service (FPLS);

(6) A statement that the request is being made to locate a person only for one of the following purposes:

(a) Establishing paternity,

(b) Securing support, or

(c) In connection with parental kidnaping or child custody cases.

(7) A statement acknowledging that any information obtained from the FPLS must be kept confidential.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1040, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-1045 What happens when I request locate services from the division of child support? (1) The division of child support (DCS) makes diligent and reasonable efforts to locate the noncustodial parent (NCP), including referral to the federal parent locator service (FPLS).

(2) A request for locate services is not an application for full support enforcement services.

(3) If DCS is successful in locating the NCP, the case does not automatically convert to a full support enforcement services case, but you may apply for full services.

(4) If DCS is unsuccessful in locating the NCP using local and state resources, DCS closes the case as provided in 388-14A-2080(12).

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1045, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-1050 The division of child support cooperates with other states and Indian tribes for support enforcement purposes. The division of child support (DCS) cooperates with the IV-D agencies of other states and of Indian tribes, according to rules and policies set by the Secretary of the Department of Health and Human Services and/or the federal Office of Child Support Enforcement (OCSE). Areas of cooperation include:

(1) Establishing paternity;

(2) Locating a noncustodial parent (NCP) who resides in Washington;

(3) Enforcing the support obligation of an NCP who resides in Washington but whose support order was entered by another state; and

(4) Any other functions required under a Title IV-D plan.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1050, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-360.]

WAC 388-14A-1055 Can the division of child support collect support owed or assigned to another state? (1) The division of child support (DCS) may, at the request of another state, collect child support which has been assigned to that state under 42 U.S.C. 602 (a)(26)(A).

(2) DCS uses the remedies in chapters 26.23, 74.20 and 74.20A RCW to collect support on behalf of another state or IV-D agency.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1055, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-365.]

WAC 388-14A-1060 The division of child support cooperates with courts and law enforcement. (1) The division of child support (DCS) is authorized to enter into cooperative arrangements and written agreements including financial arrangements with the appropriate courts and law enforcement officials (including Indian tribes) to assist DCS in administering the state plan for support enforcement.

(2) These cooperative arrangements include the investigation and prosecution of fraud related to paternity and child support.

(3) DCS shares the federal funds it receives under 42 U.S.C. 655 according to the cooperative and financial agreements.

(4) Any support payments that are made by a noncustodial parent (NCP) after DCS refers a case to a court or law enforcement official must be submitted to the Washington state support registry.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-1060, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-370.]

WAC 388-14A-2000 Who can receive child support enforcement services from the division of child support? (1) The division of child support (DCS) provides payment processing and records maintenance services (called "payment services only") to parties to a court order who are not receiving a public assistance grant when:

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

(b) The custodial parent (CP) of a dependent child or a noncustodial parent (NCP) requests payment services only, provided that:

(i) An NCP's request for payment services only may not cause a reduction of service from the level of service provided under section (2) of this section; and

(ii) The support obligation is set by a Washington state superior court order, tribal court order, administrative order or wage assignment order, directing payment to DCS or to WSSR.

(2) DCS provides full support enforcement services under Title IV-D of the social security act to custodial parents or noncustodial parents who are not receiving a public assistance grant when:

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

(b) A NCP submits a support order for inclusion in or a support payment to the WSSR, together with an application for support enforcement services;

(c) A public assistance recipient stops receiving a cash grant under the temporary assistance for needy families program;

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

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

(3) DCS provides payment processing, records maintenance, paternity establishment, medical support establishment, and medical support enforcement services when a recipient of Medicaid-only benefits declines support enforcement services in writing.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310, 45 CFR 303.106. 01-03-089, § 388-14A-2000, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-205, 388-14-300, and 388-14-310.]

WAC 388-14A-2005 When does an application for public assistance automatically become an application for support enforcement services? (1) When a custodial parent (CP) or physical custodian (also called the CP) applies for or receives cash assistance on behalf of a minor child, the family authorizes the division of child support (DCS) to provide support enforcement services to the family.

(2) These services continue until the support enforcement case is closed under WAC 388-14A-2080.

(3) The CP's public assistance application is an assignment of support rights.

(4) WAC 388-14A-2036 describes the assignment of support rights.

(5) If the community services office grants the CP good cause not to cooperate under WAC 388-422-0020, DCS does not provide services. See WAC 388-14A-2065.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310, 45 CFR 303.106. 01-03-089, § 388-14A-2005, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-205.]

WAC 388-14A-2010 Can I apply for support enforcement services if I do not receive public assistance? (1) If you are not receiving public assistance, you can apply for support enforcement services. Your case is called a nonassistance case. A nonassistance case receives the same level of services as a case that was opened because of the payment of public assistance.

(2) Generally, the person applying for nonassistance support enforcement services is the custodial parent or former custodial parent of a child. However, the noncustodial parent may apply for services as well, as provided in WAC 388-14A-2000 (2)(b) and (e).

(3) A person wishing to apply for nonassistance support enforcement services must submit a written application for support enforcement services except as provided in WAC 388-14A-2000 (2)(c); and

(a) Have or have had physical custody of the child for whom support is sought, or for whom a support debt has accrued, or be the person with whom the child resided the majority of the time for which support is sought; or

(b) Be the noncustodial parent.

(4) The applicant must:

(a) Give consent for the division of child support (DCS) to take an assignment of earnings from the noncustodial parent (NCP) if the parents are still married;

(b) Agree to send to DCS any support payments received directly from the NCP within eight days of receipt;

(c) Agree to direct a payor or forwarding agent to make payments to the Washington state support registry (WSSR);

(d) Agree not to hire an attorney or collection agency, or apply to any other state's IV-D agency to collect the same support obligation or support debt, without notifying DCS;

(e) Complete, sign, date and submit to DCS the application form and any other required documents;

(f) Supply copies of divorce and dissolution decrees, support orders and modification orders, and any related documents affecting a support obligation;

(g) Provide a statement of the amount of support debt owed by the NCP; and

(h) Include or attach a list, by date, of the support payments received from the NCP during the time period for which the CP seeks support.

(5) If someone other than the CP has legal custody of the child under a court order, the CP must affirm that:

(a) The CP has not wrongfully deprived the legal custodian of custody; and

(b) The person with legal custody has not been excused from making support payments by a court or administrative tribunal.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2010, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-310.]

WAC 388-14A-2015 Does DCS accept an application from someone who is not a resident of Washington state? (1) If you are not a resident of the state of Washington but you are applying for services, you must swear or affirm that there is not an open IV-D case in another state.

(2) The division of child support (DCS) may decline the application for nonassistance support enforcement services if:

(a) DCS already has an open case for you which was opened at the request of another state; or

(b) Neither the custodial parent nor the noncustodial parent reside, work, or own any assets in the state of Washington.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2015, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-310.]

WAC 388-14A-2020 Can the division of child support deny my application for support enforcement services? (1) The division of child support (DCS) may deny an application which is incomplete, contains unclear or inconsistent statements, is not supported by necessary documents, or requests services DCS cannot or does not provide.

(2) DCS may deny an application from a nonresident as provided in WAC 388-14A-2015(2).

(3) When DCS denies an application, DCS sends the applicant a written notice of denial by regular mail. The notice advises the applicant:

(a) Of the reasons for the denial; and

(b) That the applicant may request an administrative hearing to contest the denial.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2020, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2025 What services does the division of child support provide for a nonassistance support enforcement case? (1) The division of child support (DCS) provides full support enforcement services for every IV-D case.

(2) Some cases do not receive full support enforcement services. Nonassistance cases where DCS provides payment processing services are called payment services only (PSO) cases.

(3) In a PSO case, DCS provides only records maintenance and payment processing services if the payee under a support order does not submit an application for support enforcement services and the:

(a) Order directs support payments to DCS or to the Washington state support registry (WSSR); and

(b) The clerk of the court submitted the order under RCW 26.23.050.

(4) DCS continues to provide services without an application after a:

(a) Public assistance recipient stops receiving cash assistance; or

(b) Recipient of Medicaid-only benefits becomes ineligible for Medicaid-only benefits, unless the recipient declines support enforcement services or requests additional services.

(5) If you receive services as a former recipient of assistance, as described in subsection (4), you must cooperate with DCS in the same way as when you received a grant.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2025, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2030 Do I assign my rights to support when I apply for child support enforcement services? (1) A custodial parent applying for or receiving cash assistance on behalf of a minor child assigns the family's rights to support as provided in WAC 388-14A-2035, below.

(2) A person applying for nonassistance support enforcement services does not assign support rights, but agrees to cooperate with the division of child support as provided in WAC 388-14A-2010(3).

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.270, 74.20A.310. 01-03-089, § 388-14A-2030, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-200.]

WAC 388-14A-2035 Do I assign my rights to support when I receive public assistance? (1) When you receive public assistance you assign your rights to support to the state. This section applies to all applicants and recipients of cash assistance under the state program funded under Title IV-A of the federal Social Security Act.

(2) As a condition of eligibility for assistance, a family member must assign to the state the right to collect and keep, subject to the limitation in subsection (3), any support owing to the family member or to any other person for whom the family member has applied for or is receiving assistance.

(3) Amounts assigned under this section may not exceed the lesser of the total amount of assistance paid to the family or the total amount of the assigned support obligation.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.270, 74.20A.310. 01-03-089, § 388-14A-2035, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-200.]

WAC 388-14A-2036 What does assigning my rights to support mean? (1) As a condition of eligibility for assis-

tance, a family member must assign to the state the right to collect and keep, subject to the limitation in WAC 388-14A-2035(3), any support owing to the family member or to any other person for whom the family member has applied for or is receiving assistance.

(2) While your family receives assistance, all support collected is retained by the state to reimburse the total amount of assistance which has been paid to your family.

(3) After your family terminates from assistance, certain accrued arrears remain assigned to the state in accordance with the following rules:

(a) For assistance applications dated prior to October 1, 1997, you permanently assign to the state all rights to support which accrued before the application date and which will accrue prior to the date your family terminates from assistance.

(b) For assistance applications dated on or after October 1, 1997, and before October 1, 2000:

(i) You permanently assign to the state all rights to support which accrue while your family receives assistance; and

(ii) You temporarily assign to the state all rights to support which accrued before the application date, until October 1, 2000, or when your family terminates from assistance, whichever date is later. After this date, if any remaining arrears are collected by federal income tax refund offset, the state retains such amounts, up to the amount of unreimbursed assistance.

(c) For assistance applications dated on or after October 1, 2000:

(i) You permanently assign to the state all rights to support which accrue while the family receives assistance; and

(ii) You temporarily assign to the state all rights to support which accrued before the application date, until the date your family terminates from assistance. After this date, if any remaining arrears are collected by federal income tax refund offset, the state retains such amounts, up to the amount of unreimbursed assistance.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.270, 74.20A.310. 01-03-089, § 388-14A-2036, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-200.]

WAC 388-14A-2037 What are permanently assigned arrears? Permanently assigned arrears accrue only under the following conditions:

(1) For those periods prior to the family receiving assistance, for assistance applications dated on or before September 30, 1997; and

(2) For those periods while a family receives assistance, for assistance applications dated at any time.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2037, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2038 What are temporarily assigned arrears? Temporarily assigned arrears are:

(1) Not permanently assigned to the state;

(2) Collected and retained by the state up to the amount of unreimbursed assistance, if these arrears are collected by federal income tax refund offset at any time; and

(3) Collected and kept by the state, up to the cumulative amount of unreimbursed assistance:

(a) Until October 1, 2000 or until the date the family terminates from assistance, whichever date is later; or

(b) Only while the family receives assistance, for assistance periods beginning October 1, 2000 or later.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2038, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2040 Do I have to cooperate with the division of child support in establishing or enforcing child support? (1) You must cooperate with the division of child support (DCS) when you receive public assistance unless the department determines there is good cause not to cooperate under WAC 388-422-0020. For purposes of this section and WAC 388-14A-2075, cooperating with DCS includes cooperating with those acting on behalf of DCS (its "representatives"), namely the prosecuting attorney, the attorney general, or a private attorney paid per RCW 74.20.350. In cases where paternity is at issue, the custodial parent (CP) of a child who receives assistance must cooperate whether or not the parent receives assistance.

(2) Cooperation means giving information, attending interviews, attending hearings, or taking actions to help DCS establish and collect child support. This information and assistance is necessary for DCS to:

(a) Identify and locate the responsible parent;

(b) Establish the paternity of the child(ren) on assistance in the CP's care; and

(c) Establish or collect support payments or resources such as property due the CP or the child(ren).

(3) The CP must also cooperate by sending to DCS any child support received by the CP while on assistance, as required by RCW 74.20A.320. If the client keeps these payments, known as retained support, the CP must sign an agreement to repay under RCW 74.20A.275, and the CP must honor that agreement.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.310. 01-03-089, § 388-14A-2040, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-201.]

WAC 388-14A-2041 What happens if I don't cooperate with DCS? (1) There may be penalties, called sanctions, for not cooperating with the division of child support (DCS). These sanctions and the noncooperation process are described in WAC 388-14A-2075. You may be sanctioned if:

(a) You do not go to scheduled interviews and answer questions;

(b) There is credible evidence showing that you could have given the information but did not;

(c) You have been giving inconsistent or false information without a good reason; or

(d) You refuse to sign or honor a repayment agreement under WAC 388-14A-2040(3).

(2) You must be given the opportunity to swear you do not have the information.

(3) You cannot be sanctioned because you provided information on a possible parent who was then excluded by genetic testing. In this event you must continue to cooperate in naming other possible parents and taking part in any resulting genetic testing.

(4) You may not be able to help DCS if you do not know, do not possess, or cannot reasonably obtain the requested information. To avoid a sanction, you must, under penalty of perjury, swear or attest to your lack of information in an interview held by DCS or its representative.

(5) If you fear that cooperation may cause harm to you or your children, you may claim good cause not to cooperate.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.310. 01-03-089, § 388-14A-2041, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-202.]

WAC 388-14A-2045 What can I do if I am afraid that cooperating with the division of child support will be harmful to me or to my children? (1) If a custodial parent (CP) receiving public assistance fears that the establishment or enforcement of support may result in harm to the CP or the children, the CP may be excused from the cooperation requirements. You can claim good cause not to cooperate under WAC 388-422-0020. Go to the community services office (CSO) to claim good cause.

(2) If a CP who is not receiving public assistance fears that the establishment or enforcement of support may result in harm to the CP or the children, the CP should tell the division of child support (DCS) that family violence is an issue in the case, so that DCS may take appropriate action.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2045, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2050 Who decides if I have good cause not to cooperate? (1) The community services office (CSO) decides whether you have good cause not to cooperate with the division of child support (DCS).

(2) When you make a claim of good cause not to cooperate, DCS does not take any action on the case while the CSO is reviewing your good cause claim.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2050, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2060 Are there different kinds of good cause for not cooperating with DCS? (1) For custodial parents receiving public assistance, there are two kinds of good cause granted by the community services office (CSO):

(a) When the CSO determines that support establishment or enforcement cannot proceed at all because of a risk of danger to the custodial parent (CP) or children, this is called good cause level A.

(b) When the CSO determines that support establishment or enforcement can proceed without input from the CP, but that good cause exists for the CP not to cooperate with DCS, this is called good cause level B.

(2) See WAC 388-422-0020 for how the CSO grants good cause.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2060, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2065 Does the division of child support provide support enforcement services if the CSO decides I have "good cause level A"? If the community services office (CSO) grants you good cause level A:

(1) The division of child support (DCS) closes the case and does not take any action to establish or enforce support for the children covered by the good cause finding.

(2) If the noncustodial parent (NCP) applies for paternity establishment or support enforcement services, DCS denies the NCP's application for services.

(3) If the community services office grants good cause level A after the case has been referred to the county prosecuting attorney or attorney general's office, DCS advises the prosecutor or attorney general's office of the good cause finding.

(4) When DCS advises the prosecutor or attorney general's office that good cause level A applies in a case, DCS requests that the prosecutor or attorney general's office dismiss any action that has been filed and cease all activities to establish or enforce a child support obligation for the children covered by the good cause finding.

[Statutory Authority: RCW 74.08.090, 74.20A.310. 01-24-080, § 388-14A-2065, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2065, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2070 Does the division of child support provide support enforcement services if the CSO determines I have "good cause level B"? If the community services office (CSO) grants you good cause level B, the division of child support provides support enforcement services without requiring the custodial parent (CP) to provide information or cooperate with DCS in any way.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2070, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2075 What happens if the division of child support determines that I am not cooperating? (1) When the division of child support (DCS) or its representatives believe you are not cooperating as defined in WAC 388-14A-2040, DCS sends a notice to you and to the community service office (CSO) stating the noncooperation and explaining the following:

(a) How the noncooperation was determined, including what actions were required;

(b) What actions you must take to resume cooperation;

(c) That this notice was sent to the CSO;

(d) That you may contact the CSO immediately if you disagree with the notice, need help in order to cooperate, or believe the actions required are unreasonable; and

(e) That the CSO may sanction you by either reducing or terminating the grant.

(2) The CSO sends a notice of planned action to you as provided by WAC 388-245-1700 or any subsequent amendment.

(3) Either the notice of alleged noncooperation or the CSO's notice of planned action may serve as the basis for a sanction.

(4) If the noncooperation was due to missing an interview without reasonable excuse, you will be considered to be cooperating when you appear for a rescheduled interview and either provide information or attest to the lack of information. DCS or its representative must reschedule the interview

within seven business days from the date you contact them to reschedule an interview.

(5) If the noncooperation was due to not taking a required action, cooperation resumes when you take that action.

(6) There is no hearing right for a notice of noncooperation, but you can request a hearing on the sanction imposed by the CSO.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.310. 01-03-089, § 388-14A-2075, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-202.]

WAC 388-14A-2080 Once DCS opens a support enforcement case, under what circumstances can it be closed? Once the division of child support (DCS) starts providing support enforcement services under RCW 26.23.045 and chapter 74.20 RCW, the case must remain open, unless DCS determines that:

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

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

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

(a) Institutionalized in a psychiatric facility;

(b) Incarcerated without possibility of parole; or

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

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

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

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

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

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

(9) DCS cannot obtain a paternity order because:

(a) The putative father is dead;

(b) Genetic testing has excluded all putative fathers;

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

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

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

(10) DCS, a court of competent jurisdiction or an administrative hearing determines that the recipient of services has wrongfully deprived the NCP of physical custody of the child as provided in WAC 388-14A-3370(3);

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

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

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

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

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

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

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

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310, 45 CFR 303.11, 45 CFR 303.100. 01-03-089, § 388-14A-2080, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-420.]

WAC 388-14A-2085 Under what circumstances may DCS deny a request to close a support enforcement case? (1) The division of child support (DCS) may deny a request to close a support enforcement case when:

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

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

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

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

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

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

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

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

(b) DCS does not provide enforcement services.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310, 45 CFR 303.11, 45 CFR 303.100. 01-03-089, § 388-14A-2085, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-421.]

WAC 388-14A-2090 Who is mailed notice of DCS' intent to close a case? (1) Sixty days before closing a case the division of child support (DCS) sends a notice of intent to close, advising the parties why DCS is closing the case.

(a) DCS does not send a notice when closing a case under WAC 388-14A-2080 (11) or (12).

(b) DCS does not provide sixty days' prior notice when closing a case under WAC 388-14A-2080(4).

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

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

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

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310, 45 CFR 303.11, 45 CFR 303.100. 01-03-089, § 388-14A-2090, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-422.]

WAC 388-14A-2095 What if I don't agree with the case closure notice? (1) Only the person who applied for support enforcement services, also known as the recipient of services, may request a hearing to challenge closure of a case.

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

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

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310, 45 CFR 303.11, 45 CFR 303.100. 01-03-089, § 388-14A-2095, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-423.]

WAC 388-14A-2097 What happens to payments that come in after a case is closed? After support enforcement services are terminated, DCS returns support money to the noncustodial parent except if the case remains open as a payment services only (PSO) case as described in WAC 388-14A-2000(1).

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310, 45 CFR 303.11, 45 CFR 303.100. 01-03-089, § 388-14A-2097, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-424.]

WAC 388-14A-2099 When does DCS file a satisfaction of judgment with the superior court? (1) When the division of child support (DCS) determines that a support obligation, established by order of a superior court of this state, has been satisfied or is no longer legally enforceable, DCS sends a notice of its intent to file a satisfaction of judgment to the last known address of the payee under the order and to the noncustodial parent (NCP).

(2) DCS includes the following provisions in the notice:

(a) A statement of the facts DCS relied on in making the determination; and

(b) A statement that the payee has twenty days from the date of the notice, to:

(i) Object and request a conference board under WAC 388-14A-6400; or

(ii) Initiate an action to obtain a judgment from the court that entered the order.

(3) If the conference board or the court determines the support obligation or a support debt still exists, DCS withdraws the notice and makes reasonable efforts to enforce and collect the remaining support debt. If the conference board or court determines that a debt does not exist, DCS files a satisfaction of judgment with the clerk of superior court in which the order was entered.

(4) DCS determines that a support obligation is satisfied or is no longer legally enforceable when the obligation to pay current and future support terminates under the order, and:

(a) The NCP has made all payments owed under the support order;

(b) The support debt is no longer enforceable due to the operation of the statute of limitations;

(c) DCS determines the NCP has a valid defense to payment of the debt under Washington law; or

(d) Under RCW 74.20A.220, DCS determines the debt is uncollectible, grants a total or partial charge-off, or accepts an offer to compromise a disputed debt.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2099, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2105 Does the division of child support keep information about me confidential? (1) Under RCW 26.23.120, all information and records, concerning persons who owe a support obligation or for whom the division of child support (DCS) provides support enforcement services, are private and confidential. DCS discloses information and records only as follows:

(a) DCS discloses information and records only to:

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

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

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

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

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

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

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

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

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

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

(b) The last known address of, or employment information about, a party to a court or administrative order for, or a proceeding involving, child support may be given to another party to the order. The party receiving the information may only use the information to establish, enforce, or modify a support order. Disclosure of address information is subject to the provisions of WAC 388-14A-2110;

(c) The last known address of natural or adoptive children may be given to a parent having a court order granting that parent visitation rights with, legal custody of or residential time with the parent's natural or adoptive children. The parent may only use this information to enforce the terms of the court order. Disclosure of this information is subject to the provisions of WAC 388-14A-2110;

(d) DCS may disclose the Social Security Number of a dependent child to the noncustodial parent (NCP) to enable the NCP to claim the dependency exemption as authorized by the Internal Revenue Service;

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

(2) Except as provided elsewhere in chapter 388-14A WAC, chapter 388-01 WAC governs the process of requesting and disclosing information and records.

(3) DCS must take timely action on requests for disclosure. DCS must respond in writing within five working days of receipt of the request.

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

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

(6) Nothing in these rules:

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

(b) Requires DCS to disclose information and records obtained from a confidential source.

[Statutory Authority: RCW 74.08.090, 26.23.120. 01-03-089, § 388-14A-2105, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030.]

WAC 388-14A-2110 How do I find out the address of my children, or of the other parent of my children? (1) A request for disclosure of a parent or child's address must be submitted in writing or in person, with satisfactory evidence of identity, at any office of the division of child support (DCS);

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

(3) If you are unable to appear at a DCS office in person, DCS may waive the provision requiring submission in person if you submit a notarized request for disclosure;

(4) The person seeking disclosure must attach the following to a request for disclosure of an address:

(a) A copy of the superior court order on which the request is based. DCS waives this provision if DCS has a true copy of the order on file;

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

(c) A statement explaining the purpose of the request and how the requestor intends to use the information.

[Statutory Authority: RCW 74.08.090, 26.23.120. 01-03-089, § 388-14A-2110, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030 and 388-14-035.]

WAC 388-14A-2115 What are the requirements for making an address disclosure request? (1) The following provisions apply to a request for disclosure of the address of a party to the order or a dependent child under chapter 388-14A WAC. The division of child support (DCS) does not release the address if:

(a) The department has determined, under WAC 388-422-0021, that the custodial parent (CP) has good cause for refusing to cooperate;

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

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

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

(2) Whenever DCS denies a request for disclosure under subsection (1) of this section, DCS notifies the nonrequesting party that disclosure of the address was requested and was denied.

(3) Prior to disclosing the address of a party or a child, DCS mails a notice to the last known address of the party whose address is sought, except as provided under subsection (4) of this section. The notice advises the party that:

(a) A request for disclosure has been made;

(b) DCS will disclose the address after thirty days from the date of the notice, unless:

(i) DCS receives a copy of an order which:

(A) Enjoins disclosure of the address;

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

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

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

(iii) In any hearing under this section, either party may participate in the proceeding by telephone, from any prearranged location. The administrative law judge (ALJ) must not disclose the location and phone number.

(4) DCS is not required to mail a notice prior to disclosure if:

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

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

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

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

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

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

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

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

(b) The records of DCS contain a written authorization for address release under WAC 388-14A-2125.

[Statutory Authority: RCW 74.08.090, 26.23.120. 01-03-089, § 388-14A-2115, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030, 388-14-035, and 388-14-045.]

WAC 388-14A-2120 What happens at a hearing on an objection to disclosure of my address? (1) In any administrative hearing requested under WAC 388-14A-2115 (3)(b)(ii):

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

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

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

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

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

(c) The administrative law judge (ALJ) must not disclose the location or phone number from which the party is appearing;

(d) The initial burden of proof is on the party requesting address disclosure, to show that the address request is for a purpose for which chapter 388-14A WAC specifically permits disclosure;

(e) If the party requesting address disclosure:

(i) Fails to meet this burden, the ALJ enters an order denying the address request;

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

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

(B) Is not required to provide supporting evidence required by WAC 388-422-0020, to establish a reasonable fear of harm.

(f) If either party fails to appear, the ALJ enters an order on default:

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

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

(g) OAH arranges the attendance of the parties by telephone or other procedure showing due regard for the safety of the parties and the children;

(h) DCS issues a final response to the disclosure request within five working days of the exhaustion of administrative remedies.

(2) If the custodial parent (CP) requests a hearing under this section in response to a department initiated review of the support order for modification, both parties to the support order are independent parties in the address disclosure hearing.

[Statutory Authority: RCW 74.08.090, 26.23.120. 01-03-089, § 388-14A-2120, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030 and 388-14-050.]

WAC 388-14A-2125 How do I give DCS permission to give my address to the other parent without going through the notice procedures of WAC 388-14A-2115? (1) Any party to a support order may authorize the division of child support (DCS) to release his or her address to the other party with no prior notice.

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

(a) In writing;

(b) Notarized; and

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

[Statutory Authority: RCW 74.08.090, 26.23.120. 01-03-089, § 388-14A-2125, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030 and 388-14-040.]

WAC 388-14A-2150 How much does it cost to get copies of DCS records? (1) WAC 388-01-030 authorizes the division of child support (DCS) to charge copying and postage costs for responses to public disclosure.

(2) DCS charges fifteen cents per page for copies.

(3) DCS may waive copy fees in appropriate circumstances.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2150, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030.]

WAC 388-14A-2155 Can I appeal a denial of public disclosure by the division of child support? (1) If the division of child support (DCS) denies a request for public disclosure, you may file an appeal with DCS Public Disclosure Appeals, P.O. Box 9162, Olympia WA 98507-9162.

(2) If DCS denies your appeal, you may pursue the other options listed in WAC 388-01-080.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2155, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030.]

WAC 388-14A-2160 If my information is confidential, can DCS report me to a credit bureau? (1) When a consumer reporting agency, as defined by 45 C.F.R. 303.105(a), requests information regarding the amount of overdue support owed by a noncustodial parent (NCP), the division of child support (DCS) provides this information if the amount of the support debt exceeds one thousand dollars.

(2) Before releasing information to the consumer reporting agency, DCS sends a written notice concerning the proposed release of the information to the NCP's last known address.

(3) The notice gives the NCP ten days from the date of the notice to request a conference board to contest the accuracy of the information. If the NCP requests a conference board, DCS does not release the information until a conference board decision has been issued.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2160, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030 and 388-14-410.]

WAC 388-14A-3131 What happens if neither parent appears for the hearing? (1) If neither parent appears at the scheduled hearing after being sent a notice of hearing, the administrative law judge (ALJ) enters an initial decision and order on default, declaring the support establishment notice's claim for support to be final and subject to collection action.

(2) The initial decision and order on default is subject to collection action on the twenty-second day after the order of default was mailed by the office of administrative hearings.

(3) A parent that did not appear may petition to vacate the default order pursuant to WAC 388-14A-6150.

(a) If the ALJ vacates the order of default, the ALJ then conducts a full hearing on the merits of the NFFR, NFPR or NFMR. All parties may participate in the hearing.

(b) If the parent who did not appear at the hearing is unsuccessful in the motion to vacate the default order, the ALJ may treat the petition as a petition to modify the support order.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 01-24-081, § 388-14A-3131, filed 12/3/01, effective 1/3/02; 00-15-016 and 00-20-022, § 388-14A-3131, filed 7/10/00 and 9/25/00, effective 11/6/00. Formerly WAC 388-11-400 and 388-11-425.]

WAC 388-14A-3132 What happens if only one parent appears for the hearing? (1) If one parent appears at the hearing, but the other parent fails to appear after being sent a notice of hearing, the administrative law judge (ALJ) enters an order of default against the parent that did not appear. The hearing proceeds as described in WAC 388-14A-3140.

(2) The division of child support (DCS) and the parent that did appear may enter a consent order, but not an agreed settlement. The obligation in the consent order may be higher or lower, or different from, the terms set forth in the notice, without further notice to the nonappearing parent, if necessary for an accurate support order. The terms of the consent order become final on the twenty-second day after the mailing of the order of default to the parent that did not appear.

(3) DCS and the parent that did appear may proceed to hearing. The ALJ may enter an initial decision setting an obligation which is higher or lower, or different from, the terms set forth in the notice, without further notice to the nonappearing parent, if necessary for an accurate support order.

(4) The parent that did not appear may petition to vacate the order of default pursuant to WAC 388-14A-6150.

(5) If the ALJ vacates the order of default, the ALJ then conducts a full hearing on the merits of the notice and finding of financial responsibility (NFFR), notice and finding of parental responsibility (NFPR) or notice and finding of medical responsibility (NFMR). All parties may participate in the hearing.

(6) If the parent who did not appear at the hearing is unsuccessful in the motion to vacate the default order, the ALJ may treat the petition as a petition to modify the support order.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 01-24-081, § 388-14A-3132, filed 12/3/01, effective 1/3/02; 00-15-016 and 00-20-022, § 388-14A-3132, filed 7/10/00 and 9/25/00, effective 11/6/00. Formerly WAC 388-11-400 and 388-11-425.]

WAC 388-14A-3275 The division of child support may amend an administrative notice at any time before a final administrative order is entered. (1) The division of child support (DCS) may orally amend a notice issued under this chapter at the hearing to conform to the evidence. When DCS amends a notice at the hearing:

(a) The administrative law judge (ALJ) may grant a continuance when necessary to give the parties additional time to present evidence and argument as to the amendment; and

(b) DCS must put the terms of the amendment in writing and provide a copy, in person or by regular mail to the last known address of the parties, and to the ALJ within a reasonable time after amending the notice.

(2) The amended notice does not generate a new hearing right.

(3) When DCS has obtained reliable information that the income basis of the notice is inaccurate, DCS amends a notice issued under WAC 388-14A-3115, 388-14A-3120, or 388-14A-3125 prior to seeking a default order for failure to appear. An amendment under this subsection must be made according to the terms of subsection (1) above.

(4) Subsection (3) of this section does not apply:

(a) To cases in which no one has requested a hearing; or

(b) After the ALJ has closed the hearing record.

(5) If DCS has amended the notice under this section and either the noncustodial parent or the custodial parent fail to appear at a rescheduled hearing date, the ALJ must enter a default order on the terms of the amended notice.

[Statutory Authority: RCW 74.08.090, 74.20A.055. 01-03-089, § 388-14A-3275, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-300.]

WAC 388-14A-3300 How does the division of child support require me to make my support payments to the Washington state support registry when my support order says to pay someone else? (1) If a support order requires the noncustodial parent (NCP) to pay support to any-

where other than the Washington state support registry (WSSR), the division of child support (DCS) may serve a notice on the NCP telling the NCP to make all future payments to the WSSR.

(2) DCS may serve a notice of support debt on a noncustodial parent (NCP) as provided in RCW 74.20A.040. See WAC 388-14A-3305.

(3) DCS may serve a notice of support owed on an NCP as provided in RCW 26.23.110. See WAC 388-14A-3310.

(4) When DCS serves a notice of support debt or a notice of support owed, DCS sends a notice to the payee under the order. See WAC 388-14A-3315.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-3300, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-3304 The division of child support serves a notice of support debt when it is enforcing a foreign court order or administrative order for support. (1) The division of child support (DCS) may serve a notice of support debt on a noncustodial parent (NCP) under RCW 74.20A.040 to provide notice that DCS is enforcing a foreign court order or foreign administrative order for support.

(2) DCS serves a notice of support debt like a summons in a civil action or by certified mail, return receipt requested.

(3) In a notice of support debt, DCS includes the information required by RCW 74.20A.040, the amount of current and future support, accrued support debt, any health insurance coverage obligation, and any day care costs under the court or administrative order.

(4) After service of a notice of support debt, the NCP must make all support payments to the Washington state support registry. DCS does not credit payments made to any other party after service of a notice of support debt except as provided in WAC 388-14A-3375.

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

(a) Files a request with DCS for a conference board under WAC 388-14A-6400. The effective date of a conference board request is the date DCS receives the request; or

(b) Obtains a stay from the superior court.

(6) A notice of support debt served in another state becomes final according to WAC 388-14A-7200.

(7) Enforcement of the following are not stayed by a request for a conference board or hearing under this section or WAC 388-14A-6400:

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

(b) Any portion of the support debt that the NCP and custodial parent (CP) fail to claim is not owed.

(8) Following service of the notice of support debt on the NCP, DCS mails to the last known address of the CP and/or the payee under the order:

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

(b) A notice to payee under WAC 388-14A-3315 regarding the payee's rights to contest the notice of support debt. The CP who is not the payee under the order has the same rights to contest the notice of support debt.

(9) If the NCP requests a conference board under subsection (5)(a) of this section, DCS mails a copy of the notice of conference board to the CP informing the CP of the CP's right to:

(a) Participate in the conference board; or

(b) Request a hearing under WAC 388-14A-3320 within twenty days of the date of a notice of conference board that was mailed to a Washington address. If the notice of conference board was mailed to an out-of-state address, the CP may request a hearing within sixty days of the date of the notice of conference board. The effective date of a hearing request is the date DCS receives the request.

(10) If the CP requests a hearing under subsection (9) of this section, DCS must:

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

(b) Notify the NCP of the hearing.

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

(12) The NCP is limited to a conference board to contest the notice and may not request a hearing on a notice of support debt. However, if the CP requests a hearing, the NCP may participate in the hearing.

(13) A notice of support debt must fully and fairly inform the NCP of the rights and responsibilities in this section.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310. 01-03-089, § 388-14A-3304, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-435.]

WAC 388-14A-3310 The division of child support serves a notice of support owed to establish a fixed dollar amount under an existing child support order. (1) The division of child support (DCS) may serve a notice of support owed on a noncustodial parent (NCP) under RCW 26.23.110 to establish a fixed dollar amount of monthly support and accrued support debt:

(a) If a support obligation under a court order is not a fixed dollar amount; or

(b) To implement an adjustment or escalation provision of the court order.

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

(3) DCS serves a notice of support owed on an NCP like a summons in a civil action or by certified mail, return receipt requested.

(4) Following service on the NCP, DCS mails a notice to payee under WAC 388-14A-3315.

(5) In a notice of support owed, DCS includes the information required by RCW 26.23.110, and:

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

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

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

(6) The NCP must make all support payments after service of a notice of support owed to the Washington state support registry. DCS does not credit payments made to any other party after service of a notice of support owed except as provided in WAC 388-14A-3375.

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

(a) Contacts DCS, and signs an agreed settlement;

(i) Files a request with DCS for a hearing under subsection (9) of this section; or

(ii) Obtains a stay from the superior court.

(b) A notice of support owed served in another state becomes final according to WAC 388-14A-7200.

(8) DCS may enforce at any time:

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

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

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

(9) A hearing on a notice of support owed is only for interpreting the court order for support and any modifying orders and not for changing or deferring the support provisions of the order. The hearing is only to determine:

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

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

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

(10) If the NCP requested the hearing, he or she has the burden of proving any defenses to liability that apply under WAC 388-14A-3370 or that the amounts stated in the notice of support owed are incorrect.

(11) A notice of support owed or an initial or review decision issued under subsection (9) of this section must inform the parties of the right to request a review of the order once yearly or on the date, if any, given in the order for an annual review.

(12) If an NCP requests a late hearing, the NCP must show good cause for filing the late hearing request if it is filed more than one year after service of the notice of support owed.

(13) A notice of support owed fully and fairly informs the NCP of the rights and responsibilities in this section.

(14) For the purposes of this section, WAC 388-14A-3315 and WAC 388-14A-3320, the term "payee" includes "physical custodian" or "custodial parent."

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310. 01-03-089, § 388-14A-3310, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-415.]

WAC 388-14A-3315 When DCS serves a notice of support debt or notice of support owed, we notify the custodial parent and/or the payee under the order. (1) The division of child support (DCS) sends a notice to a payee under a court order or foreign administrative order for support when DCS receives proof of service on the noncustodial parent (NCP) of:

(a) A notice of support owed under WAC 388-14A-3305; or

(b) A notice of support debt under WAC 388-14A-3310.

(2) DCS sends the notice to payee by first class mail to the last known address of the payee and encloses a copy of the notice served on the NCP.

(3) In a notice to payee, DCS informs the payee of the right to file a request with DCS for a hearing on a notice of support owed under WAC 388-14A-3105 or a notice of support debt under WAC 388-14A-3310 within twenty days of the date of a notice to payee that was mailed to a Washington address.

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

(5) The effective date of a hearing request is the date DCS receives the request.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310. 01-03-089, § 388-14A-3315, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-440.]

WAC 388-14A-3320 What happens at a hearing on a notice of support debt or notice of support owed? (1) A hearing on a notice of support debt or a notice of support owed is for the limited purpose of determining the support debt through the date of the hearing under the order.

(2) The office of administrative hearings (OAH) sends a notice of hearing on a notice of support debt to the noncustodial parent (NCP), to the division of child support (DCS), and to the payee. The NCP and the payee each may participate in the hearing as an independent party.

(3) If only one party appears and wishes to proceed with the hearing, the administrative law judge (ALJ) holds a hearing and issues an initial decision based on the evidence presented or continues the hearing.

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

(b) If neither the NCP nor the payee appears or wishes to proceed with the hearing, the ALJ issues an order of default against both parties.

(4) If the payee requests a late hearing on a notice of support owed or a notice of support debt, the payee must show good cause for filing the late hearing request.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-3320, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-3350 Are there any limits on how much back support the division of child support can seek to establish? (1) When no public assistance is being paid to the custodial parent (CP) and the children, the division of child support (DCS) starts the claim for support as of the date DCS receives the application for nonassistance services.

(2) When another state or an Indian tribe is paying public assistance to the CP and children, DCS starts the claim for support as of the date specified by the other state or tribe.

(3) For the notice and finding of parental responsibility, WAC 388-14A-3120(9) limits the back support obligation.

(4) When the state of Washington is paying public assistance to the CP and/or the children, the following rules apply:

(a) For support obligations owed for months on or after September 1, 1979, DCS must exercise reasonable efforts to locate the noncustodial parent (NCP);

(b) DCS serves a notice and finding of financial or parental responsibility within sixty days of the date the state assumes responsibility for the support of a dependent child on whose behalf support is sought;

(c) If DCS does not serve the notice within sixty days, DCS loses the right to reimbursement of public assistance payments made after the sixtieth day and before the notice is served;

(d) DCS does not lose the right to reimbursement of public assistance payments for any period of time:

(i) During which DCS exercised reasonable efforts to locate the NCP; or

(ii) For sixty days after the date on which DCS received an acknowledgment of paternity for the child for whom the state has assumed responsibility, and paternity has not been established.

(5) The limitation in subsection (4) does not apply to:

(a) Cases in which the physical custodian is claiming good cause for not cooperating with the department; and

(b) Cases where parentage is an issue and:

(i) Has not been established by superior court order; or

(ii) Is not the subject of a presumption under RCW 26.26.040 (1)(a) or (e).

(6) DCS considers a prorated share of each monthly public assistance payment as paid on each day of the month.

[Statutory Authority: RCW 74.08.090, 74.20A.055. 01-03-089, § 388-14A-3350, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-045.]

WAC 388-14A-3370 What legal defenses are available to a noncustodial parent when DCS seeks to enforce a support obligation? (1) A noncustodial parent (NCP) who objects to a notice and finding of financial, parental, or medical responsibility has the burden of establishing defenses to liability. Defenses include, but are not limited to:

(a) Proof of payment;

(b) The existence of a superior court or administrative order that sets the NCP's support obligation or specifically relieves the NCP of a support obligation for the child(ren) named in the notice;

(c) The party is not a responsible parent as defined by RCW 74.20A.020(7);

(d) The amount requested in the notice is inconsistent with the Washington state child support schedule, Chapter 26.19 RCW;

(e) Equitable estoppel, subject to WAC 388-14A-6500; or

(f) Any other matter constituting an avoidance or affirmative defense.

(2) A dependent child's or a custodial parent's ineligibility to receive public assistance is not a defense to the assessment of a support obligation.

(3) An NCP may be excused from providing support for a dependent child receiving public assistance under chapter 74.12 RCW if the NCP is the legal custodian of the child and has been wrongfully deprived of physical custody of the child. The NCP may be excused only for any period during which the NCP was wrongfully deprived of custody. The NCP must establish that:

(a) A court of competent jurisdiction of any state has entered an order giving legal and physical custody of the child to the NCP;

(b) The custody order has not been modified, superseded, or dismissed;

(c) The child was taken or enticed from the NCP's physical custody and the NCP has not subsequently assented to deprivation. Proof of enticement requires more than a showing that the child is allowed to live without certain restrictions the NCP would impose; and

(d) Within a reasonable time after deprivation, the NCP exerted and continues to exert reasonable efforts to regain physical custody of the child.

[Statutory Authority: RCW 74.08.090, 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-3370, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-065.]

WAC 388-14A-3375 What kinds of credits does the division of child support give when establishing or enforcing an administrative support order? (1) After the noncustodial parent (NCP) has been advised of the requirement to make payments to the Washington state support registry (WSSR) by service of a support establishment notice, or by entry of a support order requiring payments to WSSR, the NCP may obtain credit against the support obligation only:

(a) By cash, check, electronic funds transfer, or money order payments through WSSR or payment of health insurance premiums; or

(b) As provided under subsections (3) and (6) of this section.

(2) The division of child support (DCS) allows credit against a NCP's support debt for family needs provided directly to a custodial parent (CP), a child, or provided through a vendor or third party only when the:

(a) Items are provided before service of the notice on the NCP;

(b) NCP proves the items provided were intended to satisfy the NCP's support obligation; and

(c) Items are food, clothing, shelter, or medical attendance directly related to the care, support, and maintenance of a child.

(3) After service of the notice, an NCP may obtain credit against the parent's current support obligation only when the NCP proves that the payments were made and:

(a) DCS determines there:

(i) Is no prejudice to:

(A) The CP, a child, or other person; or

(B) An agency entitled to receive the support payments.

(ii) Are special circumstances of an equitable nature justifying credit for payments.

(b) A court of competent jurisdiction determines credit should be granted after a hearing where all interested parties were given an opportunity to be heard.

(4) DCS does not allow credit for shelter payments made before service of the notice in an amount more than the greater of the:

(a) Shelter allocation in the public assistance standards for the period when payments were made; or

(b) One-half of the actual shelter payment.

(5) DCS does not allow credit for shelter payments made after service of the notice.

(6) DCS applies credits for dependent benefits allowed under RCW 26.19.190 as required by WAC 388-14A-4200.

[Statutory Authority: RCW 74.08.090, 74.20A.055. 01-03-089, § 388-14A-3375, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-015 and 388-14-210.]

WAC 388-14A-3400 Are there limitations on how much of my income is available for child support? (1) There are two kinds of limitations based on your income when we set your child support obligation:

(a) The monthly support amount cannot exceed forty-five percent of your monthly net income, unless there are special circumstances as provided in chapter 26.19 RCW; and

(b) The monthly support amount cannot reduce your net monthly income below the one person need standard (WAC 388-478-0015), unless there are special circumstances as provided in chapter 26.19 RCW.

(2) RCW 74.20A.090 limits the amount that can be withheld from your wages for child support to fifty percent of your net monthly earnings.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-3400, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-205.]

WAC 388-14A-3500 A person must show good cause for filing a late request for hearing. (1) A person with a right to a hearing under this chapter may file a request for a late hearing after the period for requesting a timely hearing has passed. The effective date of a hearing request is the date the division of child support (DCS) receives the request.

(2) Filing a request for a late hearing does not stop:

(a) Collection and enforcement under chapters 26.18, 26.23, or 74.20A RCW;

(b) The effect of any qualified domestic relations order;

(c) Certification of the support debt to the Internal Revenue Service for an income tax refund offset; or

(d) Distribution upon receipt of moneys collected.

(3)(a) A person who files a late hearing request must show good cause for not filing a timely hearing request unless good cause is not required by the rule governing the notice that is objected to.

(b) If the administrative law judge (ALJ) finds good cause for filing a late hearing request, the ALJ:

(i) Issues a decision on the merits of the objection to the notice; and

(ii) Considers whether to order a stay of collection activities until such time as an initial decision or a temporary order under WAC 388-14A-3850(ff) is issued. Upon request, the ALJ must, based on the evidence presented at hearing, issue an order under WAC 388-14A-3850(ff), setting or denying temporary support pending the initial decision.

(c) If the ALJ does not find good cause for filing a late hearing request, the ALJ may issue a decision on modification of the current and future support obligation, if applicable, without a showing of a change of circumstances.

(4) If the ALJ finds good cause for filing a late hearing request, the division of child support (DCS) does not refund any excess amounts collected before the finding of good cause. The ALJ may issue a decision which gives credit against future support in the amount of the excess collections, so long as this does not:

(a) Create hardship to the children for whom support is sought; and

(b) Offset an overpayment of the obligation to the custodial parent (CP) against a debt owed to the department; or

(c) Offset an overpayment of the obligation to the department against a debt owed to the CP.

[Statutory Authority: RCW 74.08.090, 34.05.220(1), 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-3500, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-310.]

WAC 388-14A-3600 The parties may resolve any child support case by entering a consent order or an agreed settlement. (1) The division of child support (DCS) may enter a consent order or agreed settlement to finalize any dispute in which a party requests a hearing. DCS attempts to settle matters through agreement when possible.

(a) An agreed settlement is signed only by the parties (DCS, the custodial parent and the noncustodial parent).

(b) A consent order must be signed by the parties and by an administrative law judge (ALJ) provided that:

(i) In a telephone hearing, the ALJ may sign on behalf of any party if that party gives their consent on the record; and

(ii) The ALJ approves a consent order without requiring testimony or a hearing, unless entry of the order would be unlawful.

(2) An agreed settlement or consent order is final and enforceable on:

(a) The date the last party signs the agreed settlement, if all parties signed the agreed settlement;

(b) The date the ALJ signs the consent order; or

(c) If the ALJ defaults one of the parties to the proceeding, the latest of the following dates:

(i) The date the ALJ signed the consent order;

(ii) The date the last party signed the agreed settlement; or

(iii) The date the order of default is final.

(3) A party to a consent order or an agreed settlement may:

(a) Not petition for review of the settlement or order under WAC 388-02-0560;

(b) Petition for modification under WAC 388-14A-3925; and

(c) Petition to vacate the settlement or consent order under WAC 388-14A-3700. However, the ALJ may only vacate a settlement or consent order after making a finding of fraud by a party, or on any other basis that would result in manifest injustice.

(4) If a hearing has been scheduled, DCS files a copy of the agreed settlement or consent order with the office of administrative hearings (OAH), and OAH issues an order dismissing the hearing. There are no hearing rights on the order dismissing the hearing.

[Statutory Authority: RCW 74.08.090, 34.05.220(1). 01-24-082, § 388-14A-3600, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 34.05.220(1), 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-3600, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-150 and 388-11-430.]

WAC 388-14A-3700 When is it appropriate to vacate a default order? (1) If a party fails to appear at a hearing, the administrative law judge (ALJ) must, upon a showing of valid service, enter an initial decision and default order or proceed in the absence of the defaulting party as provided in WAC 388-14A-3131, 388-14A-3132, or 388-14A-3140.

(2) The ALJ must state in the decision that the:

(a) Support debt and the current support obligation stated in the notice are assessed, determined, and subject to collection action;

(b) Health insurance provisions of the notice are subject to direct enforcement action; and,

(c) Relief sought in the notice served by the division of child support is granted.

(3) Decisions and orders on default become final twenty-one days from the date of mailing under WAC 388-08-464 or chapter 388-02 WAC.

(4) Any party against whom the ALJ has entered an initial decision and order on default may petition the secretary or the secretary's designee for vacation of the default order, subject to the provisions, including time limits, of civil rule 60.

(5) DCS must:

(a) Request that the office of administrative hearings (OAH) schedule a hearing to determine whether or not the petitioner has good cause for vacating the default order; and

(b) Give any other parties to the hearing notice of the time and date of the hearing. OAH must send the notice to the last known address of the party.

(6) If, in a hearing under this section, the ALJ finds that the petitioner has good cause for vacating the default order, the ALJ:

(a) Must conduct a hearing on the merits of the petitioner's objection to the notice that was the basis for the hearing at which the petitioner failed to appear; and

(b) May stay any further collection to the extent provided for under the regulations authorizing the notice the parent originally objected to.

(7) The ALJ must apply civil rule 60 to determine whether the petitioner has good cause. Before vacating an order of default at the request of the NCP or CP, the ALJ must consider the prejudice to the non-DCS party that did appear for hearing.

[Statutory Authority: RCW 74.08.090, 34.05.220(1), 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-3700, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-120.]

WAC 388-14A-3800 Once a support order is entered, can it be changed? (1) Only the court that entered the order can modify a support order entered by a superior court or tribal court. If the order specifically states how the amount of support may be adjusted, the division of child support (DCS) may bring an administrative action under RCW 26.23.110 and WAC 388-14A-3310.

(2) As provided in WAC 388-14A-3925, DCS may review any support order to determine whether DCS should petition to modify the support provisions of the order.

(3) Either DCS, the CP or the NCP may petition to modify an administrative order under WAC 388-14A-3925.

(4) Under appropriate circumstances, an administrative support order may be vacated. See WAC 388-14A-3700.

[Statutory Authority: RCW 74.08.090, chapter 26.19 RCW, 34.05.220(1), 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-3800, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-140.]

WAC 388-14A-3810 Once a child support order is entered how long does the support obligation last? (1) A noncustodial parent's obligation to pay support under an administrative order continues until:

(a) A superior or tribal court order supersedes the order;

(b) The order is modified under WAC 388-14A-3925;

(c) The child reaches eighteen years of age;

(d) The child is emancipated;

(e) The child marries;

(f) The child becomes a member of the United States armed forces;

(g) The child or the responsible parent die;

(h) A responsible stepparent's marriage is dissolved; or

(i) A superior court order terminates the responsible parent's liability as provided under RCW 26.16.205.

(2) As an exception to the above rule, a noncustodial parent's obligation to pay support under an administrative order continues and/or may be established for a dependent child who is:

(a) Under nineteen years of age; and

(b) A full-time student reasonably expected to complete a program of secondary school or the equivalent level of vocational or technical training before the end of the month in which the student becomes nineteen years of age.

(3) A noncustodial parent's obligation to pay support under an administrative order may be temporarily suspended when the:

(a) Noncustodial parent (NCP) resides with the child for whom support is sought for purposes other than visitation;

(b) NCP reconciles with the child and the custodial parent; or

(c) Child returns to the residence of the NCP from a foster care placement, for purposes other than visitation.

(4) When the NCP's obligation to pay current support on a case is suspended under subsection (3) of this section, the division of child support (DCS) informs the NCP that the obligation is suspended, in writing, sent by regular mail to the NCP's last known address.

(5) If circumstances causing an NCP's support obligation to be temporarily suspended change, the support obligation resumes. DCS sends the NCP a notice that the obligation to make current support payments has resumed.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-3810, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-155.]

WAC 388-14A-3900 Does DCS review my support order to see if it should be modified? (1) When the division of child support (DCS) is providing support enforcement services under Title IV-D of the Social Security Act, DCS must:

(a) Review a superior court or administrative order for child support to determine whether DCS will petition to modify the child support provisions of the order; or

(b) Evaluate an interstate case to determine whether to refer the case to another state or an Indian tribe for review of the support order for modification.

(2) Recipients of payment services only under WAC 388-14A-2000(1) are not eligible for a review of their support order under this section until they have submitted an application for support enforcement services.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.70, 45 CFR 303.7, 45 CFR 303.8. 01-03-089, § 388-14A-3900, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-143.]

WAC 388-14A-3901 Under what circumstances does DCS review a support order for modification? (1) DCS reviews orders for child support under WAC 388-14A-3900 when:

(a) DCS has enough locate information to obtain personal service on both parties to the order; and

(b) The department is paying public assistance or has determined that the children are eligible for medical assistance, and thirty-five months have passed since:

(i) DCS last reviewed the order under this section;

(ii) The order was last modified; or

(iii) The order was entered.

(c) A party to the order, or another state's IV-D agency submits a request for review to DCS and thirty-five months have passed since:

(i) DCS or another state's IV-D agency last reviewed the order under this section;

(ii) The order was last modified; or

(iii) The order was entered.

(2) DCS may refer a request for review to another state's IV-D agency for action.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.70, 45 CFR 303.7, 45 CFR 303.8. 01-03-089, § 388-14A-3901, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-143.]

WAC 388-14A-3902 How does DCS notify me that my order is eligible for review for modification? (1) The division of child support (DCS) must:

(a) Notify recipients of support enforcement services, that the review and modification process is available; and

(b) Send notice of a pending review by regular mail to the last known address of the parties to the order thirty days before the review. The notice explains the parties':

(i) Rights in the review and modification process; and

(ii) Responsibility to submit:

(A) Completed Washington state child support schedule worksheets; and

(B) Income verification as required by the Washington state child support schedule, chapter 26.19 RCW.

(2) During the thirty days before conducting the review, DCS uses all appropriate procedures to obtain up to date income and asset information.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.70, 45 CFR 303.7, 45 CFR 303.8. 01-03-089, § 388-14A-3902, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-143.]

WAC 388-14A-3903 How does DCS decide whether to petition for modification of a support order? (1) The division of child support (DCS) petitions to modify a support order when DCS finds during the review that each of the following conditions are present:

(a) The proposed change in child support based on the Washington state child support schedule:

(i) Is at least twenty-five percent above or below the current support obligation;

(ii) Is at least one hundred dollars per month above or below the current support obligation; and

(iii) Is at least a two thousand four hundred dollar change over the remaining life of the support order; or

(iv) Will provide enough income to:

(A) Make the family ineligible for public assistance if the noncustodial parent (NCP) pays the full amount due under the proposed order; or

(B) Allow a family, otherwise eligible for public assistance, to remain off of assistance.

(b) The case meets the legal requirements for modification under RCW 26.09.170, 74.20A.059, or WAC 388-14A-3925.

(2) DCS may petition to modify the order without regard to subsection (1)(a) of this section when:

(a) The order does not require the NCP to provide health insurance coverage for the children; and

(b) Health insurance coverage is available through the NCP's employer or union at a reasonable cost; or

(c) Both parties agree to an order modifying the support amount.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.70, 45 CFR 303.7, 45 CFR 303.8. 01-03-089, § 388-14A-3903, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-143.]

WAC 388-14A-3904 How do I find out the results of DCS' review for modification? After reviewing a case under WAC 388-14A-3903, the division of child support (DCS) notifies the parties of:

(1) The findings of the review by regular mail at the parties' last known address;

(2) The parties' right to challenge the review findings; and

(3) The appropriate forum and procedure for challenging the review findings.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.70, 45 CFR 303.7, 45 CFR 303.8. 01-03-089, § 388-14A-3904, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-143.]

WAC 388-14A-3905 What if I don't agree with DCS' findings after review? (1) Except as provided under subsection (3) of this section, a party to the review process may contest DCS's review findings by requesting a modification conference within thirty days of the date of the notice of review findings.

(2) The modification conference is conducted by:

(a) DCS when the review findings indicate that the case is not appropriate for DCS to petition for modification under WAC 388-14A-3903;

(b) The county prosecutor, or the attorney general's office when DCS has referred the case to the prosecutor or

attorney general's office as a result of a review conducted under this section.

(3) When DCS has petitioned for modification of:

(a) A superior court order, the prosecutor or attorney general's office may, in their discretion, allow the parties to contest the review findings in the modification proceeding, rather than a modification conference. The modification proceeding is the sole means to contest the review findings.

(b) An administrative order, the parties may contest the review findings in the modification proceeding. In this case, the modification proceeding is the sole means to contest the review findings.

(4) In a modification conference, DCS the prosecutor, or the attorney general's office:

(a) Review all available income and asset information to determine if the review findings are correct; and

(b) Advise the parties of the results of the modification conference.

(5) A modification conference is not an adjudicative proceeding under the administrative procedure act, chapter 34.05 RCW.

(6) This section does not limit the right of any party to petition for a modification of the support order independent from the review and modification process.

(7) The CP's refusal to accept a proposed agreed order modifying support does not constitute noncooperation for the purpose of WAC 388-14A-2075.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.70, 45 CFR 303.7, 45 CFR 303.8. 01-03-089, § 388-14A-3905, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-143.]

WAC 388-14A-3906 Are there times when DCS does not review an order which would otherwise qualify for review? The division of child support (DCS) does not review an order under this section when the community services office (CSO) has notified DCS that the custodial parent (CP) has claimed good cause under WAC 388-422-0020, unless the CP requests the review.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.70, 45 CFR 303.7, 45 CFR 303.8. 01-03-089, § 388-14A-3906, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-143.]

WAC 388-14A-3907 DCS uses the Washington state child support schedule for reviewing orders for modification. (1) DCS applies the Washington state child support schedule when reviewing support orders under this section. All deviations available under chapter 26.19 RCW are available in the review and modification process under this section.

(2) For the purpose of this section and WAC 388-14A-3900 through 388-14A-3906, the term "party" means a party to a superior court order, or a noncustodial parent or a custodial parent entitled to petition for modification under RCW 74.20A.059.

[Statutory Authority: RCW 74.08.090, chapter 26.19 RCW, 45 CFR 302.70, 45 CFR 303.7, 45 CFR 303.8. 01-03-089, § 388-14A-3907, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-143.]

WAC 388-14A-3925 Who can ask to modify an administrative support order? (1) The division of child support (DCS), the custodial parent (CP) or the noncustodial parent (NCP) may request a hearing to prospectively modify the NCP's obligation under a support establishment notice. The request must be in writing and must state:

(a) Any circumstances that have changed; and

(b) The proposed new support amount.

(2) The petitioning party must file the request for modification with DCS.

(3) DCS serves a copy of the request for modification and notice of hearing on all other parties:

(a) By first class mail, if the parties have been advised in a court or administrative order of the requirement to keep DCS advised of their addresses; or

(b) By certified mail, return receipt requested or personal service if the support order does not require the parties to tell DCS their address.

(4) DCS, the administrative law judge (ALJ), or the department review judge:

(a) Prospectively modifies orders according to the terms of chapter 26.19 RCW and RCW 74.20A.059; and

(b) May only modify an order issued by a tribunal in another state according to the terms of RCW 26.21.580.

(5) If the nonpetitioning party fails to appear at the hearing, the ALJ issues a default order based on the Washington state child support schedule and the worksheets submitted by the parties, considering the terms set out in the request for modification.

(6) If the petitioning party fails to appear at the hearing, the ALJ enters an order dismissing the petition for modification.

(7) If the petition for modification does not comply with the requirements of subsection (1)(a) and (b) of this section, the ALJ may:

(a) Dismiss the petition; or

(b) Continue the hearing to give the petitioning party time to amend according to WAC 388-14A-3275 or to complete the petition.

(8) The ALJ may set the effective date of modification as the date the order is issued, the date the request was made, or any time in between. If an effective date is not set in the order, the effective date is the date the modification order is entered.

[Statutory Authority: RCW 74.08.090, 26.23.050, 74.20A.055, 74.20A.059. 01-03-089, § 388-14A-3925, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-140.]

WAC 388-14A-4000 When may the division of child support take collection action against a noncustodial parent? (1) Chapters 26.18, 26.23, 74.20 and 74.20A RCW authorize the division of child support (DCS) to take actions enforcing and collecting support obligations.

(2) DCS may take collection action against the noncustodial parent's income and assets to collect a support debt even if the NCP is making payments under a support order, unless DCS agrees in writing to limit collection action.

(3) If the NCP fails to make the total support payment under an administrative order when it is due:

(a) The entire support debt becomes due in full; and

(b) The portion of the administrative order requiring periodic payments on the support debt is automatically vacated without modifying the order.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.33 (a)(5). 01-03-089, § 388-14A-4000, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-170.]

WAC 388-14A-4010 Can I make the division of child support stop collection action against me? (1) Once a noncustodial parent (NCP) fails to make payments when due, an administrative law judge may not stop collection action by DCS.

(2) The NCP may contest collection action by:

(a) Filing an action in superior court under RCW 74.20A.200 or other applicable statutes; or

(b) Requesting a conference board under WAC 388-14A-6400.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-4010, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-4020 What collection tools does the division of child support use? The division of child support (DCS) uses any remedies available under state and federal law to enforce support obligations. These include, but are not limited to:

(1) Payroll deduction notice under RCW 26.23.060;

(2) Order to withhold and deliver under RCW 74.20A.080;

(3) Wage assignment;

(4) License suspension (see WAC 388-14A-4500);

(5) The DCS most wanted Internet site (see WAC 388-14A-4600);

(6) Federal income tax offset;

(7) Asset seizure;

(8) Liens;

(9) Medical insurance enrollment; and

(10) Contempt referral.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-4020, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-4030 How can the division of child support collect child support from my wages or other income source? (1) The division of child support (DCS) uses a payroll deduction, order to withhold and deliver or wage assignment to collect support when the noncustodial parent (NCP) has a source of income.

(2) When an NCP does not have an identifiable employer or source of income, DCS uses any or all of the collection remedies available under chapters 26.23, 74.20 and 74.20A RCW.

(3) If the NCP's source of income is an Indian tribe or tribal enterprise, DCS may seek collection remedies through tribal court.

[Statutory Authority: RCW 74.08.090, 45 CFR 302.33(a)(5). 01-03-089, § 388-14A-4030, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-170.]

WAC 388-14A-4040 DCS can serve some collection actions by electronic service. (1) An employer, or any other person, firm, corporation or political subdivision, or any department of the state or federal government may agree with the division of child support (DCS) to accept electronic data transmission (EDT) as service of the following documents:

(a) Notice of payroll deduction under RCW 26.23.060;

(b) Order to withhold and deliver under RCW 74.20A.080;

(c) Assignment of earnings under RCW 74.20A.240;

(d) Releases of any of these collection documents; and

(e) Amendments in the amount to be withheld under any of these collection documents.

(2) Agreements for service by EDT must be in writing. The employer, person, firm, corporation, political subdivision or department must agree to accept EDT as:

(a) Personal service of the withholding documents; and

(b) A written document for the purposes of chapters 26.23 and 74.20A RCW.

(3) DCS provides the party accepting EDT with copies of the current forms listed in subsection (2) above, as well as any updates to those forms. If DCS fails to provide an updated form, this does not excuse noncompliance with withholding documents served under the EDT agreement.

(4) An agreement to accept service by EDT does not alter the rights, duties and responsibilities related to income withholding action under chapters 26.23, 74.20 or 74.20A.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-4040, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-427.]

WAC 388-14A-4100 Can the division of child support make me provide health insurance for my children? (1) If a child support order requires the noncustodial parent (NCP) to provide health insurance for the children, the division of child support (DCS) attempts to enforce that requirement according to the terms of the order.

(2) Unless the support order specifies differently, an NCP is obligated to provide health insurance for dependent children if coverage is:

(a) Available or becomes available through the NCP's employment or union; and

(b) Available at a cost of not greater than twenty-five per cent of the NCP's basic support obligation.

(3) DCS serves a notice of intent to enforce a health insurance obligation if the support order:

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

(b) Does not inform the NCP that failure to provide health insurance or prove it is not available may result in enforcement of the order without notice to the NCP.

(4) DCS serves the notice of intent to enforce a health insurance obligation on the NCP by certified mail, return receipt requested, or by personal service.

(5) The notice advises the NCP that the NCP must submit proof of coverage, proof that coverage is not available, or proof that the NCP has applied for coverage, within twenty days of the date:

(a) Of service of the notice; or

(b) When health insurance coverage becomes available through the NCP's employer or union.

[Statutory Authority: RCW 74.08.090, 26.18.170, 26.18.180, 74.20A.055. 01-03-089, § 388-14A-4100, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-215 and 388-14-460.]

WAC 388-14A-4110 If my support order requires me to provide health insurance for my children, what do I have to do? (1) Once an administrative support order is entered requiring health insurance, the noncustodial parent (NCP) must take the following actions within twenty days:

(a) Provide health insurance coverage;

(b) Provide proof of coverage to the division of child support (DCS), such as:

(i) The name of the insurer providing the health insurance coverage;

(ii) The names of the beneficiaries covered;

(iii) The policy number;

(iv) That coverage is current; and

(v) The name and address of the NCP's employer.

(2) If health insurance coverage is not immediately available, the NCP must provide for coverage during the next open enrollment period and then submit proof of coverage as outlined in (1)(b) above.

(3) Medical assistance provided by the department under chapter 74.09 RCW does not substitute for medical insurance.

(4) A child's enrollment in Indian health services satisfies the requirements of this section.

[Statutory Authority: RCW 74.08.090, 26.18.170, 26.18.180, 74.20A.055. 01-03-089, § 388-14A-4110, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-215.]

WAC 388-14A-4115 Can my support order reduce my support obligation if I pay for health insurance? (1) Some support orders reduce the noncustodial parent's support obligation based on health insurance premiums paid by the NCP.

(2) An NCP is entitled to the reduction for premiums paid only if:

(a) NCP submits proof of coverage as provided in WAC 388-14A-4110 (1)(b); and

(b) NCP actually pays the required premium.

(3) If the NCP fails to submit proof or pay the premium, the division of child support (DCS) collects the NCP's adjusted basic support obligation without a reduction for health insurance premium payments.

[Statutory Authority: RCW 74.08.090, 26.18.170, 26.18.180, 74.20A.055. 01-03-089, § 388-14A-4115, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-215.]

WAC 388-14A-4120 DCS serves a notice of enrollment to enforce an obligation to provide health insurance coverage. (1) The division of child support (DCS) serves a notice of enrollment to enforce a noncustodial parent's obligation to provide health insurance coverage under chapter 26.18 RCW.

(2) DCS serves the notice of enrollment on the NCP's employer or union in the same manner as a summons in a civil action, or by certified mail, return receipt requested.

(3) DCS serves the notice of enrollment without notice to the NCP when:

(a) A court or administrative order requires the NCP to provide insurance coverage for a dependent child;

(b) The NCP fails to provide health insurance (either by not covering the child or by letting the coverage lapse) or fails to provide proof of coverage;

(c) The requirements of RCW 26.23.050 are met; and

(d) DCS has reason to believe that coverage is available through the NCP's employer or union.

(4) The notice of enrollment advises the employer or union that:

(a) The NCP is required to provide health insurance coverage for the children named in the notice;

(b) The employer or union is required to enroll the children in a health insurance plan offered by the employer or union if insurance the children can use is or will become available as provided in subsection (d) below;

(c) The employer or union must answer the notice of enrollment by completing the answer form and returning it to DCS within thirty-five days;

(d) The answer must confirm that the employer or union:

(i) Has enrolled the children in a health insurance plan which provides accessible coverage;

(ii) Will enroll the children in a health insurance plan providing accessible coverage during the next open enrollment period; or

(iii) Cannot enroll the children in a plan which provides accessible coverage, stating the specific reasons why coverage cannot be provided.

(e) The employer or union must provide:

(i) Information about the health insurance plan and policy as requested in the notice; and

(ii) Any necessary claim forms or membership cards as soon as they are available.

(f) The employer or union must withhold premiums from the NCP's net earnings if the NCP is required to pay part or all of the premiums for coverage under the health insurance plan.

(g) Noncompliance with the notice of enrollment subjects the employer or union to a fine of up to one thousand dollars under RCW 74.20A.270.

(5) DCS may take action under RCW 74.20A.270 to impose fines if the employer or union fails to comply with the terms of the notice of enrollment. For each failure to comply, DCS may assess a fine of:

(a) Two hundred dollars for the first month in which the employer or union fails to comply;

(b) Three hundred dollars for the second month of noncompliance; and

(c) Five hundred dollars for the third month of noncompliance.

(d) The maximum fine based on a single notice of enrollment is one thousand dollars.

[Statutory Authority: RCW 74.08.090, 26.18.170, 26.18.180, 74.20A.055. 01-03-089, § 388-14A-4120, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-215 and 388-14-480.]

WAC 388-14A-4130 What must an employer or union who receives a notice of enrollment do? (1) An employer or union who receives a notice of enrollment from the division of child support (DCS) must answer the notice

within thirty-five days of receipt, as provided in WAC 388-14A-4120(4).

(2) The employer or union must enroll the children named in the notice in a health insurance plan which the employer or union offers to the noncustodial parent (NCP) and which provides coverage accessible to the children, unless the NCP's current support obligation:

(a) Equals or exceeds fifty percent of the NCP's net earnings; or

(b) Plus the amount of the insurance premium for the children named in the notice exceeds fifty percent of the NCP's net earnings.

(3) Except for the limitation in subsection (2) above, the employer or union must enroll the children named in the notice in a health insurance plan which the employer or union offers to the noncustodial parent (NCP) and which provides coverage accessible to the children:

(a) Upon receipt of the notice of enrollment, even if the plan prevents immediate enrollment; or

(b) When accessible coverage becomes available, if coverage is not available at the time of the notice.

(4) If the employer or union offers more than one health insurance plan which could cover the children named in the notice, the employer or union must enroll the children in:

(a) The NCP's plan, unless accessible coverage is not available to the children under that plan; or

(b) The least expensive plan which provides accessible coverage for the children.

(5) The notice of enrollment remains in effect until:

(a) DCS withdraws the notice; or

(b) Health insurance coverage is no longer available through the employer or union.

(6) If coverage for the children is terminated, the employer or union must notify DCS within thirty days of the date coverage ends.

[Statutory Authority: RCW 74.08.090, 26.18.170, 26.18.180, 74.20A.055. 01-03-089, § 388-14A-4130, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-215.]

WAC 388-14A-4200 Do I get credit for dependent disability payments paid on my behalf to my children? (1) When the department of labor and industries or a self-insurer pays compensation under chapter 51.32 RCW on behalf of or on account of the child or children of a noncustodial parent (NCP), the division of child support (DCS) treats the amount of compensation the department or self-insurer pays on behalf of the child or children as if the NCP paid the compensation toward the NCP's child support obligations.

(2) When the social security administration pays social security disability dependency benefits, retirement benefits, or survivors insurance benefits on behalf of or on account of the child or children of an NCP who is a disabled person, a retired person, or a deceased person, DCS treats the amount of benefits paid for the child or children as if the NCP paid the benefits toward the NCP's child support obligation for the period for which benefits are paid.

(3) Under no circumstances does the NCP have a right to reimbursement of any compensation paid under subsection (1) or (2) of this section.

(4) The NCP gets credit only for payments made to the custodial parent or the state. The NCP does not get credit for dependent payments made to the NCP.

[Statutory Authority: RCW 74.08.090, 26.18.190, 74.20A.055. 01-03-089, § 388-14A-4200, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-280.]

WAC 388-14A-4300 What can I do if I think I'm paying more than the custodial parent is spending for day care or other special expenses for my child? (1) A noncustodial parent (NCP) who has paid child support under a court or administrative order and believes that day care or special child rearing expenses were not actually incurred in the amount of the order may file an application for an administrative hearing to determine if an overpayment of at least twenty per cent has occurred and how the overpayment should be reimbursed.

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

(b) The twelve-month period may be:

(i) A calendar year; or

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

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

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

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

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

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

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

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

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

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

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

(3) The effective date of a hearing request is the date DCS receives the written request.

(4) WAC 388-14A-4300 through 388-14A-4304 apply only to amounts paid during the twelve-month period ending May 31, 1996 or later.

[Statutory Authority: RCW 74.08.090, 34.05.220, 26.23.035, 74.20A.310. 01-03-089, § 388-14A-4300, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-376.]

WAC 388-14A-4301 Can I file a petition for reimbursement if I do not receive full support enforcement services? The division of child support (DCS) considers a petition for reimbursement or an application for hearing under WAC 388-14A-4300 to be an application for full support enforcement services if there is not already an open support enforcement case.

[Statutory Authority: RCW 74.08.090, 34.05.220, 26.23.035, 74.20A.310. 01-03-089, § 388-14A-4301, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-376.]

WAC 388-14A-4302 Who participates in a hearing on petition for reimbursement? (1) The division of child support (DCS) sends notice of a hearing under this subsection to the noncustodial (NCP) and to the custodial parent (CP).

(2) The NCP and the CP participate in the hearing as independent parties with the same procedural rights.

[Statutory Authority: RCW 74.08.090, 34.05.220, 26.23.035, 74.20A.310. 01-03-089, § 388-14A-4302, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-376.]

WAC 388-14A-4303 What happens at a hearing on petition for reimbursement? (1) The noncustodial parent (NCP) has the burden of proving the amounts actually paid by the NCP under the order.

(2) The custodial parent (CP) has the burden of proving the amounts actually incurred for day care and special child rearing expenses.

(3) The CP is not required to provide the address of the day care provider unless the administrative law judge (ALJ) finds that the information may be disclosed under the standards set forth in WAC 388-14A-2105 for the disclosure of the address of the CP.

(4) If the NCP fails to appear for the hearing, upon proof of service of the notice of hearing the ALJ issues an order of default against the NCP and dismisses the petition for reimbursement.

(5) If the CP fails to appear for the hearing, upon proof of service of the notice of hearing the ALJ issues an order of default against the CP and holds a hearing on the merits of the petition for reimbursement.

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

(a) If the ALJ determines that the overpayment amounts to twenty percent or more of the NCP's share of annual day care and special child rearing expenses, the ALJ enters an order stating:

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

(ii) The amount of the overpayment; and

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

(b) If the ALJ determines that the overpayment amounts to less than twenty percent of the NCP's share of annual day care and child rearing expenses, the ALJ enters an order stating:

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

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

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

[Statutory Authority: RCW 74.08.090, 34.05.220, 26.23.035, 74.20A.310. 01-03-089, § 388-14A-4303, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-376.]

WAC 388-14A-4304 What happens if the judge determines that I have paid too much for day care and special expenses? (1) If at a hearing under WAC 388-14A-4303, the administrative lay judge (ALJ) decides that the custodial parent (CP) has not incurred costs in the amount paid by the noncustodial parent (NCP), any ordered overpayment reimbursement may be applied an as offset to any nonassistance child support arrears owed by the NCP on that case only. If there is no nonassistance debt owed on the case, the reimbursement must be in the form of a credit against the NCP's future child support obligation:

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

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

(c) With the consent of the CP, in the form of a direct reimbursement by the CP to the NCP.

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

(a) Specifically agreed to by the CP; and

(b) Specifically agreed to in writing by DCS for periods when the CP or the dependent child receives public assistance.

[Statutory Authority: RCW 74.08.090, 34.05.220, 26.23.035, 74.20A.310. 01-03-089, § 388-14A-4304, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-376.]

WAC 388-14A-4500 What is the division of child support's license suspension program? (1) RCW 74.20A.320 provides that, in some circumstances, the division of child support (DCS) may certify for license suspension a noncustodial parent (NCP) who is not in compliance with a child support order. The statute calls the NCP the responsible parent.

(a) "Certify" means to establish that the NCP is not in compliance with a child support order and to ask the department of licensing and other state licensing entities to take appropriate action against licenses held by the NCP.

(b) "Responsible parent" is defined in 388-14A-1020. The responsible parent is also called the "noncustodial parent."

(2) "Noncompliance with a child support order" is defined in RCW 74.20A.020(18) and in WAC 388-14A-4510.

(3) When DCS certifies the NCP, the department of licensing or other licensing entities take action to deny, suspend, or refuse to renew the NCP's license, according to the terms of RCW 74.20A.320 (8) and (12).

(4) This section and sections WAC 388-14A-4505 through 388-14A-4530 cover the DCS license suspension program.

(5) DCS may certify an NCP who is not in compliance with a child support order to the department of licensing or any appropriate licensing entity. In determining which licensing entity receives the certification, DCS shall consider:

(a) The number and kind of licenses held by the parent; and

(b) The effect that suspension of a particular license will have in motivating the parent to pay support or to contact DCS to make appropriate arrangements for other relief.

(6) DCS may certify a parent to any licensing agency through which it believes the parent has obtained a license. DCS may certify a parent to as many licensing agencies as DCS feels necessary to accomplish the goals of the license suspension program.

[Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4500, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-510.]

WAC 388-14A-4505 The notice of noncompliance and intent to suspend licenses. (1) Before certifying a noncustodial parent (NCP) for noncompliance, the division of child support (DCS) must serve the NCP with a notice of noncompliance and intent to suspend licenses. This notice tells the NCP that DCS intends to submit the NCP's name to the department of licensing and any other appropriate licensing entity as a licensee who is not in compliance with a child support order.

(2) DCS must serve the notice by certified mail, return receipt requested. If DCS is unable to serve the notice by certified mail, DCS must serve the notice by personal service, as provided in RCW 4.28.080.

(3) The notice must include a copy of the NCP's child support order and must contain the address and phone number of the DCS office which issued the notice.

(4) The notice must contain the information required by RCW 74.20A.320(2), telling the NCP that:

(a) The NCP may request an administrative hearing, but that the hearing is limited in scope (see WAC 388-14A-4530);

(b) DCS will certify the NCP unless the NCP makes a request for hearing within twenty days of the date of service of the notice;

(c) The NCP may avoid certification by agreeing to make timely payments of current support and agreeing to a reasonable payment schedule on the support debt;

(d) Certification by DCS will result in suspension or nonrenewal of the NCP's license by the licensing entity until DCS issues a release stating that the NCP is in compliance with the child support order;

(e) Suspension of a license may affect the NCP's insurance coverage, depending on the terms of any policy;

(f) Filing a petition to modify the support obligation may stay (or put a hold on) the certification process; and

(g) Even after certification, the NCP may obtain a release from certification by complying with the support order.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-4505, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-520.]

WAC 388-14A-4510 Who is subject to the DCS license suspension program? (1) The division of child support (DCS) may certify a noncustodial parent (NCP) who is not in compliance with a child support order when:

(a) The NCP is required to pay child support under a court order or administrative order;

(b) The NCP is at least six months in arrears; and

(c) The NCP is not:

(i) In jail or prison, except if the NCP has other resources available;

(ii) A recipient of temporary assistance for needy families (TANF), Supplemental Security Income (SSI) or other exempt public assistance program; or

(iii) A WorkFirst participant who does not receive a cash grant.

(d) The NCP is not currently making payments to the Washington state support registry under a wage withholding action issued by DCS.

(2) "Noncompliance with a child support order" for the purposes of the license suspension program means a NCP has:

(a) Accumulated a support debt, also called an arrearage or arrears, totaling more than six months of child support payments;

(b) Failed to make payments under a written agreement with DCS towards a support debt in an amount that is more than six months' worth of payments; or

(c) Failed to make payments required by a superior court order or administrative order towards a support debt in an amount that is more than six months' worth of payments.

(3) There is no minimum dollar amount for the six months of arrears. The following are examples of when a NCP is at least six months in arrears:

(a) The child support order requires monthly payments of five hundred dollars. The NCP has not made a single payment since the order was entered seven months ago. This NCP is at least six months in arrears;

(b) The child support order requires monthly payments of one hundred dollars. The NCP has paid for the last few months, but owes a back debt of over six hundred dollars. This NCP is at least six months in arrears;

(c) The NCP owes a support debt according to a superior court judgment, which requires payments of one hundred dollars per month. The NCP has not made payment for eight months. This NCP is at least six months in arrears; or

(d) The child support order required monthly payments of two hundred dollars, but the child is over eighteen so no current support is owed. However, the NCP has a debt of over twelve hundred dollars. This NCP is at least six months in arrears.

(4) For the purposes of the license suspension program, a NCP is in compliance with the child support order when the amount owed in arrears is less than six months' worth of support.

[Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4510, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-530.]

WAC 388-14A-4515 How do I avoid having my license suspended for failure to pay child support? (1) DCS stays certification action if the noncustodial parent (NCP) takes the following action within twenty days of service of the notice:

(a) Requests an administrative hearing under WAC 388-14A-4530; or

(b) Contacts DCS to negotiate a reasonable payment schedule on the arrears and agrees to make timely payments of current support.

(i) The stay for negotiation may last a maximum of thirty calendar days after the NCP contacts DCS; and

(ii) If no payment schedule has been agreed to in writing after thirty calendar days have passed, DCS may proceed with certification of noncompliance;

(iii) A reasonable payment schedule is described in WAC 388-14A-4520, below; and

(iv) The NCP may request a conference board review under WAC 388-14A-6400 if the NCP feels that DCS has not negotiated in good faith.

(2) If the NCP files a court or administrative action to modify the child support obligation, DCS stays the certification action.

(3) The stay for modification action may not exceed six months unless DCS finds good cause to extend the stay.

(4) The NCP must notify DCS that a modification proceeding is pending and must provide a copy of the motion or request for modification to DCS.

[Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4515, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-540.]

WAC 388-14A-4520 Signing a repayment agreement may avoid certification for noncompliance. (1) If a noncustodial parent (NCP) signs a repayment agreement, DCS stays the certification action. The NCP must agree to pay current support in a timely manner and make regular payments on the support debt.

(2) The repayment agreement must state that if the NCP fails to make payments under the terms of the agreement, DCS may resume certification action.

(3) In setting the repayment amount, DCS must take into account the financial situation of the NCP and the needs of all children who rely on the NCP for support. The NCP must supply sufficient financial information to allow DCS to analyze and document the NCP's financial situation and requirements, including normal living expenses and emergencies.

(4) A reasonable monthly arrears payment is defined as a percentage of the NCP's "adjusted net income," which is the NCP's net monthly income minus any current support obligation. The following table sets forth the suggested monthly payments on arrears:

Monthly adjusted net income (ANI)	Monthly arrears payment = Percentage of ANI
$1,000 or less	2%
$1,001 to $1,200	3%
$1,201 to $1,500	4%
$1,501 to $1,900	5%
$1,901 to $2,400	6%
$2,401 to $3,000	7%
$3,001 or more	8%

(5) Examples of how to calculate the arrears payment are as follows:

(a) Monthly net income	=	$1,500
Current support	=	$300
Adjusted net income	=	$1,200
Arrears payment = 3% of ANI ($1,200)	=	$36
(b) Monthly net income	=	$3,100
Current support	=	$-0-
Adjusted net income	=	$3,100
Arrears payment = 8% of ANI ($3,100)	=	$248

(6) The NCP must document any factors which make the NCP eligible for an arrears payment less than the amount shown in the table in subsection (4). Such factors include, but are not limited to:

(a) Special needs children, or

(b) Uninsured medical expenses.

(7) The custodial parent and/or DCS must document any factors which make the NCP eligible for an arrears payment higher than the amount shown in the table in subsection (4). Such factors include, but are not limited to the factors listed in RCW 26.19.075 for deviation from the standard calculation for child support obligations.

[Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4520, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-550.]

WAC 388-14A-4525 How to obtain a release of certification for noncompliance. (1) After DCS has certified a noncustodial parent (NCP) to a licensing entity, the NCP may obtain a release from DCS by taking the following actions:

(a) Paying the support debt in full; or

(b) Signing a repayment agreement under WAC 388-14A-4520 and paying the first installment due under the agreement.

(2) DCS must provide a copy of the release to any licensing entity to which DCS has certified the NCP.

(3) The NCP must comply with any requirements of the licensing entity to get the license reinstated or reissued.

[Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4525, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-560.]

WAC 388-14A-4530 Administrative hearings regarding license suspension are limited in scope. (1) An administrative hearing on a notice of noncompliance under WAC 388-14A-4505 is limited to the following issues:

(a) Whether the person named in the child support order is the noncustodial parent (NCP);

(b) Whether the NCP is required to pay child support under a child support order; and

(c) Whether the NCP is at least six months in arrears.

(2) The administrative law judge (ALJ) is not required to calculate the outstanding support debt beyond determining whether the NCP is at least six months in arrears. Any debt calculation shall not be binding on the department or the NCP beyond the determination that there is at least six months of arrears.

(3) If the NCP requests a hearing on the notice, DCS stays the certification process until the hearing results in a finding that the NCP is not in compliance with the order, or that DCS is authorized to certify the NCP.

[Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4530, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-570.]

WAC 388-14A-4600 What is the division of child support's DCS most wanted Internet site? (1) The division of child support (DCS) maintains the DCS most wanted Internet site in an effort to:

(a) Locate noncustodial parents in order to establish or enforce a child support obligation; and

(b) Collect unpaid child support from noncustodial parents who have a support obligation.

(2) Anyone who has information concerning a noncustodial parent (NCP) is encouraged to provide that information to DCS.

[Statutory Authority: RCW 74.08.090, 26.23.120(2). 01-03-089, § 388-14A-4600, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-320.]

WAC 388-14A-4605 Whose picture can go on the division of child support's DCS most wanted Internet site? (1) If the child's custodial parent (CP) requests DCS to post the NCP to the DCS most wanted Internet site (also called the "site"), the CP must:

(a) Give written permission to DCS to post the NCP on the site; and

(b) Provide a photograph of the NCP.

(2) Only the NCP's photograph appears on the site. If the CP submits a group photograph, DCS edits out everyone except the NCP.

(3) DCS may post an NCP to the site when:

(a) The NCP:

(i) Has made no payments in at least six months (intercepted IRS refunds are not considered to be payments for purposes of this section); and

(ii) Owes at least five thousand dollars in back child support; or

(b) DCS has been unable to locate the NCP after trying other means for at least twelve months, and:

(i) There is a valid support order; or

(ii) There is a valid paternity affidavit filed for a child on the case, or

(iii) The NCP is:

(A) The mother of the child(ren) on the case; or

(B) The presumed father under RCW 26.26.040.

[Statutory Authority: RCW 26.23.120(2), 74.08.090. 01-24-083, § 388-14A-4605, filed 12/3/01, effective 1/3/02; 01-03-089, § 388-14A-4605, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-325.]

WAC 388-14A-4610 How does a noncustodial parent avoid being posted on the DCS most wanted Internet site? (1) DCS mails a letter to the noncustodial parent's last known mailing address by first class mail before posting a noncustodial parent (NCP) on the site. The letter advises the NCP:

(a) Who cannot be located, to provide DCS with a current address and employer information.

(b) Who owes back support, to:

(i) Pay the back support debt in full; or

(ii) Sign a repayment agreement with DCS and make the first payment under that agreement.

(2) If the NCP does not comply within twenty days of the date on the letter, DCS may post the NCP to the site.

(3) If the NCP wishes to dispute the amount of the support debt, the NCP may request a conference board review under WAC 388-14A-6400. Such a request does not stay (stop) DCS from posting the NCP to the site.

(4) If the NCP files a court or administrative action to vacate or modify the support obligation, DCS stays the posting of the NCP to the site for up to six months. If DCS finds good cause, DCS may extend the stay.

(5) If the NCP enters into a repayment agreement, but then misses a payment under the agreement, DCS may post the NCP to the site without further notice to the NCP.

[Statutory Authority: RCW 74.08.090, 26.23.120(2). 01-03-089, § 388-14A-4610, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-330.]

WAC 388-14A-4615 When does DCS remove a noncustodial parent from the DCS most wanted Internet site? (1) DCS must remove the noncustodial parent (NCP)from the site if:

(a) The NCP pays the back support debt in full;

(b) The NCP files a court or administrative action to modify or vacate the support obligation (subject to the limitations in WAC 388-14A-3700);

(c) The NCP enters into a repayment agreement and makes the first payment under that agreement (subject to the limitations in WAC 388-14A-4520);

(d) The CP withdraws permission for the posting.

(2) DCS may remove an NCP from the site even if the NCP has not complied with the requirements of this section.

(3) If an NCP receives a warning letter for locate purposes only, DCS must remove the NCP who provides a current address and employment information.

[Statutory Authority: RCW 74.08.090, 26.23.120(2). 01-03-089, § 388-14A-4615, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-335.]

WAC 388-14A-4620 What information does the division of child support post to the DCS most wanted Internet site? (1) DCS may post to the site any information about the noncustodial parent (NCP) which may aid in locating the NCP or collecting child support from the NCP, such as:

(a) Full name and aliases;

(b) Photograph;

(c) Physical description;

(d) Birth date;

(e) Last known address;

(f) Usual occupation;

(g) Number and ages of children;

(h) Amount of back support owed; and

(i) Ongoing monthly support obligation, if any.

(2) DCS does not post the names or photographs of the CP or the children.

[Statutory Authority: RCW 74.08.090, 26.23.120(2). 01-03-089, § 388-14A-4620, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-340.]

WAC 388-14A-5000 How does the division of child support distribute support payments? (1) Under state and federal law, the division of child support (DCS) distributes support money it collects or receives to the:

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

(b) Payee under the order, or to the custodial parent (CP) of the child according to WAC 388-14A-5050;

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

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

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

(2) If DCS is unable to distribute support money because the location of the family or person is unknown, it must exercise reasonable efforts to locate the family or person. When the family or person cannot be located, DCS handles the money in accordance with chapter 458-65 WAC, the uniform unclaimed property act rules.

(3) WAC 388-14A-5000 and sections WAC 388-14A-5001 through 388-14A-5008 contain the rules for distribution of support money by DCS.

(4) DCS changes the distribution rules based on changes in federal statutes and regulations.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5000, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-250, 388-14-270, and 388-14-273.]

WAC 388-14A-5001 What procedures does DCS follow to distribute support payments? When distributing support money, the division of child support (DCS) does the following:

(1) Records payments in exact amounts of dollars and cents;

(2) Distributes support money within two days of the date DCS receives the money, unless DCS is unable to distribute the payment for one or more of the following reasons:

(a) The location of the payee is unknown;

(b) DCS does not have sufficient information to identify the accounts against which or to which it should apply the money;

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

(d) DCS receives prepaid support money and is holding for distribution in future months under subsection (2)(e) of this section;

(e) DCS mails a notice of intent to distribute support money to the custodial parent (CP) under WAC 388-14A-5050;

(f) DCS may hold funds and not issue a check to the family for amounts under one dollar. DCS must give credit for the payment, but may delay disbursement of that amount until a future payment is received which increases the amount of the payment to the family to at least one dollar. If no future payments are received which increase the payment to the family of at least one dollar, DCS transfers the amount to the department of revenue under RCW 63.29.130. This subsection does not apply to disbursements which can be made by electronic funds transfer (EFT), or to refunds of intercepted federal income tax refunds; or

(g) Other circumstances exist which make a proper and timely distribution of the money impossible through no fault or lack of diligence of DCS.

(3) Distribute support money based on the date DCS receives the money, except as provided under WAC 388-14A-5005.

[Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.188, 74.20A.310, 42 U.S.C. 666(a)14. 01-24-078, § 388-14A-5001, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5001, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270 and 388-14-273.]

WAC 388-14A-5002 How does DCS distribute support money in a nonassistance case? (1) A nonassistance case is one where the family has never received a cash public assistance grant.

(2) The division of child support (DCS) applies support money within each Title IV-D nonassistance case:

(a) First, to satisfy the current support obligation for the month DCS received the money;

(b) Second, to the noncustodial parent's support debts owed to the family;

(c) Third, to prepaid support as provided for under WAC 388-14A-5008.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5002, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5003 How does DCS distribute money in an assistance case? (1) An assistance case is one where the family is currently receiving a cash public assistance grant.

(2) The division of child support (DCS) applies support money within each Title IV-D assistance case:

(a) First, to satisfy the current support obligation for the month DCS received the money (this money is kept by the state under WAC 388-14A-2035);

(b) Second, to satisfy support debts which are permanently assigned to the department to reimburse the cumulative amount of assistance which has been paid to the family (this money is kept by the state under WAC 388-14A-2035);

(c) Third, to satisfy support debts which are temporarily assigned to the department to reimburse the cumulative amount of assistance paid to the family (this money is kept by the state under WAC 388-14A-2035);

(d) Fourth, to satisfy support debts which exceed the cumulative amount of unreimbursed assistance which has been paid to the family (this money goes to the family);

(e) Fifth, to prepaid support as provided for under WAC 388-14A-5008.

[Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.188, 74.20A.310, 42 U.S.C. 666(a)14. 01-24-078, § 388-14A-5003, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5003, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5004 How does DCS distribute money in a former assistance case? (1) A former assistance case is one where the family is not currently receiving a cash public assistance grant, but has at some time in the past.

(2) The division of child support (DCS) applies support money within each Title IV-D former-assistance case:

(a) First, to satisfy the current support obligation for the month DCS received the money;

(b) Second, to satisfy support debts which accrued after the family's most recent period of assistance;

(c) Third, to satisfy support debts which are temporarily assigned to the department to reimburse the cumulative amount of assistance which has been paid to the family;

(d) Fourth, to satisfy support debts which are permanently assigned to the department to reimburse the cumulative amount of assistance which has been paid to the family;

(e) Fifth, to satisfy support debts which exceed the cumulative amount of unreimbursed assistance which has been paid to the family; and

(f) Sixth, to prepaid support as provided for under WAC 388-14A-5008.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5004, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5005 How does DCS distribute intercepted federal income tax refunds? The division of child support (DCS) applies intercepted federal income tax refunds in accordance with 42 U.S.C. Sec. 657, as follows:

(1) First, to support debts which are permanently assigned to the department to reimburse public assistance payments; and

(2) Second, to support debts which are temporarily assigned to the department to reimburse public assistance payments; and

(3) Third, to support debts that are not assigned to the department; and

(4) To support debts only, not to current and future support obligations. DCS must refund any excess to the noncustodial parent (NCP).

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5005, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5006 How does DCS distribute support money when the paying parent has more than one case? Except as provided in WAC 388-14A-5005, when the NCP has more than one Title IV-D case, the division of child support (DCS) distributes support money:

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

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

(3) Third, within each Title IV-D case according to WAC 388-14A-5002 or 388-14A-5003.

[Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.188, 74.20A.310, 42 U.S.C. 666(a)14. 01-24-078, § 388-14A-5006, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5006, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5007 If the paying parent has more than one case, can DCS apply support money to only one specific case? (1) The division of child support (DCS) applies amounts to a support debt owed for one family or household and distributes the amounts accordingly, rather than make a proportionate distribution between support debts owned to different families, when:

(a) Proportionate distribution is administratively inefficient; or

(b) The collection resulted from the sale or disposition of a specific piece of property against which a court awarded the custodial parent (CP) a judgment lien for child support; or

(c) The collection is the result of a contempt order which provides that DCS must distribute the amounts to a particular case.

(2) If the collection is the result of an automated enforcement of interstate (AEI) transaction under RCW 74.20A.188, DCS applies the payment as provided in WAC 388-14A-5006, even if the requesting state wants the payment applied to a specific case.

[Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.188, 74.20A.310, 42 U.S.C. 666(a)14. 01-24-078, § 388-14A-5007, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5007, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5008 Can the noncustodial parent prepay support? If the division of child support (DCS) receives or collects support money representing payment on the required support obligation for future months, DCS must:

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

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

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

(a) DCS received prepaid support money;

(b) DCS intends to distribute the prepaid money as support payments become due in the future; and

(c) The person may request a conference board under WAC 388-14A-6400 to determine if DCS should immediately distribute the prepaid support money.

(d) DCS does not mail the notice referred to in WAC 388-14A-5008 of this section if the prepaid support is equal to or less than one month's support obligation.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5008, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5050 When does DCS send a notice of intent to distribute support money? (1) The division of child support (DCS) may distribute support money to a custodial parent (CP) who is not the payee under the support order if the CP signs a sworn statement that:

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

(b) The CP is not wrongfully depriving the payee of physical custody.

(2) Before DCS begins distributing support money to a CP who is not the payee under the support order, DCS sends the payee under the support order and the noncustodial parent (NCP) a notice of intent to distribute support money and a

copy of the sworn statement of the CP to their last known addresses by first class mail. The notice states:

(a) DCS intends to distribute support money collected under the support order to the CP; and

(b) The name of the CP.

(3) DCS distributes support money to the CP when the notice of intent to distribute support money becomes final.

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

(b) A notice of intent to distribute support money served in another state becomes final according to WAC 388-14A-7200.

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

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

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

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

(b) DCS may not reimburse the payee under the support order for amounts DCS sent to the CP before the administrative order on a late hearing request becomes final.

(7) The payee under the support order must give DCS and the CP notice of any judicial proceeding to contest a notice of intent to distribute support money.

(8) If the support order is a court order, DCS files a copy of the notice of intent to distribute support money or the final administrative order entered on a notice of intent to distribute support money with the clerk of the court where the support order was entered.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5050, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270 and 388-14-271.]

WAC 388-14A-5100 What kind of distribution notice does the division of child support send? (1) The division of child support (DCS) mails a distribution notice once each month, or more often, to the last known address of a person for whom it received support during the month, except as provided under subsection (6) of this section.

(2) DCS includes the following information in the notice:

(a) The amount of support money DCS received and the date of collection;

(b) A description of how DCS allocated the support money between current support and the support debt; and

(c) The amount DCS claims as reimbursement for public assistance paid, if applicable.

(3) The person to whom a distribution notice is sent may file a request for a hearing under subsection (4) of this section within ninety days of the date of the notice to contest how DCS distributed the support money, and must make specific objections to the distribution notice. The effective date of a hearing request is the date DCS receives the request.

(4) A hearing under this section is for the limited purpose of determining if DCS correctly distributed the support money described in the contested notice.

(5) A person who requests a late hearing must show good cause for being late.

(6) This section does not require DCS to send a notice to a recipient of payment services only.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5100, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270 and 388-14-274.]

WAC 388-14A-5200 What is a "total versus total" notice? (1) The division of child support (DCS) identifies cases needing a "total versus total" calculation, which compares amounts of public assistance paid to the family with amounts of support collected and uncollected support debt. DCS performs a total versus total calculation upon the request of the custodial parent (CP) or a DCS field office, usually only after the assistance grant has ended.

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

(b) The total versus total calculation indicates the amounts of support paid by each noncustodial parent (NCP) and how DCS distributed the support.

(c) DCS may at any time review a case to determine if a total versus total calculation is appropriate.

(2) When DCS completes a total versus total calculation at the request of the CP, DCS mails a total versus total notice to the last known address of the former assistance recipient.

(3) The person to whom DCS sends a total versus total notice may, within ninety days of the date of the notice, file a request for a conference board under WAC388-14A-6400 to contest the distribution of support money and the allocation of uncollected support debt. The person must state specific objections to the total versus total notice. The effective date of a request conference board is the date DCS receives the request.

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5200, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-276.]

WAC 388-14A-5300 How does the division of child support recover a support payment which has already been distributed? (1) The division of child support (DCS) may serve a notice to recover a support payment on the person who received the payment when DCS:

(a) Distributed the money in error;

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

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

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

(2) DCS serves a notice to recover a support payment like a summons in a civil action or by certified mail, return receipt requested.

(3) In the notice, DCS must identify the support payment DCS seeks to recover.

(4) DCS may take action to enforce the notice to recover a support payment without further notice once the notice becomes final.

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

(b) A notice to recover a support payment may be served in another state to recover a payment disbursed by DCS under RCW 26.21.385. A notice to recover a support payment served in another state becomes final according to WAC 388-14A-7200.

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

(6) A person who files a late request for a hearing on a notice to recover a support payment must show good cause for being late.

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

(8) If a public assistance recipient receives a support payment directly from a noncustodial parent (NCP) and fails to remit it to DCS as required, DCS recovers the money as retained support under WAC 388-14A-5500.

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

[Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5300, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-272.]

WAC 388-14A-5400 How does the division of child support tell the custodial parent when DCS adjusts the amount of debt owed on the case? (1) The division of child support (DCS) mails a debt adjustment notice to the payee under a court order within thirty days of the date DCS reduces the amount of the court-ordered support debt it intends to collect if that reduction was due to:

(a) A mathematical error in the debt calculation;

(b) A typographical error in the stated debt;

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

(d) Proof the noncustodial parent (NCP) made payments that DCS had not previously credited against the support debt.

(2) The debt adjustment notice must contain the following information:

(a) The amount of the reduction;

(b) The reason DCS reduced the support debt, as provided under subsection (1) of this section;

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

(d) A statement that DCS continues to provide support enforcement services whether or not the payee objects to the debt adjustment notice.

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

(4) A debt adjustment notice served in another state becomes final according to WAC 388-14A-7200.

(5) A hearing under this section is for the limited purpose of determining if DCS correctly reduced the support debt as stated in the notice of debt adjustment.

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

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-5400, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-450.]

WAC 388-14A-5500 How does the division of child support collect support debts owed by someone other than a noncustodial parent? (1) Sections 17 and 18, chapter 171, Laws of 1979 ex. sess. (RCW 74.20.320 and 74.20A.270), provide that a custodian of children or other person who receives support money which money was paid, in whole or in part, toward a support obligation under 42 U.S.C. 602 (a)(26)(A), sections 17 and 22, chapter 171, Laws of 1979 ex. sess., or RCW 74.20A.030 must remit that money to the division of child support (DCS) within eight days of receipt, and is indebted to the department for this amount of money.

(2) By not remitting support money described in subsection (1) of this section, a custodial parent (CP) or other person makes, without the necessity of signing any document, an irrevocable assignment to the department of an equal amount of any support debt not already assigned to the department, but owing to the CP or other person, or an equal amount of any support debt which may accrue in the future. DCS may use the collection procedures of chapter 74.20A RCW to collect this assigned delinquency, to satisfy a debt owed under subsection (1) of this section.

(3) DCS may also make a set-off to pay the debt under subsection (1) of this section from support money in DCS' possession or in the possession of a county clerk or other forwarding agent if that money was paid to satisfy a support delinquency.

(4) DCS may take action alternatively or simultaneously under subsections (1), (2) and (3) of this section but the department may not collect and retain more money than the debt described under subsection (1) of this section, refunding the excess, without deducting fees, to the CP.

(5) DCS must give the CP or other person an account of actions taken under subsections (2) or (3) of this section.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-5500, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-5505 DCS uses a notice of retained support to claim a debt owed to DCS. The division of child support (DCS) serves a notice of retained support setting forth:

(1) The amount of support money claimed by the department as property of the department by assignment, subrogation or by operation of law or legal process under chapter 74.20A RCW;

(2) The legal basis for the claim of ownership by the department;

(3) A description of the person, firm, corporation, association, or political subdivision who is or has been in possession of the support moneys together with enough detail to identify the amounts in issue;

(4) A statement that, effective with the date of service of the notice, the department will impound and hold in trust all money not yet disbursed or spent and all similar money received in the future, pending answer to the notice and any hearing which is requested;

(5) A statement that the notice must be answered, under oath and in writing, within twenty days of the date of service of the notice;

(6) A statement that the answer to the notice must include true answers to the questions in the notice and must either acknowledge the department's right to the money or request an administrative hearing to determine ownership of the money;

(7) A statement that the burden of proof in a hearing on a notice of retained support debt under this section is on the department to establish ownership of the support money claimed;

(8) A statement that, if the person, firm, corporation, association, or political subdivision or officer or agent thereof does not answer or make a request for hearing in a timely manner, the department's claim will be assessed and determined and subject to collection action as a support debt according to chapter 74.20A RCW; and

(9) A statement that the department may collect a support debt, as assessed and determined, and that the property of the debtor, without further advance notice or hearing, is subject to lien and foreclosure, distraint, seizure and sale, or order to withhold and deliver to satisfy the debt. The department may not take collection action against a recipient of public assistance during the period of time the recipient remains on assistance except as provided in RCW 74.20A.270 and WAC 388-14A-2040.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-5505, filed 1/17/01, effective 2/17/01. Formerly WAC 388-13-090.]

WAC 388-14A-5510 How does DCS serve a notice of retained support? The division of child support (DCS) serves the notice of retained support on the person, firm, corporation, association, or political subdivision or any officer or agent thereof in the manner prescribed for the service of a summons in a civil action, or by certified mail, return receipt requested. The receipt is *prima facie* evidence of service.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-5510, filed 1/17/01, effective 2/17/01. Formerly WAC 388-13-030.]

WAC 388-14A-5515 What happens if I don't respond to a notice of retained support or request a hearing? (1) After service of a notice of retained support under WAC 388-14A-5510, if the person, firm, corporation, association, or political subdivision or any officer or agent thereof fails to answer in a timely manner, the claim of the department is final and subject to collection action as a support debt according to chapter 74.20A RCW.

(2) To be timely, a hearing request or response must be received by the division of child support within twenty days of service of the notice.

[Statutory Authority: RCW 74.08.090, 34.05.220. 01-03-089, § 388-14A-5515, filed 1/17/01, effective 2/17/01. Formerly WAC 388-13-040 and 388-13-110.]

WAC 388-14A-5520 What happens if I make a timely objection to a notice of retained support? (1) Any debtor who objects to all or any part of a notice of retained support may, within twenty days from the date of service of the notice, file an application for an administrative hearing. An objection under this section is the same thing as a general denial of liability to the department.

(2) The notice of retained support does not become final until there is a final administrative order.

(3) If the objection is timely, the department serves the notice of hearing on the appellant or the appellant's representative by certified mail or another method showing proof of receipt.

(4) The department must notify the appellant that it is the appellant's responsibility to notify the department of the appellant's mailing address at the time the application is filed and also of any change of address after filing the application. Mailing by certified mail, return receipt requested, to the last address provided by the appellant constitutes service under chapters 74.20A and 34.05 RCW.

[Statutory Authority: RCW 74.08.090, 34.05.220. 01-03-089, § 388-14A-5520, filed 1/17/01, effective 2/17/01. Formerly WAC 388-13-060.]

WAC 388-14A-5525 What happens at the hearing on a notice of retained support? (1) An administrative hearing on a notice of retained support is limited to the determination of the ownership of the amounts claimed in the notice or the reasonableness of a repayment agreement offered to a public assistance recipient for recovering child support under RCW 74.20A.270 and WAC 388-14A-5505.

(2) The department has the burden of proof to establish ownership of the support money claimed, including but not limited to amounts not yet disbursed or spent.

(3) The administrative law judge (ALJ) must allow the division of child support (DCS) to orally amend the notice of retained support at the hearing to conform to the evidence. The ALJ may grant a continuance, if necessary, to allow the debtor additional time to present evidence or argument in response to the amendment.

(4) The ALJ serves a copy of the initial decision on DCS and the debtor or the debtor's representative by certified mail to the last address provided by each party or by another method showing proof of receipt.

(5) If the debtor fails to appear at the hearing, the ALJ, upon a showing of valid service, enters an initial decision and

order declaring that the amount of the support money claimed in the notice, is subject to collection action under chapter 74.20A RCW.

[Statutory Authority: RCW 74.08.090, 34.05.220. 01-03-089, § 388-14A-5525, filed 1/17/01, effective 2/17/01. Formerly WAC 388-13-070 and 388-13-110.]

WAC 388-14A-5530 Can I request a late hearing on a notice of retained support? (1) Within one year from the date the division of child support (DCS) serves a notice of retained support, the person, firm, corporation, association, political subdivision or any officer or agent thereof may petition DCS for a hearing, upon a showing of any of the grounds listed in RCW 4.72.010 or CR 60.

(2) A copy of the objection must be served by certified mail, return receipt requested, or by service in the manner of a summons in a civil action on the district field office of DCS.

(3) The filing of the petition does not stay any collection action that DCS has taken, but the debtor may petition the secretary or the secretary's designee for an order staying collection action pending final decision of the secretary or the secretary's designee or the courts on an appeal made under chapter 34.05 RCW.

(4) Any money held or taken by collection action before any such stay and any support money claimed by the department, including amounts to be received in the future, to which the department may have a claim, must be held in trust pending the final decision and appeal, if any, to be disbursed in accordance with the final decision.

(5) If someone files a petition for a hearing, the department serves the notice of hearing on the appellant, the appellant's attorney, or other designated representative by certified mail or other method showing proof of receipt.

(6) The department notifies the appellant that the appellant must notify the department of the appellant's mailing address at the time the petition is filed and also of any change of address after filing the petition. Mailing by certified mail, return receipt requested, to the last address provided by the appellant constitutes service under chapters 74.20A and 34.05 RCW.

[Statutory Authority: RCW 74.08.090, 34.05.220. 01-03-089, § 388-14A-5530, filed 1/17/01, effective 2/17/01. Formerly WAC 388-13-050.]

WAC 388-14A-5535 How does DCS collect a debt established on a notice of retained support? The division of child support (DCS) may take action under chapter 74.20A RCW to collect debts determined under WAC 388-14A-5505.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-5535, filed 1/17/01, effective 2/17/01. Formerly WAC 388-13-085.]

WAC 388-14A-5540 Can I just acknowledge that I owe money to the division of child support? If you answer the notice of retained support acknowledging that the department owns the support payments in question, the division of child support (DCS) may take collection action under chapter 74.20A RCW if you fail to pay the debt within twenty-one days of the date DCS receives the answer.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-5540, filed 1/17/01, effective 2/17/01. Formerly WAC 388-13-100.]

WAC 388-14A-6000 Which statutes and regulations govern the division of child support's hearing process? (1) Hearings under this chapter are governed by:

(a) The Administrative Procedure Act, chapter 34.05 RCW, RCW 74.20A.055; and

(b) Chapter 388-02 WAC.

(2) If any provision in this chapter conflicts with or is inconsistent with chapter 388-02 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 74.08.090, 34.05.220. 01-03-089, § 388-14A-6000, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-180 and 388-13-120.]

WAC 388-14A-6100 The division of child support accepts oral requests for hearing or conference board. (1) Except for the instances listed in subsection (8), the division of child support (DCS) accepts either a written or an oral request for hearing or conference board, even though other sections of this chapter or the relevant statutes may provide that objections and hearing requests should be in writing.

(2) The subject matter of the objection determines whether the matter is set as a conference board or hearing, unless there is a specific request for an administrative hearing under chapter 34.05 RCW.

(3) DCS processes oral and written requests for hearing in the same manner.

(4) An oral request for hearing is complete if it contains enough information to identify the person making the request, the DCS action, and the case or cases involved in the hearing request.

(5) The effective date of an oral request for hearing is the date that someone makes a complete oral request for hearing, to any DCS representative in person or by leaving a message on the automated voice mail system of any DCS field office.

(6) When making an oral request, you do not need to specify whether you want a hearing under chapter 34.05 RCW or a conference board under WAC 388-14A-6400.

(7) You can make an oral request for hearing or conference board on behalf of another person, if you have written authorization to act on their behalf. The effective date of an oral request for hearing or conference board made on behalf of another person is the date that DCS receives the written authorization.

(8) There are two types of hearing requests which must be in writing:

(a) A petition for prospective modification under WAC 388-14A-3925; and

(b) A petition for reimbursement for day care expenses under WAC 388-14A-4300.

[Statutory Authority: RCW 74.08.090, 34.05.220. 01-03-089, § 388-14A-6100, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-500.]

WAC 388-14A-6150 What can I do if there was a default order entered against me in an administrative hearing? (1) Any party against whom the administrative law judge (ALJ) has entered an initial decision and order on default may petition the DSHS board of appeals for vacation of the default order, subject to the provisions, including time limits, of civil rule 60.

(2) Specific rules on administrative support establishment notices are in WAC 388-14A-3700.

(3) Upon receipt of a request to vacate a default order, the department must ask the office of administrative hearings (OAH) to:

(a) Schedule a hearing to determine whether or not the petitioner has good cause for vacating the default order; and

(b) Give any other parties to the hearing notice of the time and date of the hearing. The notice is sent to the party's last known address.

(4) In a hearing under this section, the ALJ must first determine if the petitioner has good cause for vacating the default order by applying civil rule 60 to determine whether the petition has good cause, In making this determination, the ALJ must consider the following factors:

(a) Whether there is substantial evidence to support a prima facie defense to the notice which was the subject of the hearing;

(b) Whether the petitioner's failure to appear at the hearing was due to mistake, inadvertance, surprise or excusable neglect;

(c) Whether the petition to vacate has been brought in a timely manner; and

(d) Whether vacating the initial decision would result in a substantial hardship to the parent who did appear for hearing.

(5) If the ALJ finds good cause to vacate the default order, the ALJ:

(a) Must conduct a hearing on the merits of the petitioner's objection to the notice that was the basis for the hearing at which the petitioner failed to appear; and

(b) May stay any further collection to the extent provided for under the rules governing the notice the party originally objected to.

(6) If the parent who did not appear at the hearing is unsuccessful in the motion to vacate the default order, the ALJ may treat the petition as a petition to modify the support order.

[Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 01-24-081, § 388-14A-6150, filed 12/3/01, effective 1/3/02.]

WAC 388-14A-6200 What remedies are available to contest the division of child support's seizure of my bank account? (1) If the division of child support (DCS) takes collection action against a bank account, safe deposit box, or other property held by a bank, credit union or savings and loan (collectively, "the account"), the noncustodial parent (NCP) or the joint owner of record of the account may contest the action in a hearing.

(2) The effective date of a hearing request or objection is the date DCS receives the request.

(3) The NCP or the joint owner must file the objection within twenty days of the date DCS mailed a copy of the order to withhold and deliver to the NCP's last known address.

(4) The NCP or joint owner of record must state in the objection the facts supporting the allegation by the NCP or the joint owner that the account, or a portion of the account is exempt from satisfaction of the NCP's child support obligation.

(5) If either the NCP or the joint owner of record objects to the collection action, DCS schedules a hearing solely for the purpose of determining whether or not one of the following exemptions applies to the account attached by the order to withhold and deliver:

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

(b) The funds in a bank account, or a portion of those funds can be identified as TANF, GA-U, GA-X, SSI benefits, or other kinds of funds which are legally exempt from collection action; or

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

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310, 45 C.F.R. 303.106. 01-24-079, § 388-14A-6200, filed 12/3/01, effective 1/3/02; 01-03-089, § 388-14A-6200, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-390.]

WAC 388-14A-6205 What happens at a hearing on an objection to seizure of a bank account? (1) If either the noncustodial parent (NCP) or the joint owner of record objects to a division of child support (DCS) collection action against a bank account, DCS schedules a hearing solely for the purpose of determining whether or not one of the following exemptions applies to the funds in the bank account, or to the other property attached by the order to withhold and deliver:

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

(b) The funds in the bank account, or a portion of those funds can be identified as TANF, GA-U, GA-X, SSI benefits, or other kinds of funds which are legally exempt from collection action; or

(c) The funds or property attached by the order to withhold and deliver can be identified as being solely owned by the joint owner of record of the bank account or safe deposit box who does not owe a child support obligation to the child or children of the NCP and are exempt from satisfaction of the NCP's child support obligation.

(2) The person challenging the collection action has the burden of tracing the funds and proving the property or funds in the bank account, or property in a safe deposit box, are exempt from satisfaction of the NCP's child support obligation.

(3) The administrative law judge (ALJ) is limited to the determination of whether the funds in the bank account, or

the other property attached by the order to withhold and deliver is exempt from satisfaction of the NCP's child support obligation.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310, 45 C.F.R. 303.106. 01-24-079, § 388-14A-6205, filed 12/3/01, effective 1/3/02.]

WAC 388-14A-6210 What happens to the seized money once an objection is filed? The division of child support (DCS) holds money or property withheld as a result of collection action taken against a bank account or safe deposit box and delivered to DCS at the time of an objection, pending the final administrative order or during any appeal to the courts.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310, 45 C.F.R. 303.106. 01-24-079, § 388-14A-6210, filed 12/3/01, effective 1/3/02.]

WAC 388-14A-6215 What happens if the judge decides the seized money was exempt? If the final decision of the department or courts on appeal is that the division of child support (DCS) has caused money or property that is exempt from satisfaction of the NCP's child support obligation to be withheld by the bank or delivered to the department, DCS must:

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

(2) Refund the proportionate share of the funds having been identified as being exempt. The department is not liable for any interest accrued on any money withheld under RCW 74.20A.080.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310, 45 C.F.R. 303.106. 01-24-079, § 388-14A-6215, filed 12/3/01, effective 1/3/02.]

WAC 388-14A-6220 What remedies are available to contest the division of child support's seizure of my DOC inmate account? If the division of child support (DCS) takes collection action against the inmate account of a noncustodial parent (NCP) who is an inmate of a department of corrections (DOC) facility, the NCP may contest the seizure of the inmate account in the same way an NCP could challenge a bank account seizure, as provided in WAC 388-14A-6200 through 388-14A-6215.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310, 45 C.F.R. 303.106. 01-24-079, § 388-14A-6220, filed 12/3/01, effective 1/3/02.]

WAC 388-14A-6300 Duty of the administrative law judge in a hearing to determine the amount of a support obligation. (1) In hearings held under this chapter to contest a notice and finding of financial responsibility or a notice and finding of parental responsibility or other notice or petition, the administrative law judge (ALJ) must determine:

(a) The noncustodial parent's obligation to provide support under RCW 74.20A.057;

(b) The net monthly income of the noncustodial parent (NCP) and any custodial parent (CP);

(c) The NCP's share of the basic support obligation and any adjustments to that share, according to his or her circumstances;

(d) If requested by a party, the NCP's share of any special child-rearing expenses;

(e) The NCP's obligation to provide medical support under RCW 26.18.170;

(f) The NCP's accrued debt and order payments toward the debt; and

(g) The NCP's total current and future support obligation as a sum certain and order payments in that amount.

(2) The ALJ must allow the division of child support (DCS) to orally amend the notice at the hearing to conform to the evidence. The ALJ may grant a continuance, when necessary, to allow the NCP or the CP additional time to present rebutting evidence or argument as to the amendment.

(3) The ALJ may not require DCS to produce or obtain information, documents, or witnesses to assist the NCP or CP in proof of defenses to liability. However, this rule does not apply to relevant, nonconfidential information or documents that DCS has in its possession.

[Statutory Authority: RCW 74.08.090, 26.23.050, 34.05.220, 74.20A.055, 74.20A.056, 45 CFR 303.11, 45 CFR 303.100. 01-03-089, § 388-14A-6300, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-100 and 388-11-210.]

WAC 388-14A-6400 The division of child support's grievance and dispute resolution method is called a conference board. (1) The division of child support (DCS) provides conference boards for the resolution of complaints and problems regarding DCS cases, and for granting exceptional or extraordinary relief. A conference board is an informal review of case actions and of the circumstances of the parties and children related to a child support case.

(a) The term conference board can mean either of the following, depending on the context:

(i) The process itself, including the review and any meeting convened; or

(ii) The DCS staff who make up the panel which convenes the hearing and makes factual and legal determinations.

(b) A conference board chair is an attorney employed by DCS in the conference board unit. In accordance with section WAC 388-14A-6415, the conference board chair reviews a case, and:

(i) Issues a decision without a hearing, or

(ii) Sets a hearing to take statements from interested parties before reaching a decision.

(2) A person who disagrees with any DCS action related to establishing, enforcing or modifying a support order may ask for a conference board.

(3) DCS uses the conference board process to:

(a) Help resolve complaints and problems over agency actions;

(b) Determine when hardship in the paying parent's household, as defined in RCW 74.20A.160, justifies the release of collection action or the refund of a support payment;

(c) Set a repayment rate on a support debt; and

(d) Determine when it is appropriate to write off support debts owed to the department based on:

(i) Hardship to the paying parent or that parent's household;

(ii) Settlement by compromise of disputed claims;

(iii) Probable costs of collection in excess of the support debt; or

(iv) An error or legal defect that reduces the possibility of collection.

(4) A conference board is not a formal hearing under the administrative procedure act, chapter 34.05 RCW.

(5) A conference board does not replace any formal hearing right created by chapters 388-14A WAC, or by chapters 26.23, 74.20 or 74.20A RCW.

(6) This section and WAC 388-14A-6405 through 388-14A-6415 govern the conference board process in DCS cases.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310. 01-03-089, § 388-14A-6400, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-385.]

WAC 388-14A-6405 How to apply for a conference board. (1) A person may request a conference board, orally or in writing, at any division of child support (DCS) office.

(2) Oral requests for conference boards are governed by WAC 388-14A-6100.

(3) DCS may start conference board proceedings in appropriate circumstances.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310. 01-03-089, § 388-14A-6405, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-386.]

WAC 388-14A-6410 Explanation of the conference board process. (1) An applicant for a conference board must make reasonable efforts to resolve the dispute with division of child support (DCS) staff before the conference board can act in the case.

(2) A conference board chair reviews each application to determine appropriate action:

(a) If there are questions of both law and fact or if the dispute involves only facts, the chair may schedule a conference board hearing to gather evidence;

(b) If the factual dispute would not provide a basis on which the conference board could grant relief, even if all facts were resolved in favor of the applicant, the chair may issue a decision without a hearing; or

(c) If the dispute can be resolved as a matter of law without relying upon disputed facts, the conference board chair may issue a decision without scheduling a hearing.

(3) If the conference board chair schedules a hearing, the conference board is made up of the conference board chair and staff from the DCS field office which handles the child support case, if needed.

(a) At the hearing, the conference board makes determinations of relevant disputed facts. Decisions on factual issues are made by a majority of the conference board.

(b) Decisions on issues of law are made by the conference board chair alone.

(c) The DCS worker regularly assigned to a case may not be part of a conference board dealing with that case.

(4) The conference board chair prepares a decision, if necessary, and provides that decision to the parties to the conference board, and to the DCS staff responsible for the case.

(5) The director of DCS, or a person designated by the director, may review conference board decisions, and may alter, amend, vacate or remand decisions that are inconsistent with Washington law or DCS policy, or are grossly unfair.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310. 01-03-089, § 388-14A-6410, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-387.]

WAC 388-14A-6415 Scope of authority of conference board chair defined. The conference board chair has the authority to:

(1) Subpoena witnesses and documents, administer oaths and take testimony;

(2) Grant relief by setting payment plans, writing off debt owed to the department, or refunding collected money;

(3) Adjust support debts based on evidence gathered during the conference board process;

(4) Direct distribution of collected support; and

(5) Take any action consistent with Washington law and DCS policy to resolve disputes, grant relief or address issues of equity.

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310. 01-03-089, § 388-14A-6415, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-388.]

WAC 388-14A-6500 Can I use equitable estoppel as a defense in a hearing with the division of child support? (1) Equitable estoppel is available in adjudicative proceedings conducted under this chapter.

(2) When a party raises, or the facts indicate, a claim that equitable estoppel applies to a party to the proceeding, the administrative law judge (ALJ) must:

(a) Consider equitable estoppel according to the precedents set by reported Washington state appellate case law, where not contrary to public policy; and

(b) Enter findings of fact and conclusions of law sufficient to determine if the elements of equitable estoppel are met and apply.

(3) The party asserting, or benefitting from, equitable estoppel must prove each element of that defense by clear, cogent and convincing evidence.

(4) The ALJ must consider on the record whether a continuance is necessary to allow the parties to prepare to argue equitable estoppel when:

(a) A party raises equitable estoppel; or

(b) The facts presented require consideration of equitable estoppel.

(5) When the ALJ orders a continuance under subsection (4) of this section, the ALJ enters an initial decision and order for current support if:

(a) Current support is an issue in the proceeding; and

(b) The claim for current support is unaffected by the equitable estoppel defense.

(6) The defense of equitable estoppel is not available to a party when the:

(a) Party raises the defense against the department's claim for reimbursement of public assistance; and

(b) Act or representation forming the basis for an estoppel claim:

(i) Was made by a current or former public assistance recipient;

(ii) Was made on or after the effective date of the assignment of support rights; and

(iii) Purported to waive, satisfy, or discharge a support obligation assigned to the department.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-6500, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-067.]

WAC 388-14A-7100 An order from another state may be registered in Washington for enforcement or modification. (1) A support enforcement agency, or a party to a child support order or an income-withholding order for support issued by a tribunal of another state, may register the order in this state for enforcement pursuant to chapter 26.21 RCW.

(a) The order may be registered with the superior court pursuant to RCW 26.21.490 or it may be registered with the administrative tribunal according to subsection (2) of this section, at the option of the division of child support (DCS). Either method of registration is valid.

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

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

(2) DCS must give notice to the nonregistering party when it administratively registers a support order or income-withholding order issued in another state.

(a) The notice must inform the nonregistering party:

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

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

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

(iv) Of the amount of any alleged arrearages.

(b) The notice must be:

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

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

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

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

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

(i) Stay enforcement of the registered order;

(ii) Continue the proceeding to allow the parties to gather additional relevant evidence; or

(iii) Issue other appropriate orders.

(b) DCS may enforce an uncontested portion of the registered order by all remedies available under the law of this state.

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

(d) The custodial parent (CP) or payee of the order may participate as a party to any hearing under this section.

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

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

(b) By order of the administrative law judge (ALJ).

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

(a) The order must be registered as provided in subsection (1)(a) if the order has not yet been registered.

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

(c) DCS may enforce a child support order of another state registered for purposes of modification, as if a tribunal of this state had issued the order, but the registered order may be modified only if the requirements of RCW 26.21.580 are met.

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

[Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310. 01-03-089, § 388-14A-7100, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-260 and 388-14-495.]

WAC 388-14A-7200 DCS can serve notices in other states under the Uniform Interstate Family Support Act. (1) Except as specified in WAC 388-14A-3105, where grounds for personal jurisdiction exist under RCW 26.21.075 or other Washington law, the division of child support (DCS) may serve the following legal actions in another state by certified mail, return receipt requested or by personal service, under chapter 26.21 RCW:

(a) A notice and finding of financial responsibility under WAC 388-14A-3115; and

(b) A notice and finding of parental responsibility under WAC 388-14A-3120;

(c) A notice of paternity test costs under WAC 388-14A-8300; or

(d) An affidavit of birth costs under WAC 388-14A-3555.

(2) A notice and finding of financial responsibility, a notice of paternity test costs, or an affidavit of birth costs becomes final and subject to immediate wage withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW unless the noncustodial parent (NCP), within sixty days of service in another state:

(a) Contacts DCS and signs an agreed settlement or consent order; or

(b) Files a written request for a hearing under:

(i) WAC 388-14A-3115 for a notice and finding of financial responsibility;

(ii) WAC 388-14A-3555 for an affidavit of birth costs; or

(iii) WAC 388-14A-8300 for a notice of paternity test costs.

(3) The effective date of a hearing request is the date DCS receives the hearing request.

(4) A notice and finding of parental responsibility becomes final and subject to immediate wage withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW unless the NCP, within sixty days of service in another state:

(a) Contacts DCS and signs an agreed settlement or consent order;

(b) Files a written request for a hearing under WAC 388-14A-3120 with DCS; or

(c) Files a written request for paternity testing under WAC 388-14A-8300 to determine if he is the natural father of the dependent child named in the notice and cooperates in the testing. A request for a hearing or paternity testing is filed on the date the request is received by DCS.

(5) If the results of paternity tests requested under subsection (4) of this section do not exclude the NCP as the natural father of the dependent child, the notice and finding of parental responsibility becomes final and subject to immediate wage withholding without further notice under chapters 26.18, 26.23, and 74.20A RCW unless the NCP, within sixty days of service of the paternity test costs in another state:

(a) Contacts DCS and signs an agreed settlement or consent order; or

(b) Files a written request for a hearing under WAC 388-14A-3120.

(6) Administrative law judges and parties must conduct administrative hearings on notices served in another state under this section under the special rules of evidence and procedure in chapter 26.21 RCW and according to chapter 34.05 RCW.

[Statutory Authority: RCW 74.08.090, 34.05.220, 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-7200, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-305 and 388-14-260.]

WAC 388-14A-8100 Are there special rules for setting child support for children in foster care? (1) Child support obligations for children in foster care are set under chapter 26.19 RCW, just like any other support obligation.

(2) The division of child support does not establish or enforce support obligations for children in foster care who have been certified as eligible for DDD services.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-8100, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-8105 Does the cost of care affect how much child support I pay when my child is in foster care? (1) Child support obligations for children in foster care are set according to chapter 26.19 RCW, without regard to how much the department is expending in foster care funds.

(2) The administrative law judge or review judge may not limit the noncustodial parent's support obligation to the amount the department expends each month for foster care.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-8105, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-8110 What happens to the money if current support is higher than the cost of care? (1) When the division of child support (DCS) collects child support from the parent(s) of a child in foster care, DCS sends the amounts collected to the division of child and family services (DCFS), which administers foster care funds.

(2) DCFS and its Office of accounting services (OAS) apply child support payments collected by DCS.

(3) DCFS and/or OAS deposits in a trust account for the child any child support payments which they don't use to reimburse foster care expenses.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-8110, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-8120 Are there special rules for collection in foster care cases? (1) Whenever the department provides residential care ("foster care") for a dependent child or children, the noncustodial parent (NCP) or parents (NCPs) satisfy their obligation to support the child or children by paying to the department the amount specified in a court order or administrative order, if a support order exists.

(2) The division of child support (DCS) takes action under the provisions of chapters 74.20 and 74.20A RCW and this chapter to enforce and collect support obligations owed for children receiving foster care services.

(3) If, during a month when a child is in foster care, the NCP is the "head of household" with other dependent children in the home, DCS does not collect and retain a support payment if:

(a) The household's income is below the need standard for temporary assistance for needy families (TANF) (see WAC 388-478-0015); or

(b) Collection of support would reduce the household's income below the need standard.

(4) The NCP's support obligation for the child or children in foster care continues to accrue during any month DCS is prevented from collecting and retaining support payments under this section.

(5) If the department has collected support payments from the head of household during the months which qualify under section (3), the NCP may request a conference board in accordance with WAC 388-14A-6400.

(6) The NCP must prove at the conference board that the income of the household was below or was reduced below the need standard during the months DCS collected payments.

(7) If the conference board determines that DCS has collected support payments from the head of household that the department is not entitled to retain according to this section, DCS must promptly refund, without interest, any support payments, or the portion of a payment which reduced the income of the household below the need standard.

(8) This section does not apply to payments collected prior to August 23, 1983.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-8120, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-395.]

WAC 388-14A-8200 All Washington employers must report new hires to the Washington state support registry. (1) RCW 26.23.040 requires all employers doing business in the state of Washington to comply with the employer reporting requirements regarding new hires.

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

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

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

[Statutory Authority: RCW 74.08.090, 26.23.040. 01-03-089, § 388-14A-8200, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-490.]

WAC 388-14A-8300 Who pays for genetic testing when paternity is an issue? (1) As provided in WAC 388-14A-3120(14), the noncustodial parent (NCP) and/or the mother of the child may request genetic testing, also called paternity tests, after the service of a notice and finding of parental responsibility.

(2) After receiving a request for paternity tests, the division of child support (DCS) must:

(a) Arrange and pay for the genetic testing, except as provided in subsection (6) of this section, with a laboratory under contract with the department; and

(b) Notify the NCP and the mother of the time and place to appear to give blood samples.

(3) After DCS receives the test results, DCS must:

(a) Mail a notice of the test results to the:

(i) NCP's last known address by certified mail, return receipt requested; and

(ii) Mother's and/or custodial parent's last known address by first class mail.

(b) Notify the NCP:

(i) Of the costs of the tests;

(ii) That an administrative order entered as a result of the notice and finding of parental responsibility will include the cost of the tests; and

(iii) That DCS may take collection action to collect the genetic testing costs twenty days after the date the NCP receives notice in Washington, or within the time specified in WAC 388-14A-7200, of the test results if the NCP fails to:

(A) Request either a hearing on the issue of reimbursement to DCS for genetic testing costs under WAC 388-14A-3120 or the initiation of a parentage action in superior court; or

(B) Negotiate an agreed settlement.

(iv) If the notice was served in another state, DCS may take collection action according to WAC 388-14A-7200.

(4) When the genetic tests do not exclude the NCP from being the father, the NCP must reimburse the department for the costs of the tests.

(5) When the paternity tests exclude the NCP from being the father, DCS must:

(a) File a copy of the results with the state center for health statistics;

(b) Withdraw the notice and finding of parental responsibility; and

(c) Request the dismissal of any pending action based on the notice and finding of parental responsibility.

(6) RCW 74.20A.056 does not require DCS to arrange or pay for genetic testing when:

(a) Such tests were previously conducted; or

(b) A court order establishing paternity has been entered.

[Statutory Authority: RCW 74.08.090, 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-8300, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-048 and 388-11-220.]

WAC 388-14A-8400 Does the division of child support have the right to approve my child support order before the court enters it? (1) If the department is providing or has provided cash assistance to the family, parties to a court order must give the division of child support (DCS) twenty calendar days prior notice of the entry of any final order and five days prior notice of the entry of any temporary order in any proceeding involving child support or maintenance, because the department has a financial interest based on an assignment of support rights under RCW 74.20.330 or the state has a subrogated interest under RCW 74.20A.030.

(2) Either party may serve notice on DCS, by personal service on, or mailing by any form of mail requiring a return receipt to, the office of the attorney general.

(3) If you don't give sufficient notice before entering the support order, DCS may ask the prosecuting attorney or attorney general to vacate the terms of the support order.

(4) DCS or the department are not entitled to terms for a party's failure to serve the department within the time requirements for this section, unless the department proves that the party knew that the department had an assignment of support rights or a subrogated interest and that the failure to serve the department was intentional.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-8400, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-8500 Can the division of child support issue subpoenas? (1) The division of child support (DCS) issues subpoenas requiring the production of documents or records, or appearance of witnesses, under RCW 34.05.588 and 74.04.290.

(2) Compliance with DCS subpoenas is enforced under RCW 34.05.588 and 74.20A.350.

[Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-8500, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-220.]

Chapter 388-15 WAC

SOCIAL SERVICES FOR FAMILIES, CHILDREN AND ADULTS

WAC

388-15-150 Repealed.
388-15-160 Repealed.
388-15-220 Repealed.
388-15-570 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-15-150 Child foster care. [Order 1238, § 388-15-150, filed 8/31/77; Order 1088, § 388-15-150, filed 1/19/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-15-160 Adoption services. [Order 1238, § 388-15-160, filed 8/31/77; Order 1088, § 388-15-160, filed 1/19/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-15-220 Homemaker services. [Statutory Authority: RCW 74.08.090. 81-17-024 (Order 1689), § 388-15-220, filed 8/12/81; 80-15-003 (Order 1551), § 388-15-220, filed 10/2/80; Order 1238, § 388-15-220, filed 8/31/77; Order 1088, § 388-15-220, filed 1/19/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-15-570 Family reconciliation services. [Statutory Authority: RCW 74.08.090. 82-01-040 (Order 1732), § 388-15-570, filed 12/16/81; 81-20-063 (Order 1708), § 388-15-570, filed 10/5/81. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-15-570, filed 9/10/79. Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-15-570, filed 9/1/78; Order 1238, § 388-15-570, filed 8/31/77.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

WAC 388-15-150 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-160 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-220 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-15-570 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-25 WAC

CHILD WELFARE SERVICES—FOSTER CARE

WAC

WAC 388-25-0005 What is the legal basis for the foster care program? RCW 74.13.020 authorizes the department to provide foster care placement services.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0005, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0010 What definitions apply to the foster care program? The following definitions are important:

"Alcohol affected infant" means a child age birth through twelve months who was exposed to alcohol in utero and may demonstrate physical, behavioral, or cognitive signs that may be attributed to alcohol exposure.

"Behavior rehabilitation services" (BRS) is a comprehensive program of positive behavioral support and environmental structure in a supervised group or family living setting. Resources are designed to modify a child's behavior or to appropriately care for a child's intensive medical condition. Services are tailored to each client's needs and offered in the least restrictive setting possible.

"Child placing agency" means a private licensed or certified agency that places a child or children for temporary care, continued care, or for adoption.

"Children's administration" (CA) means the cluster of programs within the department of social and health services responsible for the provision of child welfare, child protective, child care licensing, and other services to children and their families.

"Crisis residential center" (CRC) means a secure or semi-secure facility established under chapter 74.13 RCW.

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

"Dependency guardian" means the person, nonprofit corporation, or Indian tribe appointed by the court pursuant to RCW 13.34.232 for the limited purpose of assisting the court in the supervision of the dependency.

"Division of children and family services" (DCFS) is the division of children's administration that provides child welfare, child protective, family reconciliation, and support services to children in need of protection and their families.

"Division of licensed resources" (DLR) is the division of children's administration responsible for licensing or certifying child care homes and facilities under the authority of chapter 74.15 RCW.

"Drug affected infant" means a child age birth through twelve months who was exposed to drugs or substances in utero and demonstrates physical, behavioral, or cognitive signs that can be attributed to exposure to drugs or substances.

"Early and periodic screening, diagnosis and treatment" (EPSDT), also known as "healthy kids," is a federal

program for preventive health care for children and teens served by Medicaid. The physical/well child examination helps find health problems early and enables the child to receive treatment for concerns identified in the examination.

"Foster care" means twenty-four-hour per day temporary substitute care for the child placed away from the child's parents or guardians and for whom the department or a licensed or certified child placing agency has placement and care responsibility. This includes but is not limited to placements in foster family homes, foster homes of relatives, licensed group homes, emergency shelters, staffed residential facilities, and preadoptive homes, regardless of whether the department licenses the home or facility and/or makes payments for care of the child.

"Foster care services" for the department include:

(1) The determination of needs of the child;

(2) The determination of need for foster care;

(3) The placement of the child in the type of foster care setting that best meets the child's needs;

(4) The referral of a child to a private child placement agency or institution to meet the child's specific needs;

(5) Medical services according to the rules of the department's medical program;

(6) Reimbursement for the care of a child in a licensed family foster home;

(7) The purchase of care from a licensed private child placing agency, behavioral rehabilitation services provider, or maternity home;

(8) Supervision of the foster care placement by direct supervision through departmental social work services; or indirect supervision through evaluation of periodic reports from private child placing agencies, rehabilitation services providers, or maternity homes with which the department has contractual arrangements.

"Foster home or foster family home" means person(s) regularly providing care on a twenty-four-hour basis to one or more children in the person's home.

"Group care" means a twenty-four-hour facility licensed or certified under chapter 388-148 WAC for more than six children. The facility provides the basic needs for food, shelter, and supervision. The facility also provides therapeutic services required for the successful reunification of children with the children's family resource or the achievement of an alternate permanent living arrangement.

"Independent living services" means the program services and activities established and implemented by the department to assist youth sixteen years or older in preparing to live on their own after leaving foster care.

"Overpayment" means any money paid by the department for services or goods not rendered, delivered, or authorized or where the department paid too much for services or goods or services rendered, delivered, or authorized.

"Regional support network" is an administrative body which oversees the funding for provision of public mental health services.

"Relative" means a person who is related as defined in RCW 74.15.020 (2)(a).

"Responsible parent" means a birth parent, adoptive parent, or stepparent of a dependent child or a person who has signed an affidavit acknowledging paternity that has been filed with the state office of vital statistics.

"Responsible living skills program" means an agency licensed by the secretary that provides residential and transitional living services to persons ages sixteen to eighteen who are dependent under chapter 13.34 RCW and who have been unable to live in his or her legally authorized residence and, as a result, lives outdoors or in another unsafe location not intended for use as housing.

"Staffed residential home" means a licensed home providing twenty-four-hour care for six or fewer children or expectant mothers. The home may employ staff to care for children or expectant mothers.

"Shelter care" means the legal status of a child at entry in foster care prior to a disposition hearing before the court.

"Vendor" means an individual or corporation that provides goods or services to or for clients of the department and that controls operational decisions.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0010, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0015 What are the department's placement priorities? Within the limits of available financial resources, the department provides placement services to children according to the following ordered priorities:

(1) The department must place children who urgently need protection from child abuse or neglect (CA/N) if the department has legal authority for placement consistent with WAC 388-25-0025.

(2) The department may place children whose mental, emotional, behavioral or physical needs present a risk to their safety and resources do not exist within the family to provide for those needs.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0015, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0020 What are the department's limitations on placement? Children's administration (CA) social workers must place only those children who meet the criteria for child protective services (CPS), family reconciliation services (FRS), or child welfare services as defined in RCW 74.13.020. Children in situations outlined below do not meet those criteria:

(1) Children whom the CA social worker determines, after assessment, will not be helped in out-of-home care.

(2) Youths ages twelve through seventeen years of age in conflict with their parents and who have not received family reconciliation services, except families receiving adoption support that have already received extensive counseling services.

(3) Youths ages twelve through seventeen years of age whose family has received family reconciliation services and parents are unwilling to have the youths at home solely due to misbehavior.

(4) Youths for whom the primary placement issue is community protection, including sexual predators covered by the sexually aggressive youth (SAY) statute, RCW 74.13.075.

(5) Youths who are unwilling to live in the home of parents who are willing to have them at home, when this is the only presenting problem.

(6) Youths who have a mental illness and are a danger to themselves or others as defined by a mental health professional (see chapter 71.34 RCW).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0020, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0025 When may the department or a child placing agency authorize foster care placement? The department or a child placing agency may place a child in foster care only under the following circumstances:

(1) The child has been placed in temporary residential care after having been taken into custody under chapter 13.32A RCW, Family Reconciliation Act, to alleviate personal or family situations that present an imminent threat to the health or stability of the child or family.

(2) The child, the child's parent(s), or the department has filed a petition requesting out-of-home placement for the child pursuant to RCW 13.32A.120 or 13.32A.140:

(a) Placement has been approved after a fact finding hearing under RCW 13.32A.170; or

(b) A child has been admitted directly to placement in a crisis residential center (CRC), and the parents have been notified of the child's whereabouts, physical and emotional condition, and the circumstances surrounding the child's placement.

(3) A child has been placed in shelter care under one of the following circumstances:

(a) The child has been taken into custody by law enforcement or through a hospital administrative hold and placed in shelter care; or

(b) A petition has been filed with the juvenile court alleging that the child is dependent; that the child's health, safety, and welfare will be seriously endangered if not taken into custody; and the juvenile court enters an order placing the child in shelter care (see RCW 13.34.050 and 13.34.060).

(4) A juvenile court has made a determination of dependency for a child and has issued a disposition order under RCW 13.34.130 that removes the child from the child's home.

(5) A juvenile court has terminated the parent and child relationship as provided in chapter 13.34 RCW and has placed the custody of the child with the department or with a licensed or certified child placing agency.

(6) The child's parent(s) or persons legally responsible to sign a consent for voluntary placement that demonstrates agreement with an out-of-home placement as described in RCW 74.13.031.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0025, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0030 When may the department serve a child through a behavior rehabilitation services program? (1) The department may serve a child through the behavior rehabilitation services (BRS) program only when the CA social worker has assessed the child's and family's needs and determined that rehabilitative services are necessary and that this is the most appropriate placement for the child.

(2) The department may only provide financial support for a child's BRS placement when the CA social worker has determined this level of care is necessary, the placement is in a licensed or certified home or facility, the provider meets the department's qualifications, and the department has contracted with the provider for that service.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0030, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0035 What is the department's authority to remove a child from a behavior rehabilitation services placement? The department has the authority to remove the child after at least seventy-two hours notice to the child care provider. The department may waive notice in emergency situations or when a court has issued an order changing a child's placement.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0035, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0040 How long may a child served by the department remain in out-of-home placement before a court hearing is held? Within seventy-two hours after a child enters care, a shelter care hearing must be held. Saturdays, Sundays and holidays are excluded in the seventy-two-hour requirement. A court order must be obtained to keep a child in shelter care for longer than thirty days.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0040, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0045 Under what circumstances may a parent sign a consent for voluntary placement of a child in foster care with the department? (1) If alternative placement resources, including social supports in the family home, have been considered and eliminated; and

(2) The department agrees that the child needs to be placed; then

(3) A child's parent may sign a consent for voluntary placement of a child in foster care (if the child is Native American refer to the Indian Child Welfare Act):

(a) If the child and a parent cannot agree to the child's return home but do agree to the child's placement out of the home; or

(b) When a parent is unable to care for a child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0045, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0050 What must a parent do to place the child in foster care with the department? A child's parent may sign a Voluntary Placement Agreement (VPA), DSHS 09-004B(X), to voluntarily place a child in foster care. The consent for voluntary placement must agree with child welfare services as described under RCW 74.13.031. The consent becomes valid when signed by a representative of children's administration.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0050, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0055 How long may a voluntary placement last with the department? A voluntary placement must last no longer than one hundred eighty days. By the end of one hundred eighty days, the child must return to the child's parent or guardian unless the juvenile court has made a judicial determination that:

(1) Return to the parent or guardian is contrary to the welfare of the child; and

(2) Continued placement in foster care is in the best interest of the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0055, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0060 May the department grant an exception to the length of stay in voluntary placement? (1) The DCFS regional administrator or the regional administrator's designee may grant exceptions to the one hundred eight-day limit on voluntary placements only:

(a) If the department conducts an administrative review fulfilling the requirements of title 42, United States code (USC), chapter 675, section 475, and the review chairperson recommends continuation of voluntary placement; and

(b) If a specific date within six months is scheduled for the child to return home; or

(c) The child is seventeen years of age or older.

(2) Exceptions which cause the child to remain in care for longer than twelve months require a court review hearing that meets the dispositional and permanency plan hearing requirements of 42 USC 675, section 475.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0060, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0065 What are the department's placement procedures for an infant residing in foster care with the infant's teen parent? (1) When a teen parent and infant reside in the same facility, the infant's "home" is considered to be the infant's parent's home. Maintenance payments for the teen parent must be increased to provide for the maintenance of the infant. A legal authorization-to-be-placed is not required in order to include an amount sufficient for the infant's maintenance or to issue medical coupons for the infant.

(2) For protection of the infant, a dependency order placing the child in temporary custody of the department may be appropriate. Even if dependency is established, a legal authorization-to-be placed must be obtained to keep the infant in out-of-home care should the teen parent placement setting change so as not to include the infant.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0065, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0070 When does the department authorize foster care payments? The CA social worker authorizes foster care payments when:

(1) The CA social worker documents the need for the type and level of foster care; and

(2) The social worker has documentation showing the department's authority for the placement of the child in foster care as required by WAC 388-25-0025.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0070, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0075 To whom does the department make payment for foster care? (1) The department makes foster care payments only to persons and agencies the department has appropriately licensed and approved, or, if not subject to licensing, the department has certified as meeting the department's licensing requirements, or:

(a) If in another state, persons or agencies meeting the requirements of that state; or

(b) If in a tribal program, persons or agencies meeting the requirements of that tribal program.

(2) The department makes payment for out-of-state foster care placements only after approval from the two state offices involved (see WAC 388-25-0440).

(3) The department may make foster care payments to licensed or certified foster parents and to persons granted dependency guardianship, if the dependency guardians are licensed or certified as foster parents (see RCW 13.34.234).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0075, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0080 Are dependency guardians who are licensed foster parents able to receive payment from more than one source? (1) When the child is eligible for foster care payments and Social Security Act, Title XVI, Supplemental Security Income (SSI) payments, or Social Security Act, Title II, Survivor's Benefits, Veterans' Administration (VA) benefits, or other sources of income, the dependency guardian may choose one payment source or the other, but not more than one.

(2) If the dependency guardian chooses to receive foster care payments rather than SSI payments or another source in behalf of the child, the department places SSI benefits or the other cited benefit in an account the department may use to meet the cost of care or special needs of the child in accordance with RCW 74.13.060.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0080, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0085 What happens if the dependency guardian receives payments from more than one source? If the dependency guardian has received payment from SSI or another source as well as foster care, an overpayment has occurred. The department must recover the foster care payments made to the dependency guardian for those months for which the dependency guardian also received SSI or other benefits, as well as foster care payments, in behalf of the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0085, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0090 What are the department's expectations for foster care providers to whom the department makes reimbursement for services? (1) Foster care providers are responsible for:

(a) Protecting and nurturing children in a safe, healthy environment that provides positive support and supervision for the child in care;

(b) Taking the child to a physician or nurse practitioner to complete an EPSDT (early and periodic screening, diagnosis and treatment) examination. EPSDT exams must be scheduled within one month of initial placement and annually thereafter.

(c) Reporting to the social worker the fact that an EPSDT examination took place and if the examination showed that further treatment is needed.

(d) Observing and sharing information about the child's behavior, school and medical status, response to parental visits, and the child's growth and development with persons designated by the assigned CA social worker (see chapter 388-148 WAC).

(e) Meeting the developmental needs of the child by:

(i) Teaching age appropriate skills;

(ii) Supporting cultural identity;

(iii) Helping the child attach to caring adults;

(iv) Building self esteem;

(v) Encouraging and modeling positive social relationships and responsibilities;

(vi) Supporting intellectual and educational growth;

(f) Supporting the permanent plan for the child;

(g) Participating as a member of the child's treatment team by taking part in the development of the service plan for the child and providing relevant information about the child's progress for court hearings;

(h) Providing assistance to the social worker, when working with the biological parents is part of the service plan, by assisting in family visitation and modeling effective parenting behavior for the family.

(2) Therapeutic foster care and rehabilitative service providers are responsible for additional therapeutic services as defined in their service agreements or contracts with the department.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0090, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0095 What are the requirements for release of foster parents' care records? Foster parent care records may be disclosed upon request in accordance with RCW 42.17.260.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0095, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0100 What are the department's responsibilities regarding financial assistance to support children in the department's foster homes and child placing agency foster homes? (1) The department pays only for placements and plans the department has approved.

(2) The department has final responsibility for determining initial and ongoing eligibility for financial support.

(3) Payment for children served through the behavior rehabilitation services program is limited to those children who are ages six to eighteen.

(4) The department maintains control and oversight of placements and payments through written agreements with the child placing agencies, quarterly reports, and planning meetings with the agency or facility.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0100, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0105 What is the effective date for payment of foster care? (1) The department begins foster care payment for a child on the date the department or its authorized designee places the child in the licensed foster home.

(2) The department pays for each night a child resides in foster care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0105, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0110 What is the effective date for termination of foster care payments? (1) The department ends payment on the day before the child actually leaves the foster home or facility. The department does not pay for the last day that a child is in a foster care home or facility.

(2) The department terminates family foster care payments for children in family foster care effective the date:

(a) The child no longer needs foster care; or

(b) The child no longer resides in foster care except as provided in WAC 388-25-0180; or

(c) The child reaches the age of eighteen. If the child continues to attend, but has not finished, high school or an equivalent educational program at the age of eighteen and has a need for continued family foster care services, the department may continue payments until the date the child completes the high school program or equivalent educational or vocational program. The department must not extend payments for a youth in care beyond age twenty.

(3) The department must terminate foster care payments for children in the behavior rehabilitative services program effective the date:

(a) The child no longer needs rehabilitative services; or

(b) The child is no longer served through contracted rehabilitative services program except as provided in WAC 388-25-0030; or

(c) The child reaches the age of eighteen and continues to attend, but has not finished, high school or an equivalent educational program and has a need for continued rehabilitative treatment services, the department may continue payments until the date the youth completes the high school program or equivalent educational or vocational program. The department must not extend payments for a youth in care beyond age twenty.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0110, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0115 What are the department's general standards for family foster care reimbursement? (1) The standards of payment explained in WAC 388-25-0120 through 388-25-0215 are the basis for the reimbursement rates the department provides for care of children placed in licensed foster care under the department's direct supervision and those children under the supervision of child placing agencies.

(2) The CA social worker must determine the payment plan for all types of family foster care through a review of the needs and resources of each child and the activities of the foster parent which meet those needs.

(3) The CA social worker must discuss any plan above the basic foster care rate with the foster parent so that the foster parent knows:

(a) The basis for payment;

(b) Any increased expectations of the foster parent for service delivery or participation in the case plan for the child; and

(c) The amount included for each item of the child's care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0115, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0120 What is the department's reimbursement schedule for regular family foster care? (1) The foster care basic rate reimburses the foster parent for costs incurred in the care of the child for room and board, clothing, and personal incidentals. The amount of reimbursement varies according to the age of the child.

(2) The department's children's administration may approve exceptions to the basic rates.

(3) To determine the payment rates, the department considers the child's birth date to be the first day of the month in which the child's birthday occurs.

(4) The standard reimbursement rate allowed is limited to the scheduled rate in existence for the time period(s) in which the child was placed in the foster home.

(5) The department's foster care reimbursement rates are as follows:

Effective Date* July 2000			
Age	0-5	6-11	12 & Older
Totals**	$351.31	$426.81	$499.95

*Schedule will be updated to comply with mandated changes.
**Totals include room and board, clothing allowance, and personal incidentals.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0120, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0125 When may the department authorize a clothing allowance for a child in out-of-home care? When the department or a contracted child placing agency places a child in foster care or, at other times, the social worker may authorize a clothing allowance to supplement a child's clothing supply, when necessary. This allowance may not exceed two hundred dollars unless authorized by the DCFS regional administrator or the regional administrator's designee. The allowance must be based on the needs of the child and be provided within available funds. Clothing purchased becomes the property of the child and will be sent with the child if placement changes.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0125, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0130 What are the standards for use and reimbursement of receiving home care? The department or a child placing agency uses receiving homes to place a child in a licensed family foster home on a temporary, emergent, or interim basis to provide sufficient time for the development of a plan. This planning includes the involvement of the child, the child's parent(s), and the child's extended family whenever possible.

(1) A DCFS regional administrator must designate family foster homes which are to receive child placements twenty-four hours per day. These homes provide care for children on a temporary, emergent, or interim basis as regular or specialized receiving homes.

(2) If the regional administrator designates a receiving home to be available on a twenty-four-hour basis, the regional administrator must specify this designation in a written agreement with the foster parent. Regular foster homes may also agree to accept children on an emergent basis.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0130, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0135 What are the types of receiving homes and what children are served in them? There are two types of receiving homes: Regular and specialized. Each type of home provides the following services:

(1) Regular receiving homes for children age birth through age seventeen; and

(2) Specialized receiving homes for children who require more intensive supervision than normally provided to children in foster care. The child may require more intensive supervision due to behavioral problems, developmental disability, emotional disturbance, erratic and unpredictable behavior or medical condition (not on personal care or medically intensive DDD program).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0135, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0140 Who decides on the number of receiving homes needed in an area? Each DCFS regional administrator must decide on the number of receiving homes needed for the regional administrators' respective geographical areas.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0140, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0145 How long may a child stay in a receiving home? (1) The department limits a child's maximum length of stay in a receiving home:

(a) Maximum length of stay for regular receiving homes is thirty consecutive days per placement;

(b) Maximum length of stay for specialized receiving homes is fifteen-consecutive days per placement.

(2) The DCFS regional administrator or the administrator's designee may approve extensions of a child's stay in a licensed family foster home paid at a receiving care rate beyond the limits contained in subsection (1) of this section.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0145, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0150 What are the rates for reimbursement to receiving home providers? The current reimbursement rates, effective July 1, 2000, to receiving homes are:

Type of Home	Monthly Retention Fee - Per Bed	Daily Rate per Child in Care
Regular receiving (all ages)	$51.12	$19.06
Special receiving, ages 12-17	$102.99	$26.08

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0150, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0155 How are rates authorized for reimbursement to receiving home providers? (1) The DCFS regional administrator or the administrator's designee may authorize payments in excess of the standard for individual child-specific situations. The department may, within available funds, purchase clothing and personal incidentals for the child in receiving home care as needed.

(2) The department does not pay the receiving home rate if the child is expected to stay in this placement for longer than thirty days.

(3) The department may make reimbursement for assessment and interim care through the behavior rehabilitative services program.

(4) The department may, at the direction of the DCFS regional administrator or designee, use qualified, contracted behavior rehabilitative services to provide assessment or interim care for children and youth requiring that level of care as determined by the CA social worker. Unless the department and the provider make an alternate agreement, the department must pay for contracted rehabilitative services at the facility's contracted daily rate for interim or assessment care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0155, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0160 What are the reimbursement standards for payments above the basic foster care rate? (1) In addition to the basic rate for regular family foster care specified in this chapter, the department may reimburse an additional amount for the specialized care of a child with special needs.

(2) For the child to be eligible for payment above the basic rate, the department's social worker must assess the child's behaviors, intellectual functioning, and/or physical disabilities and determine, with the child's foster parent or prospective foster parent, what services the foster parent will provide to meet the child's special needs.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0160, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0170 What other services and reimbursements may be provided for the support of children placed in foster care by the department? (1) The department may provide additional support services and reimbursements to meet specific needs of the child in care or of the family foster home provider. The department must approve all services and reimbursement amounts in advance of the service being provided. Services are subject to the availability of funds.

(2) Additional services may include the following:

(a) **Receiving home contracted and noncontracted respite** - This service for receiving homes includes child care, relief care, extra supervision for special activities, as well as basic respite care. Respite is subject to the availability of respite homes. Respite contracted but not available will be reimbursed to the regular foster parent.

(b) **Receiving home transportation** - This service reimburses receiving home parents for selected transportation costs, such as demands for training or special appointments for a child in care. The department makes direct payment to the receiving home parent.

(c) **Receiving home contracted support services** - These services are intended to enhance the capacity of regular and specialized receiving homes by increasing the skills of the provider to provide a stable emergency placement. The services include consultation for obtaining resources, training, case conferences, and visits to a child's parents' home by the receiving home provider.

(d) **Receiving home ancillary support services** - These services are reimbursements for activities or items enabling receiving homes to provide extra services to youth in care. Examples of such supports include craft items, recreational materials, and tickets to events.

(e) **Hourly or daily foster care respite** - Respite care by the hour or day for receiving and regular foster homes. The department may reimburse foster parents for relief supervision or additional supervision for special activities. The department defines "day" as either an eight-hour period or a block of time, up to twenty-four hours, paid as an eight-hour day. "Light" is defined as care provision that is not significantly different from that required by a child in the general population. However, the child may require some additional attention or assistance. The appropriate rate is determined after assessing the child's care requirement as either "light" or "heavy." "Heavy" is defined as care that requires the caregiver to provide intensive attention or total assistance. Regular intervention is needed to meet the needs of the child. Children having areas of need that are "light" in one area and "heavy" in another are assessed as "moderate."

(f) **Hourly or daily agency foster care respite** - Respite care by the hour or day for receiving and ongoing foster homes. Care may be child specific or related to all the children in the foster home. The department reimburses agencies for purchase of relief supervision and additional supervision for special activities.

(g) **Foster care clothing and personal incidentals** - The monthly rate that the department may reimburse to defray the cost of clothing and personal items for children in selected circumstances when the department is not paying for the child's board and room. The department makes reimbursement to the foster home or facility.

(h) **Foster care personal incidentals** - An amount to reimburse foster parents for purchase of personal items needed by a child in receiving care.

(i) **Foster care medical services** - Reimbursement arranged and made for medical services not covered by the

department's regular health insurance program (e.g., orthodontia or corrective surgery) for a child in foster care placement.

(j) **Foster care physical examination/report** - This medical service is used after the decision to place the child has been made and if the child is ineligible for an EPSDT examination or does not have private medical insurance. The service includes arranging and making payment for a physical examination and/or report necessary for a child in or needing foster care placement.

(k) **Foster care psychological evaluation and report** - The department may arrange for this service and make payment to a psychologist, psychiatrist, or other appropriate person for an evaluation of a child, parent, or foster parent. The department authorizes this service to assist in preventing a foster care placement or making an appropriate placement to implement a permanent plan.

(l) **Foster care psychological treatment and report** - The department arranges this service and makes payment to a psychologist, a psychiatrist, or other appropriate person for treatment of a child and/or parent(s) necessary to assist in preventing out-of-home placement, making an appropriate out-of-home placement, or implementing a permanent plan. This service includes a written report of the treatment goals, progress and outcomes.

(m) **Foster care transportation** - Reimbursement for the cost of transportation by car and associated expenses incurred by or on behalf of a child in foster care, receiving family reconciliation services (FRS), adoption services, or for return of a runaway. The department makes reimbursement directly to a vendor or to a foster parent.

(n) **Foster care business account transportation** - Reimbursement for the cost of air and rail transportation and associated expenses incurred by or on behalf of a child in foster care, receiving family reconciliation services (FRS), adoption services, or for return of a runaway. The department makes reimbursement directly to a vendor and charges expenses to the business transportation account (BTA).

(o) **Parent-child visitation** - Transportation and visitation services for children in out-of-home care. Services include:

(i) Transportation to and from scheduled visits;

(ii) Monitoring and supervision of family visits; and

(iii) Reports regarding the nature and progress of visits and the parent/child interaction.

(3) The rates for the specialized services described in this section are contained in the following table. The rates are effective July 1, 2000.

Specialized Services and Reimbursement Rates

Receiving Care Service	Rating*	Per Hour
Receiving home contracted and non-contracted respite	Light	$5.84
	Moderate	$5.98
	Heavy	$6.25
Receiving home transportation	Amount authorized	
Receiving home contracted support services	Contracted amount	
Receiving home ancillary support services	Amount authorized	
Receiving Foster Care Service	Rating*	Per Hour
Hourly foster care respite	Light	$6.39
	Moderate	$5.53
	Heavy	$6.84
Daily foster care respite	Light	$49.97
	Moderate	$52.15
	Heavy	$54.65

*To determine rating for child's care requirements in physical/medical and behavior/psychological areas:
Rating of light in both areas = light
Rating of light in one area and heavy in the other area = moderate
Rating of heavy in both areas = heavy

Foster care clothing/monthly (for children not in a paid placement)	Age	7/1/2000
	0-11	$37.13
	12 & older	$44.14
Foster care personal incidentals (one time payment)	Age	7/1/2000
	0-5	$50.65
	6-11	$55.10
	12 & older	$59.13
Foster care medical services	Amount authorized	
Foster care physical examination by health care practitioner	$8.50 - $25.00 (one time payment)	
Foster care psychological evaluation/report	Up to $105.00 per unit of service	
Foster care transportation	Up to $1,000.00	
Foster care business transportation account transportation	Up to $1,000.00	
Foster care psychological treatment/report	Up to $1100.00 per unit of service	
Parent-child visitation	As contracted	

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0170, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0175 Under what circumstances may the department provide foster care for educational purposes? (1) The department may provide licensed foster care for a child with physical or mental disabilities when requested by a school district and in concurrence with the wishes of the parents, in accordance with WAC 388-25-0030.

(2) The department will not make the payment when the only need for foster care arises from the need for an education. The department will only pay the cost of foster care when one of the conditions of WAC 388-25-0030 applies.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0175, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0180 Under what circumstances may the department provide reimbursement for foster care if the child is temporarily absent from the foster home or facility? (1) When a child is temporarily absent from a foster home or a facility to which the department is paying the cost of placement, the department may pay for the actual number of days absent, if the number of consecutive days of absence does not go over fifteen days within a thirty-day period. The care provider must notify the DCFS social worker of the absence and whether the absence is planned or unplanned.

(2) The following requirements apply to planned absences:

(a) The care provider must notify the DCFS social worker at least three days in advance of any planned absence. The notification must include the following information:

(i) Child's name;

(ii) The address the child will visit;

(iii) The reason for the visit;

(iv) The planned beginning and ending dates of absence; and

(v) A statement as to whether or not the foster care provider will hold the child's unoccupied bed for the child's return to the home or facility.

(b) A private agency must report the frequency, duration, and reasons for visits to the responsible DCFS social worker or local office in the child's quarterly progress report prepared by the private agency.

(c) When there is a planned temporary absence of a child from a foster family home supervised by DCFS, the assigned social worker will participate in the plan.

(3) The following requirements apply to unplanned absence of children from out-of-home care:

(a) The foster care provider must notify the supervising DCFS social worker by the next working day or within eight hours following the child's unplanned absence. Notification may be by a telephone call to the DCFS social worker or the worker's supervisor. The written notification must provide the following information:

(i) Child's name, age, and home address;

(ii) Date and time the child left the premises;

(iii) A statement as to whether the foster care provider is willing to accept the child back into the home or facility; and

(iv) A statement as to whether or not the foster care provider will hold the child's unoccupied bed for the child's return to the home or facility.

(b) If the foster care provider is willing to accept the child back and holds a vacant bed for the child, the department may continue payment for fifteen days from the date of the child's departure.

(c) The foster care provider must notify the DCFS social worker or local office of the date of the child's return.

(4) In addition to the preceding requirements, the department places the following limitations on the payments for temporary absences of children from foster care:

(a) A child's cumulative total of forty-five days of absence within a six-month period is the maximum allowable for payment unless the DCFS regional administrator or the administrator's designee approves an exception request.

(b) The social worker must provide adequate justification of unusual circumstances to support a request for extension of the consecutive fifteen-day and cumulative forty-five-day limitations.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0180, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0185 May the department consider foster care payments to the foster family in determining eligibility for public assistance? When the department or a child placing agency places a child in foster care with a family receiving public assistance under 42 U.S.C. 601, et seq., the department must not consider payment received by the family for the foster child in determining the family's eligibility for public assistance. The department makes payments, including special or exceptional payments, for the child's board, clothing and personal incidentals.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0185, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0190 What are the department's standards for making foster care payment to a relative providing care to the child served by department? (1) A relative caregiver, licensed or certified as a family foster home under chapter 74.15 RCW and eligible for temporary assistance for needy families (TANF) in behalf of the child, may select either foster care or TANF payments in behalf of the child, but not both.

(2) A relative caretaker who is not related to the specified degree defined in RCW 74.15.020 by blood, marriage, or legal adoption may receive foster care payments in behalf of the child if licensed as a foster family home under chapter 74.15 RCW.

(3) A relative caretaker who is not licensed or certified for foster care may apply for TANF.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0190, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0195 How does the department make reimbursement for foster care for a child served by the department who moves out of state with the foster family? (1) A child may join a foster family in a move out of state only if this move supports achieving a permanency goal as outlined in the child's case plan.

(2) The department and the foster parent must follow CA requirements when a foster child and the licensed foster family moves out of state. This may include obtaining permission of the court before the move.

(3) When the foster family moves to another state, the department must arrange with the other state or local social service agency to license and supervise the home and the placement (see chapter 26.34 RCW). The department does not need to make such arrangements for supervision when the family leaves this state during a vacation.

(a) Before the foster family moves from Washington to the new state, the social worker or the foster parent may request a foster home license application from the new state.

(b) If the department and the foster parent are unable to obtain an application for license before the foster family leaves Washington, the foster parent must, upon arrival in the new state of residence, contact the local foster home licensing agency in the new state to apply for a license in that state.

(4) When the foster family moves to another state with a child in the department's custody, the child's DCFS social worker must submit necessary interstate compact on the placement of children (ICPC) application forms to the department's ICPC program manager. The social worker must do this as soon as the foster family has a new residence or address in the new state. The ICPC request must ask that the new state license the family as a foster home and provide ongoing supervision of the child in care.

(5) The department continues payments at the department's current rates until the other state fully licenses the home. After receiving a copy of the foster family home license from the other state, the DCFS supervising social worker authorizes payment at the receiving state's rates (see WAC 388-25-0195).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0195, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0200 What payment procedures must the department follow for children placed across state borders? (1) When the department places a child into a new placement with a family residing and licensed in another state, the DCFS social worker must obtain the payment rates from that state. Following receipt of the other state's rates, the department will pay that state's rates in accordance with ICPC procedures when:

(a) Those rates are higher than Washington's rates; and

(b) The other state identifies its rates to the department.

(2) When the child welfare department in another state places a child, who is a resident of the state of Washington, in foster care the department makes foster care payments at the rate requested by that state.

(3) The CA ICPC program manager must approve out-of-state placement before the department makes payment for foster care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0200, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0205 How does the department treat the earnings of a child in foster care? The department does not include the earnings of a child in out-of-home care when considering if a child is eligible for a particular funding source nor when determining a child's possible participation in the cost of care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0205, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0210 How does the department treat resources and unearned income of a child in foster care? (1) Unearned income includes Supplemental Security Income (SSI), Retirement, Survivors and Disability Insurance (RSDI), veteran's benefits, railroad retirement benefits, inheritances, or any other payments for which the child is eligible, unless specifically exempted by the terms and conditions of the receipt of the income. The department must use income not exempted to cover the child's cost of care, except for resources held in trust for an American Indian child.

(2) Any person, agency or court that receives payments on behalf of a child in out-of-home care must send the payments to the department's division of child support.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0210, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0215 What is the parents' obligation to support their child in foster care? Parents of children in foster care must provide financial support for their child in accordance with rules contained in chapter 388-14A WAC.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0215, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0220 Who has authority to recommend or negotiate amounts for parental participation in the cost of foster care? (1) The department's division of child support determines the amount of parental financial support, except when stated in a superior court order. Chapter 74.20A RCW and chapter 388-14A WAC provide the authority and procedures for the division of child support to collect financial support from the parent to pay for a child in foster care.

(2) Only the division of child support may recommend to the court, on behalf of the department, to establish, raise, lower, release, or forgive support payments for a child placed in foster care. No other agency or staff may make agreements with parent(s) or their representatives regarding this matter.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0220, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0225 What cases must the department refer to the division of child support (DCS)? (1) The DCFS office must refer to the division of child support every foster care placement in which DCFS participates in payment for care, except:

(a) Cases, if any, in which the division of child support has determined it would not be cost effective to pursue collection, including placements of seventy-two hours or less; or

(b) Cases exempt by law from collection action; or

(2) The children's administration must refer to DCS cases in which the department determines that sufficient good cause exists to not pursue collection. The following constitute good cause for requesting that DCS not pursue collection action on foster care cases referred to DCS:

(a) The department's division of developmental disabilities (DDD) has determined that the child is developmentally disabled. DCS still must establish paternity.

(b) The parent or other legally obligated person, or the parent or other person's child, spouse, or spouse's child was the victim of the offense for which the child was committed to the custody of the juvenile rehabilitation administration (JRA) and the child is being placed directly into foster care from a JRA facility until this placement episode closes.

(c) Adoption proceedings for the child are pending in court or the custodial parent is being helped by a private or public agency to decide if the child will be placed for adoption.

(d) The child was conceived as a result of incest or rape and establishing paternity would not be in the child's best interest.

(e) The juvenile or Tribal court in the dependency proceeding finds that the parents will be unable to comply with an agreed reunification plan with the child due to the financial hardship caused by paying child support. The social worker also may determine that financial hardship caused by paying child support will delay or prevent family reunification.

(f) The custodial parent and/or the child may be placed in danger as a result of the presence of or potential for domestic abuse perpetrated by the other parent or responsible person.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0225, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0230 Are adoption support cases exempt from referral to the division of child support (DCS) for collection? Adoption support cases may be referred to DCS. Each case will be reviewed for determination of good cause exemption from collection.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0230, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0235 To whom must parents' send child support payments for their child in foster care? The parents must make all payments for the benefit of the child and/or the costs for a child in out-of-home care to the division of child support, unless a court order directs payment through a clerk of the court. A clerk of the court must send payments, under a court order, to the division of child support.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0235, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0240 Under what circumstances must child care judgment and limited power of attorney for parental support payments be assigned to the department? (1) The department must advise any person or agency having custody of the child that court ordered child support payments are to be received by the department under RCW 74.20A.030 and 74.20A.250.

(2) The person or agency having custody must acknowledge this transferred right to the department by execution of an assignment of judgment and limited power of attorney, which must remain in effect as long as the child receives foster care assistance.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0240, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0245 Who receives veterans' benefits for children in foster care? By agreement with the regional office of the veterans' administration, the department may receive benefits on behalf of children who have been placed by court order under the department's supervision or custody.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0245, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0250 What limitations exist on administrative hearings regarding foster care payments? The foster care provider, the licensed or certified child placement or care agency, and the parents are not entitled to request an administrative hearing to dispute established rates. Chapter 34.05 and 43.20A RCW, chapter 388-01 and 388-148 WAC, and this chapter provide specific rights to administrative hearings.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0250, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0255 What standards must the department apply to contracted and noncontracted service providers and vendors when the department has identified an overpayment to the provider or vendor? (1) RCW 43.20B.675 provides that all vendors have the right to request a hearing if they have a bona fide overpayment dispute. The department must offer a prehearing conference to all clients and vendors that request an administrative hearing.

(2) Contracted and noncontracted service providers may seek dispute resolution through these rules, under the Administrative Procedure Act and RCW 43.20B.675, with respect to overpayments. However, the following limitations apply:

(a) The right of vendors to seek an administrative hearing to contest alleged overpayments applies only to overpayments for goods or services provided on or after July 1, 1998.

(b) These procedures do not create a right to a hearing where no dispute right previously existed except as provided in RCW 43.20B.675.

(c) These rules limit disputes for foster family and child day care providers to alleged overpayments. Homes and facilities licensed under chapter 74.15 RCW may appeal adverse licensing actions under the provisions of chapter 388-148 or 388-155 WAC, as applicable.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0255, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0260 Do vendor overpayment rules in this chapter also apply to adoptive parents? Adoptive parents who receive assistance through the adoption support program are not vendors within the meaning of the law and do not fall within the scope of this chapter.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0260, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0265 Are there time limitations on identifying and recovering an overpayment? There is no time limit on identifying and initiating recovery of overpayments.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0265, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0270 May overpayments be waived or forgiven? Children's administration employees do not have authority to forgive or waive overpayments nor to offset overpayments from future payments. All such authority rests with the department's office of financial recovery (OFR). Designated CA staff may mediate a disputed payment with the vendor, but final approval for any negotiated proposed settlement rests with OFR.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0270, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0275 Do other governmental organizations have the right to an adjudicative hearing? Governmental organizations, including Indian Tribes, with an interlocal agreement with the department do not have the right to an adjudicative hearing through the office of administrative hearings (OAH). The disputes process described in the agreement between the entity and the department governs the resolution process.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0275, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0280 What steps must a provider or vendor take when requesting an administrative hearing in regards to an overpayment? A provider or vendor must follow the procedure indicated on the department's Vendor Overpayment Notice, DSHS 18-398A(X), dated 07/1998.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0280, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0285 When is payment due on an overpayment? When a vendor files a timely and complete request for an administrative hearing, payment on the overpayment is not due on the amount contested until the office of administrative hearings or its designee makes a final decision about the vendor's liability and any amount due.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0285, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0290 Which is the deciding authority if another WAC rule or the provisions of the Administrative Procedure Act conflict with the information in this chapter? The Administrative Procedure Act, chapter 34.05 RCW, chapter 388-02 WAC, and this chapter govern the proceeding. The provisions in this chapter govern if a conflict exists in chapter 388-02 WAC. Chapter 34.05 RCW is the overall governing authority.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0290, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0295 Who establishes guidelines to identify overpayments and to mediate overpayment disputes? (1) Each DCFS regional administrator, division of licensed resources (DLR) regional manager, or CA division director, as applicable, must establish procedures to provide for consistency in the handling of provider or vendor disputes in accordance with the children's administration prehearing procedures and this chapter.

(2) Staff at the following organizational levels will handle disputes:

(a) The DCFS regional administrator is responsible for the dispute resolution process for:

(i) All payments authorized by local office social workers;

(ii) All payments authorized under regionally managed contracts and service agreements.

(b) Regional staff are responsible for the following activities to resolve disputes:

(i) Prehearing conferences;

(ii) Mediation activities;

(iii) Administrative hearings for payments authorized in local offices; and

(iv) Administrative hearings for regionally-managed contracts.

(c) For CA child care subsidy program payment disputes, DLR office of child care policy (OCCP) headquarters staff is responsible for:

(i) Prehearing conferences;

(ii) Mediation activities; and

(iii) Administrative hearings.

(d) Assigned CA division of program and policy development or office of foster care licensing (OFCL) headquarters staff, as applicable, will handle disputes arising from headquarters-managed contracts and service agreements. These staff will handle:

(i) Prehearing conferences;

(ii) mediation activities; and

(iii) Administrative hearings.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0295, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0300 What is the foster parent liability fund? (1) The foster parent liability fund authorized under RCW 74.14B.080 allows for insurance coverage for foster parents licensed under chapter 74.15 RCW. The coverage includes personal injury and property damage caused by foster parents or foster children that occurred while the children were in foster care.

(2) Such insurance covers acts of ordinary negligence but does not cover illegal conduct or bad faith acts taken by foster parents in providing foster care. Monies paid from liability insurance for any claim are limited to the amount by which the claim exceeds the amount available to the claimant from any valid and collectible liability insurance.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0300, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0305 What is the period of coverage for foster parent liability fund? Coverage under the foster parent liability fund is for valid claims arising out of occurrences on or after July 1, 1991.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0305, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0310 Who is eligible for coverage under the foster parent liability fund? A person eligible for foster parent liability fund coverage must be licensed or certified by the department or a child placing agency under chapter 74.15 RCW to provide foster family care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0310, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0315 What are the limits of coverage under the foster parent liability fund? The limits of coverage under the foster parent liability are:

(1) Up to twenty-five thousand dollars per occurrence. "Occurrence" means, for purposes of this chapter, the incident which led to the claim.

(2) The claim must be for a third party personal injury or property damage arising from a foster parent's act or omission in the good faith provision of family foster care and supervision of a foster child.

(3) The department must not make a payment of claims from this liability fund if the foster parent is not liable to the third party or the foster child's birth or adoptive parent or guardian because of any:

(a) Immunities;

(b) Limitations; or

(c) Exclusions provided by law.

(4) The foster parent must, first, exhaust all monetary resources available from another valid and collectible liability insurance before seeking payment from this liability fund. Coverage under this foster parent liability fund must be in excess of any other available liability insurance.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0315, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0320 The department excludes what claims from coverage under the foster parent liability fund? The department excludes the following claims from coverage under the foster parent liability fund:

(1) Claims arising as a result of a foster parent's illegal conduct or bad faith acts in providing family foster care. Such conduct or act includes but is not limited to:

(a) Loss arising out of a dishonest, fraudulent, criminal, or intentional act or omission;

(b) Loss arising out of licentious, immoral, or sexual behavior;

(c) Loss occurring because the foster parent provided a foster child with an alcoholic beverage or controlled substance, other than medication prescribed for the foster child in the amounts prescribed by a physician or other licensed or authorized medical practitioner;

(d) A judgment against the foster parent based on alienation of affection.

(2) Claims based on an occurrence not arising from the family foster care relationship. This includes a foster child's act occurring while the child was temporarily assigned outside the jurisdiction of the foster parent.

(3) Claims for a bodily injury or property damage arising out of the operation or use of any motor vehicle, aircraft, or water craft owned by, operated by, rented to, or loaned to any foster parent; or

(4) Claims for an injury or damage from an occurrence before July 1, 1991.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0320, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0325 What if there are multiple claims for one occurrence under the foster parent liability fund? The twenty-five thousand dollar limitation per occurrence must apply regardless of whether there are multiple claims arising from the same occurrence. The department will consider a claim by one or more foster parents occupying the same household a single claim.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0325, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0330 May another source be used to recover on the same claim paid by the liability fund? (1) If the liability fund pays for a claim, the foster parent must transfer to the department the foster parent's rights of recovery against any person or organization against whom the foster parent may have a legal claim.

(2) The foster parent must sign and deliver to the department any documents necessary to transfer such foster parent's rights to the state.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0330, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0335 What are the department's authority and the foster parent's responsibilities regarding investigation of claims? (1) The department may conduct an investigation of any foster parent liability fund claim.

(2) The foster parent must fully cooperate with the department for any liability fund claims filed against the foster parent.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0335, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0340 What are the department's responsibilities and limitations for reimbursement for damage or loss caused by a child in family foster care? (1) Within available funds and subject to the conditions in this chapter, the department must reimburse family foster care providers who incur property damages, losses, and emergency medical treatment expenses that are caused by the foster child or respite care child during placement in the foster family's home.

(2) For occurrences on or after October 1, 1999, the department must reimburse the foster parent for the replacement value of any property covered under and subject to the limitations of this chapter (see RCW 74.13.335).

(3) For occurrences before October 1, 1999, the department will reimburse the depreciated value of any property covered under and subject to the limitations of the this chapter.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0340, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0345 What are the eligibility requirements for reimbursements to foster parents for damages? Foster parents are eligible for reimbursement if the foster parents are:

(1) Licensed by DSHS or certified by a child-placing agency and licensed by the department under chapter 74.15 RCW; and

(2) Providing approved DSHS-funded foster care to children in the care, custody, and supervision of DSHS or a licensed child placing agency; or

(3) Providing department-approved and funded respite care to children.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0345, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0350 What are the department's reimbursement limitations? The following reimbursement limitations apply for claims:

(1) The **PER OCCURRENCE/TOTAL** amount the department will pay as the result of any one occurrence must not exceed:

(a) Five thousand dollars for all property damages and losses; or

(b) One thousand dollars for all personal bodily injuries regardless of the number of foster parents or their household members who sustain property damages, losses, or personal bodily injuries.

(2) **PROPERTY DAMAGE ITEMS** are limited to the repair/cleaning cost or the replacement value. The department pays replacement value if the item cannot be repaired or cleaned as substantiated by a detailed retailer estimate or if the repair cost goes over the replacement value of the item. The department may request the final repair bill from foster

parents for payment made from estimates provided for purposes of recovery.

(3) **PROPERTY LOSS ITEMS** are limited to the replacement value as substantiated by the original purchase receipt, if available, and two replacement estimates or replacement purchase receipt.

(4) **PERSONAL BODILY INJURY** claims are limited to the costs incurred for receiving emergency medical treatment services that is not payable or required to be provided under workmen's compensation, or disability benefits law, or under any similar law, or provided under a personal/business medical plan.

(5) For **POLICY DEDUCTIBLES**, foster parents must disclose if their property damages or losses were paid or will be paid under their homeowner, automobile, or other personal/business insurance policy. The department will then limit reimbursement to the policy deductible.

(6) **DENTAL EXPENSES** are limited to costs not payable under a dental plan. The department will pay comparable replacement of dental appliances up to the maximum per occurrence.

(7) **VISION EXPENSES** are limited to costs not payable under a medical plan.

(8) **LABOR EXPENSES** are limited to out-of-pocket costs (materials), incurred by foster parents and substantiated by a retailer. Items requiring installation are to be considered reimbursable expense.

(9) **VETERINARY EXPENSES** are limited to initial treatment expense incurred immediately following an occurrence up to five hundred dollars. Initial treatment expense is defined as emergent care and diagnosis. The department pays replacement value for a property loss sustained not to exceed the substantiated value of the animal or maximum per occurrence, whichever is less.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0350, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0355 What types of claims are specifically excluded from reimbursement? The department specifically excludes the following from reimbursement:

(1) Claims resulting from giving alcoholic beverage or other illegal substance, including tobacco products, to a foster child or respite care child for whatever reason.

(2) Claims resulting from violation of any statute, ordinance, or regulation by the foster child or respite care child.

(3) Claims resulting from failure of the foster parent to give directions, instructions, or to provide proper or adequate supervision to the foster child or respite care child.

(4) Claims resulting from the sexual abuse, or licentious, immoral, or other sexual behavior between foster children and/or respite care children or initiated by a foster parent.

(5) Follow-up medical treatment expenses incurred by foster parents or their household member for a personal bodily injury sustained as a result of an action of the foster/respite care child.

(6) Claims for items which belong to the foster child or respite care child.

(7) Claims resulting from acts of foster children that occur while the child is on a temporary planned, unplanned, or voluntary absence from the foster home.

(8) Claims for lost wages.

(9) Claims for property damages, losses, and emergency medical treatment costs arising out of an act of the foster/respite child, with or without the permission of the foster parent, related to the ownership, operation, or maintenance of any owned motor vehicle, including surface, air, or water.

(10) Claims filed by any person other than the foster parent or their household member.

(11) Claims for unsubstantiated property damages or losses alleged to have been caused by the foster child or respite care child.

(12) Claims not received by the department's office of risk management (ORM) within a year after the date of occurrence, regardless of the reason for the delay in filing the claim.

(13) Property damages or loss of items that do not depreciate, including but not limited to antiques, heirlooms, jewelry, figurines, and coin collections.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0355, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0360 What is the procedure for filing a claim? (1) Within thirty days of an occurrence of property damage, loss, or emergency medical treatment, the foster parent must:

(a) Request from the child's social worker a Foster Parent Reimbursement Plan Claim, DSHS 18-400(X) (Rev. 6/96) to file a claim;

(b) Submit the completed claim with all requested information plus any required substantiating documentation;

(2) The claimant must include a statement documenting the reasons for the delay in filing the claim on claims filed more than thirty days after an occurrence.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0360, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0365 Which office within the department determines damage reimbursement? The department's office of risk management determines whether a claim will be paid.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0365, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0370 How are exception requests made? Written requests for exceptions to the terms, limitations, and exclusions specified in the foster parent reimbursement plan must be made to the ORM, Risk Management Administrator, P.O. Box 45844, Mail Stop 45844, Olympia, WA 98504-5844. The request must include the justification for the request and alternatives explored. ORM staff will discuss and review requests for exceptions with the CA foster care program manager. Staff in the CA division of program and policy development make final decisions on exceptions.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0370, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0375 What claims may the department deny? The department must deny any claim in which any material fact or circumstance of a property damage, loss, or

personal bodily injury is misrepresented or willfully concealed by the foster parent. The department is entitled to recover any payments made in these cases. Claims found to be fraudulent involving theft or collusion are subject to criminal investigation.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0375, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0380 What must a foster parent do to have a denied claim reconsidered? The foster parent must submit a request for reconsideration in writing within thirty days of the previous decision to the claims program manager, DSHS Office of Risk Management (ORM), P.O. Box 45844, Mail Stop 45844, Olympia, WA 98504-5844. The request must include information or documentation not previously provided. All determinations made by the risk management administrator are final and do not constitute a basis for requesting or obtaining an administrative fair hearing.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0380, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0385 Will the department investigate claims? The foster parent must permit the department, upon request, to inspect the damaged property. The department retains the authority to have an inspector of its choice make a damage estimate when, and as often, as the department may require.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0385, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0390 What are the training requirements for licensed foster parents? See chapter 388-148 WAC for required training for licensed foster parents.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0390, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0395 What are the department's responsibilities for management of juvenile records? The department must comply with the requirements of chapter 13.50 RCW for management of juvenile records. The department's responsibilities for management of those records are:

(1) To maintain accurate information and remove or correct false or inaccurate information;

(2) To take reasonable steps to ensure the security of records and to prevent tampering;

(3) To make every effort to ensure the completeness of records, including action taken by other agencies with respect to matters in its files; and

(4) To facilitate inquiries concerning access to records.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0395, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0400 To whom may the department release records? Subject to review the department may release records to the following persons:

(1) Other participants in the juvenile justice or care system only when an investigation or case involving the juvenile is being pursued by the other participants or when that participant is assigned the responsibility of supervising the juvenile. "Juvenile justice or care agency" means any of the following: Police, diversion units, court, prosecuting attorney, defense attorney, detention center, attorney general, the legislative children's oversight committee, the office of family and children's ombudsman, the department and its contracting agencies, schools; persons or public or private agencies having children committed to their custody; and any placement oversight committee created under RCW 72.05.415;

(2) A contracting agency or service provider of the department that provides counseling, psychological, psychiatric, or medical services may release to the office of the family and children's ombudsman information or records relating to the provision of services to a juvenile who is dependent under chapter 13.34 RCW. The department may provide these records without the consent of the parent or guardian of the juvenile, or of the juvenile if the juvenile is under the age of thirteen, unless otherwise prohibited by law;

(3) A juvenile, a juvenile's parents, the juvenile's attorney, and the juvenile's parent's attorney;

(4) Any person who has reasonable cause to believe information concerning that person is included in the record;

(5) A clinic, hospital, or agency which has the subject person under care or treatment;

(6) Individuals or agencies engaged in legitimate research for educational, scientific, or public purposes when permission is granted by the court.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0400, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0405 Under what circumstances may the department exclude or deny information from release unless authorized by law or court order? The department may withhold the following information unless authorized or ordered by the court:

(1) Information determined by the department to likely cause severe psychological or physical harm to the juvenile or the juvenile's parents;

(2) Information obtained in connection with provision of counseling, psychological, psychiatric, or medical services to the juvenile, when the services have been sought voluntarily by the juvenile, and the juvenile has a legal right to receive those services without the consent of any person or agency. Such information may not be disclosed to the juvenile's parents without the informed consent of the juvenile.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0405, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0410 What may a juvenile or the juvenile's parent do if the department denies access to information? (1) A juvenile or the juvenile's parent may file a motion in juvenile court requesting access to the records.

(2) The person making the motion must give reasonable notice of the motion to all parties.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0410, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0415 What are the department's expectations for child placing agencies (CPA) to which the department makes reimbursement for services or admin-

istrative costs? (1) The department requires that the child placing agency (CPA) be licensed or certified under chapter 74.15 RCW and have a contract with the department for the provision of child placement and related services.

(2) The CPA must document the services provided in a format described by the department in the contract.

(3) When the department agrees to place a child with a CPA, the licensed or certified agency must maintain the license of the foster family home and provide support services to the foster parents. The department will only place and pay for services with an agency with which the department has a contract. The agency must provide payment to the foster family in accordance with this chapter.

(4) The department requires that private agencies bringing children from other countries for adoption remain financially responsible for the child's placement costs if the adoption is not finalized, disrupts prior to finalization, or until the child reaches age eighteen.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0415, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0420 What steps must the department take when a child whose case management responsibility remains with the department is placed in a home certified by a CPA? (1) The DCFS social worker follows regionally-designated procedures for accessing services and sharing responsibility for utilizing child placing agency foster homes.

(2) The CPA and the DCFS social worker must sign a DSHS Private Child Placing Agency Agreement/Child in Foster Care, DSHS 15-190(X). The agreement designates which agency is responsible for case management services, support activities, and specific parts of the service plan while the child is placed in the CPA foster home. The agency representative and the department social worker must review and revise the agreement by mutual agreement at the request of either party.

(3) The CPA must provide the assigned DCFS social worker with quarterly progress reports for each child placed in homes certified by the CPA.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0420, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0425 What activities must a child placing agency provide in order to receive payment from the department? The CPA must undertake the following activities to receive payment from the department:

(1) Accept referrals of children and families from the department and negotiate a child-specific written service agreement with the department;

(2) Provide child and family case management and support activities as agreed;

(3) Document the case management and support activities as described in the contract between the department and the CPA;

(4) Provide adequate quarterly progress reports to the assigned social worker for each child whose placement or other services the department financially supports.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0425, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0430 Under what conditions and how much will the department reimburse to child placing agencies licensed or certified under chapter 74.15 RCW to provide care to children? (1) The CPA representative must discuss with the department social worker for the child the roles of the agency and the department in the placement, permanency planning, and supervision of the child. The agency representative and the department social worker must also discuss services the department or the agency will provide to the child's parents and extended family.

(2) The CPA must maintain the documentation required by contract to demonstrate all services provided to children in care and for whom the department makes payment.

(3) The department will pay a monthly administrative fee to a CPA if the agency, in addition to supervision of the child, provides services to the child or the child's family.

(4) If the department wants to borrow a CPA-certified home for placement of a child, the department pays the agency for the use of the CPA's foster home with approval of the agency. The department pays the borrowed home fee described in the contract between the department and the agency.

(5) The department will pay a set monthly fee to a child placing agency for a borrowed home if the agency provides supervision services only to the child and no services to the child's family. The department pays this fee only to enable the agency to maintain the foster care license and to provide any related licensing training and support services. This activity includes maintenance of a foster care license for foster parent dependency guardianships in the agency-certified home. The following conditions also apply:

(a) The department may pay for a maximum of two borrowed beds in one foster home.

(b) If one CPA borrows a bed from another CPA, the department will pay only one service fee to one agency for the child. The two private agencies and the department will mutually identify and agree upon the agency the department will pay.

(6) The department may enter into contracts with CPAs to provide intensive treatment and supervision services to children with behavioral, emotional, medical, or developmental disabilities. The department will assess the needs of the child, assign a service level, and pay the rate provided in the contract.

(7) Before making payment for care of a child, the department must determine initial and ongoing eligibility for financial support, approve the placement, and approve the case plan for care of the child and services to the family. The department will document this approval through written agreements, documentary reports, and supervisory conferences with the CPA.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0430, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0435 What steps may the department take if a child placing agency does not meet the requirements of this chapter? (1) In addition to any sanctions included in the department's contract with the CPA, the DCFS social worker must stop payment of the agency admin-

istrative fees in accordance with department procedures if the department does not receive the child's report in the timeframe stipulated in WAC 388-25-0425.

(2) The DCFS social worker must inform the regional licenser and contracts coordinator when there are continuing problems with reports.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0435, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0440 What are the department's obligations regarding children placed by the department between states? The department must comply with the interstate compact on the placement of children (ICPC) in the interstate placement of children (see chapter 26.34 RCW).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0440, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0445 Under what circumstances does the department choose a relative as the placement for a child in need of out-of-home care? (1) When the department determines that a child needs to be placed outside the home, the department must search for appropriate relatives to care for the child before considering nonrelative placements. See RCW 74.15.020 for the definition of "relative."

(2) The department reviews and determines the following when selecting a relative placement:

(a) The child would be comfortable living with the relative;

(b) The relative has a potential relationship with the child;

(c) The relative is capable of caring for the child and is willing to cooperate with the permanency plan for the child;

(d) The relative is able to provide a safe home for the child;

(e) Each child has his or her own bed or crib if the child remains in the home beyond thirty days.

(3) The department may consider nonrelated family members as potential resources, if these family members become licensed to provide foster care (see RCW 74.15.030).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0445, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0450 Under what circumstances may a relative not be considered as a placement option for a child? The department may exclude relatives who have criminal histories as included in the Adoption and Safe Families Act (ASFA) regulations.

(1) If the department finds that, based on a criminal records check, a court of competent jurisdiction has determined that the relative or a member of the household has been convicted of a felony involving:

(a) Child abuse or neglect;

(b) Spousal abuse;

(c) A crime against a child or children (including child pornography); or

(d) Crimes involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery.

(2) The department may not approve a relative placement if the department finds the relative, or a member of the household, has, within the last five years, been convicted of a felony involving:

(a) Physical assault;

(b) Battery; or

(c) A drug related offense.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0450, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0455 What sources of financial support are available to a relative caring for a child that the department has placed in the relative's home? (1) For relatives needing financial support to care for the child, the social worker may assist the family to apply for temporary assistance for needy families (TANF) through the department's local community services office (CSO).

(2) Relatives who are licensed as foster parents may choose to receive foster care payments. The relative must not receive TANF benefits in behalf of the child in care while at the same time receiving foster care payments (see RCW 74.15.030).

(3) A relative who is not a licensed foster parent at the time of placement may apply to become a foster parent as described in chapter 388-148 WAC.

(4) The relative caring for the child in out-of-home placement may apply to be the representative payee for Supplemental Security Income (SSI) or Social Security Administration benefits for the related child living with the relative. However, if the child is a dependent of the state of Washington with custody assigned to the department by the court, the department will usually remain the payee in behalf of the child until the dependency is dismissed.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0455, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0460 How does the department treat relatives of specified degree with legally free children? (1) The department acknowledges a continuing relationship between relatives of specified degree and children who are legally free where the relatives choose to continue a relationship with the child and the continuing relationship is in the best interest of the child (see RCW 74.15.020 for the definition of relative of specified degree).

(2) Relatives of specified degree remain legal relatives when a child becomes legally free if those relatives wish to maintain a relationship with the child and the assigned social worker determines the continuing relationship is in the best interest of the child.

(3) Department staff must treat relatives of specified degree as the department treats all relatives under the rules of ICPC and the foster care and foster family home licensing programs.

The rights of the affected relatives of specified degree do not extend beyond adoption of the child except through an open adoption agreement (see RCW 26.33.295).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0460, filed 3/30/01, effective 4/30/01.]

Chapter 388-27 WAC

CHILD WELFARE SERVICES—ADOPTION SERVICES AND ADOPTION SUPPORT

WAC

WAC 388-27-0005 What is the legal basis for and purpose of the department's adoption program? (1) Adoption services are included in RCW 74.13.020 as a child welfare service.

(2) The purpose of the department's adoption program is to meet the permanency needs of children who are in the department's care and custody.

(a) The agency that has the responsibility for providing services to the family and makes permanent plans for children.

(b) The permanent plan must include a primary outcome and may also include alternate outcomes (see RCW 13.34.145). Possible permanent plans include:

(i) Return home;

(ii) Adoption;

(iii) Guardianship;

(iv) Permanent legal custody; or

(v) Independent living if the child is over age sixteen.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0005, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0010 What definitions apply to the department's adoption program? **"Agency"** means any public or private association, corporation, or individual licensed or certified by the department as a child placing agency under chapter 74.15 RCW or as an adoption agency.

"Adoptee" means a person who is to be adopted or who has been adopted.

"Adoption" means the legal granting of the adoption decree consistent with chapter 26.33 RCW.

"Adoptive parent" refers to a person or persons who seeks to adopt or who has adopted.

"Alleged father" refers to a person whose parent-child relationship has not been terminated, who is not a presumed father under chapter 26.26 RCW, and who alleges himself or whom a party alleges to be the father of the child. It includes a person whose marriage to the mother was terminated more than three hundred days before the birth of the child or who was separated from the mother more than three hundred days before the birth of the child.

"Approved adoptive home" refers to any person or persons who has been approved for adoption in a preplacement report completed pursuant to RCW 26.33.190.

"Birth parent" means the biological mother or biological or alleged father of a child, including a presumed father under chapter 26.26 RCW, whether or not a court of competent jurisdiction has terminated the person's parent-child relationship.

"Child placing agency" means an agency licensed by the department to place children for temporary care, continued care, or adoption.

"Children's administration" (CA) means the cluster of programs within the department of social and health services responsible for the provision of child welfare, adoption, child protective, child care licensing, and other services to children and their families.

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

"Department placement" refers to the placement of a child for whom the department has placement authority in an approved adoptive home.

"Division of children and family services" (DCFS) is the division of children's administration that provides child welfare, child protective, family reconciliation, and support services to children in need of protection and their families.

"Division of licensed resources" (DLR) is the division of children's administration responsible for licensing or certifying child care homes and facilities under the authority of chapter 74.15 RCW.

"Foster-adopt" refers to families that are interested in adoption who have an approved adoptive home study and who have also been granted a foster home license in accordance with chapter 388-148 WAC.

"Independent placement" refers to the placement of a child in an adoptive home by a doctor, attorney, or other individual acting as a facilitator.

"Inter-country placement" refers to the placement of a child for adoption who is not a resident and/or citizen of the United States.

"Relative" means a person related by blood, marriage, or legal adoption, as defined in RCW 74.15.020.

"Voluntary adoption plan" means an agreement by the birth parent(s) to the termination of parental rights with a specific proposal for adoptive placement for the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0010, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0015 What are the eligibility criteria for the department's adoption program? (1) The department provides adoption services to any child in the department's care and custody:

(a) With an identified permanent plan of adoption; or

(b) When the department considers adoption as an alternate permanent plan; and

(i) The child is in supervised out-of-home care; or

(ii) The child's birth parent(s) requests adoption as a permanent plan prior to the child's placement in out-of-home care.

(2) The department considers families who apply for adoption services to be resources for children in the department's care and custody if the potential parent(s) is:

(a) Legally competent;

(b) Eighteen years of age or older; and

(c) Has an approved adoptive home study.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0015, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0020 When does the department provide general adoption services? The department provides general adoption services throughout the case planning of any child with an identified primary or alternate permanent plan of adoption until:

(1) Finalization of the adoption; or

(2) Adoption is no longer the identified permanent plan.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0020, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0025 What general adoption services does the department provide? (1) The department provides the following general adoption services prior to the finalization of an adoption:

(a) Social work services to birth parents and children to achieve a permanent family for each child;

(b) Use of the courts, legal counsel, and juvenile court specialists for termination of parental rights and granting of adoption petitions;

(c) Obtaining available child and family medical and social background information for disclosure to adoptive families;

(d) Recruitment, study, and approval of adoptive and foster-adopt families;

(e) Assessment of the child and the current caretaker to determine if the placement is an appropriate adoptive placement;

(f) Placement of children with waiting adoptive or foster-adopt family;

(g) Social work services and/or referral of children and families to services after placement to facilitate the adoption;

(h) Development of alternate plans when the planned adoptive placement is not in the best interest of the child and/or the adoptive family; and

(i) Location and exchange, on a state and national basis, of information about children and adoptive families.

(2) The department administers the state's adoption support program on behalf of eligible children adopted through the department or a private child-placing agency (see WAC 388-25-0120 and following).

(3) The department administers the interstate compact on the placement of children (ICPC) and the interstate compact on adoption and medical assistance (ICAMA) and cooperates, upon request, with other state and tribal child welfare agencies in adoptive planning for children.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0025, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0030 What procedures must the department follow for the interstate placement of children? (1) Washington state is a member of Interstate Compact on Placement of Children (ICPC) and Interstate Compact on Adoption and Medical Assistance (ICAMA) and must meet all compact requirements (see chapter 26.34 RCW).

(2) The rules of this chapter apply to accepted ICPC cases.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0030, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0035 What adoption services does the department provide for children in the department's care and custody? (1) The department's adoption services for children include:

(a) Social work services with birth parents focused on locating a permanent home for the children.

(b) Social work services with children focusing on the child's educational, medical, psychological, and developmental needs;

(c) Petitioning the court for termination of parental rights;

(d) Facilitating voluntary relinquishments when a voluntary adoption is in the child's best interests;

(e) Assessment of children to determine their medical and social needs including, as needed:

(i) Psychiatric evaluations;

(ii) Psychological evaluations;

(iii) Educational evaluations; and

(iv) Medical evaluations;

(f) Evaluating prospective adoptive families through the use of the adoptive home study, also known as the preplacement report, to determine appropriateness for adoption generally and to determine What specific child characteristics or needs that the family will best be able to meet.

(g) Making adoptive placements that are best able to meet a child's needs, from available resources;

(h) Social work services and/or referral of children and families to services after placement;

(i) The department social worker assigned to finalizing the adoption will assist families complete the adoption support program application for children who may be eligible for the adoption support program;

(j) Provision of post-placement reports and other documents required for finalization to the court for a child when the department:

(i) Conducts the post-placement reports and other documents required for finalization to the court for a child when the department:

(ii) Has custody of the child;

(k) Provision of the consent to the adoption of a child in the department's custody.

(2) Every six months, the department must review and adjust the case plan for children continuing in foster care under department care and supervision. The CA social worker must develop the case plan in accordance with chapter 13.34 RCW to achieve the permanency planning goals for the child.

(3) The department may utilize the following methods to locate an adoptive resource for a child until the child has been placed with an adoptive family:

(a) Ask birth parents to identify a potential adoptive family;

(b) The department prefers to place a child for adoption with a fit and willing relative who is known to the child and with whom the child is comfortable:

(i) Conduct searches for relatives who are fit and willing to adopt the child, who are known to the child and with whom the child is comfortable;

(ii) Ask the relatives to be considered as a potential adoptive family;

(c) Ask current and past foster parents if they wish to be considered as a potential adoptive family;

(d) Consider families that have an approved adoptive home study; and/or

(e) Conduct individualized child specific family recruitment.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0035, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0040 What adoption services does the department provide for prospective and approved adoptive families? (1) For department placements, the department:

(a) Accepts applications from families residing in the state of Washington that are interested in adopting a child who is in the care and custody of the department. Children in the care and custody of the department may have special needs.

(b) Initiates an adoptive home study and achieves one of the following outcomes:

(i) Approves the family for an adoptive placement and registers the family with the contracted adoption resource exchange unless a placement decision has already been made;

(ii) Denies the application to adopt; or

(iii) The family withdraws the application to adopt.

(c) Searches for an appropriate placement for families with an approved adoptive home study;

(d) Obtains the prospective adoptive child's available medical and family background information and discloses the available information to the adoptive family;

(e) Removes a family from the contracted adoption resource exchange for any of the following reasons:

(i) A child has been placed with the family;

(ii) The family decides to receive adoption services through a private agency or an independent placement;

(iii) The department receives additional information that causes the department to revoke the approved status of a family;

(iv) The family and/or social worker determines that adoption is no longer an appropriate plan for the family; and/or

(v) The family relocates its residence to another state.

(f) Reevaluates a family's situation at the time of reapplication if a family was removed from the exchange registry and reapplies for adoption services;

(g) Informs families in writing of action the department has taken, according to the rules of this chapter;

(2) The department does not provide adoption or adoption-related services for inter-country adoptions or for independent adoptions.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0040, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0045 When may the department place a dependent child (not legally free) into an adoptive home? The department may place a child into a foster-adopt home under the following conditions:

(1) When the identified family has been granted a foster home license in accordance with chapter 388-148 WAC; and

(2) When the identified family has an approved adoptive home study that has been filed with the court in compliance with RCW 26.33.190.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0045, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0050 When may a legally free child be placed into an adoptive home? The department may place a child into an adoptive home under the following conditions:

(1) When the identified prospective adoptive family has an approved adoptive home study; and

(2) The adoptive home study has been filed with the court in compliance with RCW 26.33.190.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0050, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0055 What is a voluntary adoption plan? A voluntary adoption plan (VAP) occurs when a parent(s) has agreed to the termination of parental rights and has proposed a specific adoptive placement for the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0055, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0060 When must the department follow a voluntary adoption plan? The department must follow the voluntary plan for adoption if:

(1) The prospective adoptive parents chosen by the parent are properly qualified to adopt in compliance with chapter 26.33 RCW or WAC 388-25-0025; and

(2) The court determines that this adoption is in the best interest of the child; and

(3) The VAP is proposed to the department before a petition for termination of the parent-child relationship has been filed.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0060, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0065 Will the department consider a proposed voluntary adoption plan if a termination petition has already been filed at the request of the department? If the attorney general's office has filed a termination petition at the request of the department, the department must consider, but is not required to support, an adoptive resource proposed by the parent.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0065, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0070 What will the department do to implement a voluntary adoption plan? The department must take the following actions to implement a VAP:

(1) The assigned CA social worker must work with the parent to determine whether the parent will identify a preferred adoptive placement by name.

(2) If a parent identifies a preferred placement, the assigned social worker must advise the parent and the proposed adoptive parent(s) that an adoption home study must be completed. CA, a private agency, or a qualified individual may complete the adoptive home study (see RCW 26.33.190).

(3) If the proposed adoptive parent chooses to have an adoptive home study completed by a private agency or qualified individual, CA retains the right to do its own home study if CA has concerns regarding the recommendations contained in the nondepartmental home study.

(4) Using approved procedures for determining suitability to be an adoptive resource, the child's social worker and the social worker for the adoptive family must determine:

(a) That the preplacement investigation and report, as described in RCW 26.33.190, on the proposed family results in approval of the adoptive placement; and

(b) That this placement is in the best interest of the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0070, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0075 What must the department do to maintain confidentiality of adoption records? (1) In accordance with chapter 26.33 RCW all records and information the department obtains in providing adoption services are confidential.

(2) To ensure that the department case file of an adopted child remains confidential, the CA local office must send the child's case file to CA headquarters for archiving upon the issuance of the decree of adoption.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0075, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0080 Under what conditions may the department reveal identifying information about the birth parent? When providing reports or information on the adoptive child to the prospective or actual adoptive parents, the department must not reveal the identity of the birth parents of the child, unless:

(1) There is a written open communication agreement where the identity of the birth parent(s) is known;

(2) The birth parent is already known to the adoptive family; or

(3) The birth parent has selected the adoptive family, and the birth parent's identity has already been established.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0080, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0085 What must the department, private practitioner, or child placing agency do to locate records and information relating to the birth parents and the child? (1) The social worker, child placing agency, or another assigned worker must make the following efforts to locate records and information relating to the birth parent and the child:

(a) Ask the birth parents, the child, and relatives, when available, for names of all:

(i) Physicians;

(ii) Treatment agencies for medical, psychological, or educational services that have seen the parent or child for examination, evaluation, or treatment; and

(iii) Schools attended by the child and the parent.

(2) The social worker, contractor, or another assigned worker must contact the children's administration Supplemental Security Income (SSI) facilitator to obtain medical, psychological, or social information gathered during any SSI screen or application process.

(3) The social worker, contractor, or another assigned worker must document efforts, including unsuccessful efforts, made to obtain information by:

(a) Placing the gathered records in the child's case file;

(b) Documenting the information on the child's health and education record;

(c) Documenting on the health and education passport in CAMIS;

(d) Maintaining copies of written requests to service providers for records in the child's case file;

(e) Documenting efforts on the Child's Medical and Family Background Report, DSHS 13-041(X), unless the information is already documented on the health and education passport in CAMIS.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0085, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0090 What information must the department or child placing agency provide to prospective adoptive parents about the child that is being considered for adoption? (1) The department or the child placing agency must provide a medical report containing all known and available information concerning the mental, physical, and sensory handicaps of an adopted child, or a child placed for adoption, to the adoptive or prospective adoptive parents under the authority of RCW 26.33.020, 26.33.340, 26.33.343 and 26.33.350.

(2) The department or the child placing agency worker must provide the Child's Medical and Family Background Report, DSHS 13-041(X), to the prospective adoptive parents. This report must include documentation of efforts made to obtain medical and social information on the child and birth parents.

(3) The department must provide a social history report on the child and birth family that includes, at a minimum in accordance with RCW 26.33.380:

(a) Circumstances of the child's birth;

(b) Chronological report of how the child came to be available for adoption;

(c) The child's placement history;

(d) All court reports pertaining to the dependency and custody of the child;

(e) The child's education history, including school reports and records; and

(f) The child's psychological and psychiatric reports and recommendations.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0090, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0100 What information must the department or child placing agency provide to prospective adoptive parents about the birth parent(s) of a child being considered for adoption? The department or the child placing agency must provide a nonidentifying report on the birth parent(s) that includes any known and available social and medical information on the child's birth parent(s) in accordance with RCW 26.33.380. This information regarding the birth parent(s) must include but is not limited to:

(1) First names only;

(2) Current age of parent(s);

(3) Heritage, including nationality, ethnic background, and race;

(4) General physical appearance, including height, weight, color of hair, eyes, and skin or other information of a similar nature;

(5) Education, including the number of years of school completed at the time of the adoption, and school report (if still attending), but not the name or location of the school;

(6) Religion or religious heritage;

(7) Occupation, but no specific titles or places of employment;

(8) Talents, hobbies, and special interests;

(9) Family history and circumstances leading to the adoption;

(10) Medical and genetic history including:

(a) Available psychiatric, psychological, and substance abuse reports;

(b) Available medical history including any acute or chronic conditions;

(c) Available medical history of the birth and pregnancy, including any known substance abuse by the birth mother while pregnant.

(11) First names other children of birth parents by age and sex;

(12) Available medical histories of other children;

(13) Extended family of birth parents by age and sex;

(14) Medical histories of extended family members, if known;

(15) The fact of the death, age at death, and cause, if known, of a birth parent;

(16) Photographs of child and birth family, if available; and

(17) Name of agency or individual that facilitated the adoption.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0100, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0105 When will the department, private practitioner, or child placing agency disclose required information? The department, private practitioner, or child placing agency must disclose available child and birth family medical and social background information prior to the finalization of an adoption. Disclosure may occur:

(1) Prior to the placement of a child into an adoptive home; or

(2) At the time when a placement is identified as an adoptive placement.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0105, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0110 How does an adoptee, adoptive parent, or birth parent obtain nonidentifying information from an archived adoptive record? (1) Nonidentifying information about the birth parents, adoptee, or adoptive parent may be shared with persons identified in RCW 26.33.020 and 26.33.340.

(2) If the adoption was facilitated through the department, a request for information must be made in writing to the state office of Children's Administration, P.O. Box 45713, Olympia WA 98504-5713. The state office is the sole source for releasing information from an archived record.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0110, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0115 What is the department response to requests for public disclosure of an adoptive record? The department complies with the requirements for disclosure of public records in RCW 26.33.340.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0115, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0120 What is the legal basis of the department's adoption support program? The legal authorities for the program are:

(1) Revised Code of Washington (RCW) 74.13.100 through 74.13.159;

(2) Chapter 42 United States Code (U.S.C.) 673; and

(3) The U.S. Department of Health and Human Services policy announcement ACFY-CB-PA-01-01 (issued January 23, 2001) establishing guidelines for states to use in determining a child's eligibility for Title IV-E adoption assistance.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0120, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0125 What is the purpose of the adoption support program? The adoption support program encourages the adoption of special needs children in the legal custody of public or private nonprofit child care agencies who would not be adopted if support for the child was not available.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0125, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0130 What definitions apply to the adoption support program? The following definitions apply to this chapter:

"Adoption" means the granting of an adoption decree consistent with chapter 26.33 RCW.

"Adoption support agreement" means a written contract between the adoptive parent(s) and the department that identifies the specific support available to the adoptive parents(s) and other terms and conditions of the agreement.

"Adoption support cash payment" means basic monthly cash payments paid to the adoptive parent(s) by the department after the child's adoption.

"Adoption support special rate" means monthly cash payments in addition to the basic adoption support rate. The department may authorize payment of these funds only to

meet documented exceptional expenses necessary to address the special needs condition of the child.

"Adoption support supplemental cash payment" means cash payments in addition to the adoption support basic monthly cash payments and the adoption support special rate. These supplemental payments enable the special needs child to receive services not funded by the monthly cash support payment or other resources. Note: Only children adopted on or after July 1, 1996 are eligible for supplemental cash payments.

"Applicant" means a person or couple applying for adoption support on behalf of a child the person or couple plans to adopt.

"Child placing agency" means a private nonprofit agency licensed by the department under chapter 74.15 RCW to place children for adoption or foster care.

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

"Extenuating circumstances" means a finding by an administrative law judge or a review judge that one or more certain qualifying conditions or events prevented an otherwise eligible child from being placed on the adoption support program prior to adoption.

"Medical services" means services covered by Medicaid (and administered by the medical assistance administration) unless defined differently in the adoption support agreement.

"Nonrecurring costs" means reasonable, necessary, and directly related adoption fees, court costs, attorney fees, and other expenses the adoptive parent incurs when finalizing the adoption of a special needs child. Total reimbursement from the department may not exceed one thousand five hundred dollars.

"Placing agency" means the agency that has the legal authority to place the child for adoption. This may be the department or a private nonprofit child placing agency.

"Program" means the department's adoption support program.

"Reconsideration" means the limited state-funded support available to an eligible child whose adoption was finalized without a valid adoption support agreement in place.

"Resident state" (for purposes of the child's Medicaid eligibility) means the state in which the child physically resides. In some cases this may be different from the state of the parent's legal residence.

"Special needs" means the specific factors or conditions that apply to the child and that may prevent the child from being adopted unless the department provides adoption support services. See WAC 388-27-0140 for a detailed description of the factors or conditions.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0130, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0135 What are the eligibility criteria for the adoption support program? For a child to be eligible for participation in the adoption support program, the department must first determine that adoption is the most appropriate plan for the child. If the department determines that adoption is in the child's best interest, the child must:

(1) Be less than eighteen years old when the department and the adoptive parents sign the adoption support agreement;

(2) Be legally free for adoption;

(3) Have a "special needs" factor or condition according to the definition in this rule (see WAC 388-27-0140); and

(4) Meet at least one of the following criteria:

(a) Is in state-funded foster care or child caring institution or was determined by the department to be eligible for and likely to be so placed (For a child to be considered "eligible for and likely to be placed in foster care" the department must have opened a case and determined that removal from the home was in the child's best interest.); or

(b) Is eligible for federally funded adoption assistance as defined in Title IV-E of the Social Security Act, the Code of Federal Regulations, the U.S. Department of Health and Human Services policy announcement, ACFY-CB-PA-01-01 (issued January 23, 2001) establishing guidelines for states to use in determining a child's eligibility for Title IV-E adoption assistance, and any policy issuances of the Department of Health and Human Services.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0135, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0140 What constitutes a "special needs"? To be considered a child with special needs the following three statements must be true:

(1) One or more of the following factors or conditions must exist:

(a) The child is of a minority ethnic background;

(b) The child is six years of age or older at the time of application for adoption support;

(c) The child is a member of a sibling group of three or more or of a sibling group in which one or more siblings meets the definition of special needs;

(d) The child is diagnosed with a physical, mental, developmental, cognitive or emotional disability; or

(e) The child is at risk for a diagnosis of a physical, mental, developmental, cognitive or emotional disability due to prenatal exposure to toxins, a history of serious abuse or neglect, or genetic history.

(2) The state has determined that the child cannot or should not be returned to the home of the biological parent; and

(3) The department or child placing agency that placed the child for adoption must document that except where it would be against the best interests of the child the department or child placing agency had made a reasonable but unsuccessful effort to place the child for adoption without adoption support.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0140, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0145 What constitutes a reasonable effort to place a child for adoption without adoption support? Reasonable effort to place a child without adoption support includes:

(1) A child registered for three months with the Washington adoption resource exchange (WARE) without finding an adoptive family; or

(2) A child for whom a documented, formal agency search was conducted for three months, without finding a family who would adopt the child without adoption support services; or

(3) A child for whom the placing agency's selected prospective adoptive family is unable to adopt the child without assistance from the adoption support program.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0145, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0150 Under what circumstances would it be against the best interest of the child to search for a family that could adopt the child without adoption support? Searching for a family that could adopt the child without adoption support is against the best interest of the child when:

(1) A foster parent desires to adopt a child who:

(a) Has been in the foster parent's home for six months or more before that child becomes legally free for adoption; and

(b) The child has close emotional ties to the current foster parent which, if severed, may cause emotional damage to the child; and

(c) The foster parent is identified as the adoptive parent of choice by the department or agency staff having responsibility for the child (RCW 26.33.190 and 74.13.109(4)); or

(2) The adoptive parent is a relative of specified degree as defined in RCW 74.15.020 (4)(a) and has an approved adoptive home study per RCW 26.33.109 and 74.13.109(4).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0150, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0155 Are there other factors affecting a child's eligibility for adoption support? (1) A child is not eligible for adoption support program services and payments if the adopting parent is the birth parent or stepparent of the child.

(2) The department must not use the adoptive parents' income as a basis for determining the child's eligibility for the adoption support program.

(3) The department must consider income and other financial circumstances of the adopting family as one factor in determining the amount of any adoption support cash payments to be made. (See WAC 388-27-0230, 388-27-0235, and 388-27-0240 for details.)

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0155, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0160 How does a prospective adoptive parent apply for adoption support services? There are two ways a prospective adoptive parent (applicant) may apply for adoption support services:

(1) An applicant may apply through the social worker of the child to be adopted. The social worker must:

(a) Register the child with the adoption support program; and

(b) Submit the applicant's completed program application.

(2) An applicant may also apply directly to the adoption support program for adoption support services if:

(a) The child does not have an assigned social worker; or

(b) The applicant and the social worker have a dispute regarding the content of the program application.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0160, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0165 What requirements apply to an application for ongoing adoption support? (1) The application must include a copy of the child's medical and family background report signed by the adoptive parent(s) (DSHS 13-041 minus the attachments). It must also include copies of medical and/or therapist reports that document the child's physical, mental, developmental, cognitive or emotional disability or risk of any such disability.

(2) If the applicant is requesting a cash payment, the applicant and the department must mutually determine both the type and amount according to the requirements of WAC 388-27-0230 and 388-27-0235.

(3) If the applicant is requesting a supplemental cash payment, the applicant and the department must mutually determine the services for which the payment will be used and the expected duration of those services according to the requirements of WAC 388-27-820.

(4) If the applicant is requesting reimbursement of nonrecurring costs, the applicant must include this request in the application. (See WAC 388-27-0380 and 388-27-0385 for the type and amount of expenses the department may reimburse.)

(5) The applicant must furnish a copy of the applicant's most recently filed federal income tax return. If the applicant is not required to file a federal income tax return, the applicant must submit a financial statement with the applicant's adoption support application.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0165, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0170 What is the nature and purpose of an adoption support agreement? The adoption support agreement is a binding contract between the adoptive parent(s) and the department that identifies the terms and conditions that both parties must follow.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0170, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0175 What must be included in an adoption support agreement? The adoption support agreement must:

(1) State the amount of cash payments (if any) the department must make to the adoptive parent(s) on behalf of the child;

(2) Include an itemized list of the additional services (including Title XIX Medicaid and Title XX social services) for which the child is eligible;

(3) Contain statements that:

(a) Assure that participation in the adoption support program must continue, as long as the child is eligible, regardless of where the adoptive family resides;

(b) Inform the adoptive parent(s) that the agreement must be reviewed (and may be revised) at least once every five years; and

(c) Inform the adoptive parents(s) that the department may suspend a child from the program within thirty days of any changes in circumstances (of the child or family) that affect the child's eligibility for program payments if the adoptive parent has failed to notify the department of the changes.

(d) Define the circumstances under which the agreement may be terminated.

(4) Be signed by all relevant parties before the final adoption decree is issued (45 C.F.R. Sec. 1356.40).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0175, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0180 If the adoptive family resides in or moves to another state, how is the child's participation in the adoption support services affected? If the adoptive family resides in or moves to another state the child's participation in the adoption support program is affected as follows:

(1) Social services (Title XX) become the responsibility of the new state of residence.

(2) Medical benefits (Title XIX Medicaid) remain the responsibility of Washington state if the child is not eligible for federal Title IV-E adoption assistance. However, Washington state is no longer responsible if the child becomes eligible for the resident state's Title XIX program through the Interstate Compact on Adoption and medical assistance or other eligibility factors.

(3) Title XIX Medicaid benefits become the responsibility of the resident state if the child receives Title IV-E adoption assistance.

(4) Medicaid benefits included in Washington state's Medicaid plan, but not included in the resident state's plan, must remain the responsibility of Washington state and subject to Washington state plan limits.

(5) Washington state remains responsible for any cash payments made to the adoptive parent(s) on behalf of the child or any non-Medicaid counseling that has been preauthorized by the adoption support program per WAC 388-27-0245.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0180, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0185 When does the adoption support agreement become effective? (1) Unless otherwise stated in the adoption support agreement, an adoption support agreement takes effect on the first day of the month following the month in which the court finalizes the adoption.

(2) If the child to be adopted needs support benefits prior to finalization, the assigned regional adoption support program manager may arrange an early effective date. To be eligible for an early effective date, the applicant must:

(a) Have an adoption support agreement signed by all parties;

(b) Sign the child's medical and family background report (DSHS 13-041) and a statement of the applicant's intention to adopt; and

(c) Have the department's designee sign "an exception to policy" statement.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0185, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0190 If the department implements adoption support services prior to the adoption, may the adoptive parent(s) continue to receive department-funded foster care payments while also receiving adoption support payments? (1) The adoptive parent(s) may not continue to receive department-funded foster care payments for a child while also receiving adoption support payments for the same child.

(2) If the adoptive parent(s) receives department-funded foster care for the child to be adopted, the department's social worker assigned to the child must terminate that coverage on the last day of the month preceding the month in which the adoption support becomes effective.

(3) Foster care payments are paid after the month of service. Adoption Support payments are paid prior to the month of service.

(4) The adoptive parent(s) may not receive foster care payments and adoption support cash or supplemental payments for the same child for the same month of service.

(5) If the adoptive parent is adopting a relative child and has been receiving a nonneedy relative grant the adoptive parent must notify the community services office financial services specialist that the adoption has been finalized. The adoptive parent may not receive both the grant and adoption support payments for the same month for the same child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0190, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0195 May the adoptive parent(s) change the benefits contained in the adoption support program? The adoptive parent may submit a written request asking that the department reexamine the benefits offered in the adoption support agreement whenever either the family's economic circumstances or the condition of the child changes.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0195, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0200 When may the department modify the terms of the adoption support agreement? The department's adoption support program may modify the terms of an adoption support agreement:

(1) At the request of the adoptive parent(s);

(2) When the department loses contact with the adoptive parent(s);

(3) When the child is placed outside of the adoptive parents' home at department expense;

(4) If the adoptive parent is no longer providing for the child's daily care and living expenses; or

(5) If the adoptive parent fails to notify the department's adoption support program within thirty days of a change of

circumstance which affects the adopted child's continuing eligibility for adoption support program cash payments or services.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0200, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0205 Does the adoptive parent need to let the department know if the family's circumstances change? The adoptive parent must inform the department's adoption support program of circumstances that might make the parent and the adoptive child either ineligible for adoption assistance payments or benefits or eligible for adoption assistance payments or benefits in different amounts. Such changes include but are not limited to:

(1) A significant change in the child's condition;

(2) A change in the marital status of the adoptive parent(s);

(3) A change in the legal or physical custody of the child; or

(4) A change in the adoptive family's mailing address.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0205, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0210 Under what circumstances would the adoption support agreement be terminated? The adoption support agreement is terminated according to the terms of the agreement or if any one of the following events occurs:

(1) The child reaches eighteen years of age; (If a child is at least eighteen but less than twenty-one years old and is a full-time high school student or working full time toward the completion of a GED (high school equivalency) certificate and continues to receive financial support from the adoptive parent(s), the department may extend the terms of the adoption support agreement until the child completes high school or achieves a GED. Under no circumstances may the department extend the agreement beyond the child's twenty first birthday.) Adoption support benefits will automatically stop on the child's eighteenth birthday unless the parent(s) requests continuation per this rule and have provided documentation of the child's continuation in school. To prevent disruption in services the parent should contact the adoption support program at least ninety days prior to the child's eighteenth birthday if continued services are to be requested.

(2) The adoptive parents request termination of the agreement;

(3) The adoptive parents no longer have legal responsibility for the child;

(4) The adoptive parents are no longer providing financial support for the child;

(5) The child dies; or

(6) The adoptive parents die. (A child who met federal Title IV-E eligibility criteria for adoption assistance will be eligible for adoption assistance in a subsequent adoption.)

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0210, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0215 What benefits may the adoptive parent or child receive from the adoption support program? The adoption support program may provide one or more of the following benefits:

(1) Reimbursement for nonrecurring adoption finalization costs;

(2) Cash payments;

(3) Supplemental cash payments (only for adoptions finalized on or after July 1, 1996);

(4) Payment for counseling services as pre-authorized (see WAC 388-27-0255 for conditions and terms);

(5) Medical services through the department's Medicaid program; or

(6) Child care as pre-authorized per WAC 388-27-0270 (for children adopted on or after July 1, 1996).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0215, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0220 What factors affect the amount of adoption support benefits a child receives? The department bases the amount of support it provides on the child's needs and the family's circumstances, but limits the amount to the rates set by these rules, federal laws and rules, and the state legislature.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0220, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0225 What are the current maximum rates available for basic adoption support monthly cash payments and special rate? Effective July 1, 2000 the maximum basic monthly adoption support rates as established by the state legislature are:

Age of Child	Maximum Rate
Less than six years old	$316.62
Six through eleven years old	$390.11
Twelve years or older	$462.24
Special rate	$147.94

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0225, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0230 How does the department evaluate a request for basic adoption support monthly cash payments? (1) To determine the amount of basic monthly cash payment to be made, the department considers the child's physical, mental, developmental, cognitive and emotional condition and expenses as well as the adoptive family's:

(a) Size, including the adopted child;

(b) Normal living expenses, including education and childcare expenses;

(c) Exceptional circumstances of any family member;

(d) Income;

(e) Resources and savings plans;

(f) Medical care and hospitalization needs;

(g) Ability to purchase or otherwise obtain medical care; and

(h) Additional miscellaneous expenses related to the adopted child.

(2) The department and the adoptive parents will jointly determine the level of adoption support cash payments needed to meet the basic needs of the child without creating a hardship on the family.

(3) Under no circumstances may the amount of the basic adoption support monthly rate the department pays for the child exceed the adoption support rate established by the legislature for a child of that age.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0230, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0235 How does the department evaluate a request for adoption support special rate cash payments? (1) The adoption support program may pay the special rate of up to an additional one hundred forty-seven dollars and ninety-four cents per month for children whose diagnosed condition requires adaptive or specialized support in order for the child to participate in the typical environment to the fullest extent possible.

(2) The department and the adoptive parents will jointly determine the level of adoption support special rate payments (if any) that may be needed to meet the specialized support of the child.

(3) The department will not authorize special rate payments for services available through other departmental or community resources/services.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0235, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0240 How does the department evaluate a request for adoption support supplemental cash payments? The department and the adoptive parents will jointly determine the level of adoption support supplemental cash payments.

(1) Supplemental cash payments are to assist the family in purchasing goods and services that are necessary to meet the physical, mental, developmental, cognitive or emotional needs of the child when those goods and services are not otherwise available through other resources.

(2) Supplemental cash payments must not be used to compensate the parent for difficulty of care (i.e., for the parents' time and energy spent caring for the child).

(3) Not all children are eligible to receive supplemental cash payments.

(4) Services necessary to meet the child's physical, mental, developmental cognitive or emotional needs may include:

(a) Special diets;

(b) Minor modifications to the environment to meet the medical needs of the child;

(c) Additional supervision needs required for the safety of the child or others which result from the child's disabilities; or

(d) Other costs to meet the child's needs as mutually agreed upon by the department and the adoptive parent.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0240, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0245 What specific department requirements apply to supplemental cash payments? (1) If the child was adopted on or after July 1, 1996 the child may be eligible for additional support through supplemental cash payments.

(2) For supplemental cash payments, the department must:

(a) Base the payments upon needs documented and identified by the adoptive parent, the child's social worker, and/or the other professionals who are providing services to the child;

(b) Review payments annually (or as specified in the agreement) to determine the level of continued payments;

(c) Continue or modify payments based upon documented needs and mutual agreement between the adoptive parent(s) and the department.

(3) Under no circumstances may the total amount of payment to the family exceed the amount of the foster care maintenance payment that would be paid for that child if that child were in foster care.

(4) The department will not authorize supplemental cash payments for services available through other departmental or community resources/services.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0245, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0250 What specific department requirements apply to medical services? (1) While an adoption support agreement remains in effect, the department's medical program rules apply to the adopted child.

(2) The department must make all medical payments according to established department procedures and directly to the child's physician(s) or service provider(s).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0250, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0255 What specific department requirements apply to outpatient counseling and/or mental health services not covered by Medicaid? When the department's adoption support program directly pays for a child's counseling and/or mental health services, the following conditions apply:

(1) The adoptive parent must obtain written authorization from the department's adoption support program before the service is rendered;

(2) The adoptive parents' primary health care coverage must be billed prior to billing the department's adoption support program;

(3) The department will pay the adoption support program's authorized rate minus any payment made by the primary (and other) insurer;

(4) The department may grant verbal authorization for no more than three counseling sessions prior to providing the required written authorization;

(5) The child's therapist or other treatment provider must submit a written treatment plan prior to authorization for continued treatment;

(6) The department may authorize counseling as follows:

(a) Up to six hours of outpatient counseling per month for up to twelve months; or

(b) Up to a total of twenty hours per quarter when critical need warrants;

(7) The department may extend the authorization for counseling (beyond the initial time period authorized) upon receipt of an updated treatment plan and documentation supporting the need for additional treatment from the treatment provider and a parent's request for continuing counseling (DSHS 10-214);

(8) The department may authorize this service for only one provider at a time unless a second provider is required for a different service.

(9) The department encourages adoptive parents to seek an annual assessment of the functioning of the adoptive child within the family to determine if there are mental health services needed to help maintain and/or strengthen the adoptive placement.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0255, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0260 If the adoptive parent requests residential placement services for the parent's adopted child, what department requirements apply? (1) The adoption support program must not pay for residential treatment placements. See RCW 74.13.080 and WAC 388-25-0025.

(2) If the adoptive parent requests residential treatment services for a child:

(a) For treatment of a mental illness, the department must refer the family to the local regional support network (RSN);

(b) If a diagnosis of physical, mental, developmental, cognitive or emotional disability is present, department staff must refer the child to the division of developmental disabilities (DDD) to determine eligibility of services for which the child might be eligible; or

(c) For reasons other than treatment of mental illness or developmental disabilities, department staff must refer the adoptive parent to the child welfare services intake at the local office of the division of children and family services (DCFS).

(3) The adoption support program manager may assist the adoptive parent in arranging residential service for the child but must not be responsible for the child's placement or for the payment of the residential service.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0260, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0265 What are the consequences of the department placing the adopted child in foster care, group care, or residential treatment? (1) If a child is on active status with Washington state's adoption support program and the department places the child in foster care, group care, or residential treatment, the department may report to the division of child support that good cause exists for not pursuing collection of support payments.

(2) The department must review the adoption support agreement and must discontinue any cash payments to the adoptive parent during the child's out-of-home placement unless the adoptive parent(s) documents continuing expenses directly related to the child's needs.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0265, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0270 What department requirements apply to child care services? For children adopted on or after July 1, 1996 the adoption support program may authorize childcare. The following conditions must exist:

(1) In a two-parent home, both parents must be employed out of the home;

(2) In a single parent home, the parent must be employed out of the home;

(3) The department must make payment directly to the child care provider at the department rate for child care in that geographic area;

(4) The child must be less than twelve years of age;

(5) The childcare facility must have a valid license;

(6) The total (gross) income of the adoptive family must not exceed eighty-five percent of the state median income adjusted for family size (SMIAFS);

(7) The adoptive parent may be expected to participate in the cost of childcare, depending on individual circumstances; and

(8) If the family qualifies for the state childcare program the family must use that program first. The adoption support program may assist the family in making the co-payment to the state childcare program. The adoption support program must determine assistance with the co-payment on an individual case-by-case basis.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0270, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0275 When does the department review an adoption support agreement? (1) The adoption support program must review an agreement:

(a) At least once every five years; or

(b) When the adoptive parents request a change in the terms of the agreement.

(2) The department may review an adoption support agreement:

(a) Whenever variations in medical opinions, prognosis, or costs warrant a review; or

(b) At the department's request.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0275, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0280 What is involved in the review process? (1) The review process provides an opportunity for the adoptive parent to describe any changes in family circumstances or the child's condition and request a change in the terms of the adoption support agreement.

(2) The adoptive parent must provide supporting documentation upon department request.

(3) The department may request a copy of the adoptive parents' most recently filed IRS form 1040. If not required to file a federal tax return the adoptive parent(s) must submit a financial statement upon department request.

(4) The adoptive parent must request that the child's medical provider complete an EPSDT (early periodic screening, diagnosis and treatment) exam and submit a report of the results to the adoption support program.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0280, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0285 What is the department's responsibility when the adoptive parent(s) requests a review of the adoption support agreement? The adoption support program must initiate a review of the adoption support agreement no later than thirty days after receiving the adoptive parents' request for review of the agreement.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0285, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0290 What if the department does not respond to a request for a review of an adoption support agreement within thirty days? If the department does not respond to an adoptive parent's request for a review of an adoption support agreement within thirty days, the adoptive parent has the right to an administrative hearing (see RCW 74.13.127).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0290, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0295 What requirements apply to the review of a support agreement? (1) The adoptive parent and the department must negotiate any changes in the agreement that result from a review;

(2) Changes in the terms of the agreement may be retroactive to the date the department received the written request; and

(3) If the department modifies the terms of the agreement, the adoptive parent and the department must sign a new agreement.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0295, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0300 After a review, what if the department and the adoptive parent cannot agree on the terms of the adoption support agreement? If the department proposes service changes without the adoptive parent's consent, the department must give written notification of those changes. In that notice, the department must clearly state the department's reasons for the proposed changes and inform the adoptive parent of the adoptive parent's right to an administrative hearing.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0300, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0305 May an adoptive parent apply for adoption support services after the adoption has been finalized? Federal and state laws and rules require that a prospective adoptive parent must apply for adoption assistance prior to adopting a special needs child and that the prospective adoptive parent must have a valid adoption support agreement, signed by all parties, before the adoption is finalized.

However, both state and federal governments have recognized that in some situations there may have been extenuating circumstances that prevented the child from being placed on the adoption support program prior to adoption. For these situations separate remedies have been created depending on which eligibility criteria are met by the child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0305, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0310 If a child met federal Title IV-E eligibility for adoption assistance before the adoption, but was not placed on the adoptive support program, what may the adoptive parent do after adoption finalization to obtain adoption support services for the adopted child? For a child who met the Title IV-E eligibility criteria for adoption assistance prior to adoption, federal rules allow for a possible finding of extenuating circumstances through an administrative hearing process. In these situations the adoptive parent must request a review by an administrative law judge or a review judge to obtain an order authorizing the department to enter into a post-adoption agreement to provide adoption support services to a special needs child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0310, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0315 What constitutes "extenuating circumstances"? An administrative law judge or a review judge may make a finding of extenuating circumstances if one or more of the following situations exist:

(1) Relevant facts regarding the child, the biological family or child's background were known by the agency placing the child for adoption and not presented to the adoptive parents prior to the legalization of the adoption;

(2) The department denied adoption assistance based upon a means test of the adoptive family;

(3) Erroneous determination or advice by the department or private child placing agency that a child is ineligible for adoption assistance; or

(4) Failure by the placing agency to advise adoptive parents of the availability of adoption assistance.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0315, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0320 What is the effective date of an adoption support agreement that results from a finding of extenuating circumstances? The effective date of an adoption support agreement the department and the adoptive parent have entered into as a result of a finding of extenuating circumstances may not be before the date the department received the written request from the adoptive parent for participation in the adoption support program. Under no circumstances may the department back date an adoption support agreement more than two years from the date of an order of an administrative law judge or review judge authorizing the department to enter an adoption support agreement after finalization of the adoption.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0320, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0325 If a child did not meet federal Title IV-E eligibility for adoption assistance before the adoption, what may the adoptive parent do after adoption finalization to obtain adoption support services for the adopted child? For children ineligible for federal Title IV-E Adoption Assistance, the department may provide limited support through the state-funded adoption support reconsideration program.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0325, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0330 What is the adoption support reconsideration program? (1) The adoption support reconsideration program allows the department to register an eligible adopted child for limited state-funded support (see RCW 74.13.150).

(2) The reconsideration program provides for payment of medical and counseling services to address the physical, mental, developmental, cognitive, or emotional disability of the child that resulted in the child's eligibility for the program.

(3) There is a twenty thousand dollar per child lifetime cap on this program.

(4) The program requires the adoptive parent and the department to sign an adoption support reconsideration agreement specifying the terms, conditions, and length of time the child will receive limited support.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0330, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0335 How does a child qualify for the adoption support reconsideration program? To be eligible for the adoption support reconsideration program, a child must:

(1) Have resided, immediately prior to adoption finalization, in a department funded pre-adoptive placement or in department funded foster care;

(2) Have a physical or mental handicap or emotional disturbance that existed and was documented before adoption or was at high risk for future physical or mental handicap or emotional disturbance due to conditions to which the child was exposed before adoption;

(3) Reside in Washington state with an adoptive parent who lacks the financial resources to care for the child's special needs; and

(4) Be covered by a primary basic health insurance program.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0335, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0340 How does an adoptive parent apply for the adoption support reconsideration program? To apply, the adoptive parent must complete an application for adoption support reconsideration and attach:

(1) A written cost estimate of the child's proposed corrective-rehabilitative services;

(2) A current medical evaluation of the child including the cause(s) of the condition requiring corrective-rehabilitative services;

(3) A written statement explaining the child's current medical and counseling needs;

(4) A written statement giving the department permission to request and review pre-adoption information held by the adoption agency facilitating the child's adoption; and

(5) A copy of the adoptive parents' most recently filed IRS 1040 federal income tax form.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0340, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0345 What types of services does the department provide through the adoption support reconsideration program? The reconsideration program provides some support for counseling and medical services needed to treat the child's qualifying condition.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0345, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0350 What department requirements apply to adoption support reconsideration services? (1) The department must authorize, in writing, any services paid by the adoption support reconsideration program before the services are provided.

(2) The department must base the authorized level of service on the child's needs and must limit the level of service to established program rates.

(3) The department must limit medical services to those services that would be available to the child if the child were eligible for Medicaid coverage.

(4) The department must make no cash payments to the family.

(5) The department must make payment directly to the provider of the authorized service.

(6) The adoptive parents' basic health insurance must provide primary coverage and must be used before billing the reconsideration program. The adoption support reconsideration program must be the secondary insurer.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0350, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0355 Under what conditions or circumstances would a child become ineligible for the adoption support reconsideration program? (1) Eligibility for adoption support reconsideration services ends according to the terms of the adoption support reconsideration agreement or when the child:

(a) Reaches eighteen years of age;

(b) Is eligible for the federal Title IV-E adoption assistance program and has been placed on that program;

(c) Has received twenty thousand dollars in department paid medical, dental, and/or counseling services; or

(d) Is no longer the financial responsibility of the adoptive parent(s).

(2) If the parent dies, the reconsideration agreement becomes invalid. Neither the agreement nor the child's eligi-

bility for the program are transferable to a subsequent adoption.

(3) The department may suspend services when the child:

(a) Resides outside the adoptive parents' home for more than thirty continuous days; or

(b) Is no longer covered by primary basic health insurance.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0355, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0360 What happens if the state no longer funds the adoption support reconsideration program? If the department no longer has funds available for the program, a child's participation in the program will cease. The department will terminate the adoption support reconsideration agreement.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0360, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0365 Does an adoptive parent have the right to appeal department decisions regarding adoption support issues? (1) An adoptive parent has the right to an administrative hearing to contest the following department actions:

(a) Denial of a child's initial eligibility for the adoption support program or the adoption support reconsideration program;

(b) Failure to respond with reasonable promptness to a written application or request for services;

(c) Denial of a written request to modify the level of payment or service in the agreement;

(d) A decision to increase or decrease the level of the child's adoption support payments without the concurrence of the adoptive parent(s);

(e) Denial of a request for nonrecurring adoption expenses; or

(f) Termination from the program.

(2) The adoptive parent must submit a request for an administrative hearing to the office of administrative hearings within ninety days of receipt of the department's decision to deny a request or failure to respond to a request.

(3) The office of administrative hearings must apply the rules in WAC 388-27-0120 through 388-27-0390 as they pertain to the issues being contested.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0365, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0370 What information about adoption support agreements may be used in an administrative hearing? Adoption and adoption support files are confidential, and information contained in those files may not be disclosed without the consent of the person who is the subject of the file. By requesting an administrative hearing to challenge a department decision relating to adoption support the adoptive parent is agreeing that the department may release factual information about the case during the course of the proceedings. Actions taken by the department and decisions by administrative law judges or review judges in adoption support cases which do not directly involve the case being heard may not be cited or relied upon in any administrative proceeding (RCW 26.33.340 and 74.04.060).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0370, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0375 Will the department reimburse an adoptive parent for nonrecurring adoption expenses? The department may agree to reimburse some or all of an adoptive parent's nonrecurring adoption expenses if:

(1) The child has a qualifying factor or condition identified in WAC 388-27-0140(1);

(2) Washington state has determined that the child cannot or should not be returned to the home of the child's biological parent; and

(3) Except where it would be against the best interest of the child, the department or a child placing agency has made a reasonable but unsuccessful effort to place the child with appropriate adoptive parents without the benefit of adoption assistance; and

(4) The child has been placed for adoption according to applicable state and local laws or Tribal laws.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0375, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0380 What types of nonrecurring adoption expenses will the department reimburse? The department may reimburse:

(1) Court costs directly related to finalizing an adoption;

(2) Reasonable and necessary adoption fees;

(3) Reasonable and necessary attorney fees directly related to finalizing an adoption; and

(4) Costs associated with an adoption home study, including:

(a) Health and psychological examination;

(b) Placement supervision before adoption;

(c) Transportation, lodging, and food costs incurred by the adoptive parent(s) and child during pre-placement visits; and

(d) Other costs directly related to finalizing the legal adoption of the child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0380, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0385 Is there a limit to the amount of nonrecurring adoption expenses that the department will reimburse? Department reimbursement of nonrecurring adoption expenses must not exceed one thousand five hundred dollars per child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0385, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0390 How does an adoptive parent get reimbursed for nonrecurring adoption expenses? (1) Before the adoption is finalized, the adoptive parent must sign an agreement with the department specifying the nature and amount of nonrecurring adoption expenses. This agreement may be part of an adoption support agreement or it may be a separate agreement specific to the reimbursement for

nonrecurring adoption finalization costs. The department will make no reimbursement payments unless such an agreement exists.

(2) Upon finalization of the adoption, the adoptive parent may request reimbursement. A copy of the adoption decree and documentation supporting actual costs incurred must accompany the request for reimbursement.

(3) The department must reimburse documented actual costs or the amount specified in the signed agreement, whichever is less.

(4) The department will not reimburse nonrecurring adoption expenses that are reimbursable from other sources (for example: IRS, military, or the adoptive parent's employer).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0390, filed 3/30/01, effective 4/30/01.]

Chapter 388-31 WAC

LIFELINE TELEPHONE ASSISTANCE PROGRAM

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-31-010 Purpose of program. [Statutory Authority: RCW 80.36.440. 90-18-007 (Order 3063), § 388-31-010, filed 8/23/90, effective 9/23/90. Statutory Authority: 1987 c 229. 87-19-093 (Order 2541), § 388-31-010, filed 9/17/87.] Repealed by 01-09-023, filed 4/9/01, effective 6/1/01. Statutory Authority: RCW 74.08.090, 80.36.440.

388-31-015 Definitions. [Statutory Authority: RCW 80.36.440. 90-18-007 (Order 3063), § 388-31-015, filed 8/23/90, effective 9/23/90. Statutory Authority: 1987 c 229. 87-19-093 (Order 2541), § 388-31-015, filed 9/17/87.] Repealed by 01-09-023, filed 4/9/01, effective 6/1/01. Statutory Authority: RCW 74.08.090, 80.36.440.

388-31-020 Conditions of eligibility. [Statutory Authority: RCW 80.36.440. 90-18-007 (Order 3063), § 388-31-020, filed 8/23/90, effective 9/23/90. Statutory Authority: 1987 c 229. 87-19-093 (Order 2541), § 388-31-020, filed 9/17/87.] Repealed by 01-09-023, filed 4/9/01, effective 6/1/01. Statutory Authority: RCW 74.08.090, 80.36.440.

388-31-025 WTAP benefits. [Statutory Authority: RCW 80.36.440. 90-18-007 (Order 3063), § 388-31-025, filed 8/23/90, effective 9/23/90. Statutory Authority: 1987 c 229. 87-19-093 (Order 2541), § 388-31-025, filed 9/17/87.] Repealed by 01-09-023, filed 4/9/01, effective 6/1/01. Statutory Authority: RCW 74.08.090, 80.36.440.

388-31-030 Notification and eligibility periods. [Statutory Authority: RCW 80.36.440. 90-18-007 (Order 3063), § 388-31-030, filed 8/23/90, effective 9/23/90. Statutory Authority: 1987 c 229. 87-19-093 (Order 2541), § 388-31-030, filed 9/17/87.] Repealed by 01-09-023, filed 4/9/01, effective 6/1/01. Statutory Authority: RCW 74.08.090, 80.36.440.

388-31-035 WTAP fund. [Statutory Authority: RCW 80.36.440. 93-16-043 (Order 3604), § 388-31-035, filed 7/28/93, effective 8/28/93; 90-18-007 (Order 3063), § 388-31-035, filed 8/23/90, effective 9/23/90. Statutory Authority: 1987 c 229. 87-19-093 (Order 2541), § 388-31-035, filed 9/17/87.] Repealed by 01-09-023, filed 4/9/01, effective 6/1/01. Statutory Authority: RCW 74.08.090, 80.36.440.

WAC 388-31-010 through 388-31-035 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-32 WAC

CHILD WELFARE SERVICES TO PREVENT OUT-OF-HOME PLACEMENT AND ACHIEVE FAMILY RECONCILIATION

WAC

WAC 388-32-0005 What are home support services? The department's children's administration (CA) offers home support services (HSS), within available funds, to provide supportive, culturally appropriate, skill-building services in partnership with CA's client families. Only CA staff may provide the services in the family home or other appropriate setting and must provide the services as part of a comprehensive case plan. The department does not contract for this service.

(1) CA typically offers HSS during the normal work week but may provide HSS on weekends and beyond normal working hours.

(2) Child and family resource specialists (CFRS) have primary responsibility to provide HSS, which may include the following services:

(a) Teach and demonstrate basic physical and emotional care of children, including child development and developmentally appropriate child discipline;

(b) Teach homemaking and other life skills, including housekeeping, nutrition and food preparation, personal hygiene, financial budgeting, time management and home organization, with consideration given to the family's cultural environment;

(c) Help families obtain basic needs by networking families with appropriate supportive community resources; e.g., housing, clothing and food banks, health care services, and educational and employment services;

(d) Provide emotional support to families and build self-esteem in family members; aid family members in developing appropriate interpersonal and social skills;

(e) Provide client transportation/supervision of visits on a nonroutine, short-term basis;

(f) Observe family functioning, assisting the social worker to identify family strengths as well as areas needing intervention or improvement, providing reports and assessments to the assigned social worker on the family's progress in skill-building, family functioning, and other areas defined in the case plan;

(g) Participate in child protection teams, multi-disciplinary teams, interagency case staffings, and family intervention meetings;

(h) Provide court testimony when requested by the attorney representing DSHS or when subpoenaed.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0005, filed 3/30/01, effective 4/30/01.]

WAC 388-32-0010 What are the eligibility criteria for HSS? Children's administration uses the following criteria to determine eligibility for HSS, within available funding:

(1) The family must be a current recipient of CA services.

(2) The case plan for the family must document the need for teaching, skill-building, community networking, or visitation.

(3) HSS does not provide long-term maintenance for a family, is not a housekeeping service, and is not interchangeable with CHORE services, which are provided by the department's aging and adult services administration.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0010, filed 3/30/01, effective 4/30/01.]

WAC 388-32-0015 What are home based services and under what circumstances may the department provide the services to the child's parent or relative caregiver? (1) Home based services (HBS) are designed to prevent or improve conditions that may result in out-of-home placement. Children's administration (CA) provides these services in the context of a comprehensive case plan. CA purchases services from community providers within available funds for this purpose. Services may include:

(a) Basic goods and services; e.g., food, clothing, shelter, furniture, health care, utilities, transportation

(b) Paraprofessional services; e.g., parent aides;

(c) Parent training;

(e) In-home counseling or assistance to prevent out-of-home placement.

(2) For a family or individual to receive HBS, the following conditions must be met:

(a) The client has a case open for child protective services (CPS), child welfare services (CWS), or family reconciliation services (FRS);

(b) The department may provide services to the family of origin, relatives, or foster families when the intent of HBS is to maintain or reunify a permanent or long-term stable home for the child;

(c) The family is willing and able to cooperate with HBS services; and

(d) In the assigned social worker's judgment, the child may be safely maintained in the home or be safely returned to the home within the next three months with provision of HBS.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0015, filed 3/30/01, effective 4/30/01.]

WAC 388-32-0020 What is the purpose of the family reconciliation services program? (1) The purpose of family reconciliation services (FRS) is to achieve reconciliation between the parent and child, to reunify the family, and to maintain and strengthen the family unit to avoid the necessity of out-of-home placement of children.

(2) The department provides these services, within available funds, to:

(a) Alleviate personal or family situations that present a serious and imminent threat to the health or stability of the child or family and that do not meet the definition of child abuse or neglect; and

(b) Maintain families intact whenever possible.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0020, filed 3/30/01, effective 4/30/01.]

WAC 388-32-0025 Who may receive FRS services? (1) CA provides FRS to runaways and families in conflict. These populations are defined as follows:

"Families in conflict" means families in which personal or family situations present a serious and imminent threat to the health or stability of the child, which may include an at-risk youth, or family.

"Runaways" means youths who are absent from home for a period of time without parental permission. Services are to actual runaways and not to threatened runaways, unless the threatened runaways meet the definition of families in conflict.

(2) FRS is not provided for the following situations:

(a) Chronic or long-term multi-problem situations requiring long-term interventions;

(b) Custody and marital disputes unless the dispute creates a conflict between the child and parent with physical custody;

(c) Families currently receiving counseling services related to the parent-child conflict/relationship from other agencies;

(d) Child abuse and neglect cases, unless those cases meet the definition of family in conflict;

(e) Youth receiving foster care or group care services or follow up to those services; and

(f) Post-adoption cases still under supervision of an agency, except when those cases meet the definition of families in conflict.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0025, filed 3/30/01, effective 4/30/01.]

WAC 388-32-0030 What FRS services does the department provide? The assigned social worker provides services to develop skills and supports within families to resolve family conflicts, achieve a reconciliation between parent and child, and to avoid out-of-home placement. The services may include, but are not limited to, referral to services for suicide prevention, psychiatric or other medical care, or psychological, financial, legal, educational, or other social services, as appropriate to the needs of the child and family. Typically FRS is limited to a ninety-day period.

(1) The CA social worker provides intake/assessment services (IAS). The social worker must initiate these short-term counseling sessions within forty-eight hours of the family's request for services. These sessions are intended to defuse the immediate potential for violence, assess problems, and explore options leading to problem resolution.

(2) CA or its contractors may provide crisis counseling services for up to thirty days within a ninety-day period.

(3) Families eligible for thirty-day crisis counseling are those who, in the opinion of the family and the CA social worker, require more intensive services than those provided through IAS.

(4) Families must make a commitment to participate in the thirty-day crisis counseling service and must not be receiving similar family counseling services through other agencies or practitioners. At a minimum, there must be a parent and a child willing to participate.

(5) Thirty-day crisis counseling services may not exceed fifteen hours within thirty days. The assigned counselor helps the family develop skills and supports to resolve conflicts. The counselor may refer to resources including medical, legal, ongoing counseling and CPS for problem resolution.

(a) The CA supervisor may extend thirty-day crisis counseling for an additional thirty days and up to fifteen additional hours of service, subject to availability of funds and the family's continued progress toward resolving conflicts.

(b) The thirty-day crisis counseling is available a maximum of twice in a lifetime for any one child within a family.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0030, filed 3/30/01, effective 4/30/01.]

Chapter 388-39A WAC
CHILD WELFARE SERVICES—COMPLAINT RESOLUTION

WAC

WAC 388-39A-010 What definitions apply to the department's child welfare services complaint resolution process? "Children's administration" (CA) means the cluster of programs within the department of social and health services responsible for the provision of child welfare, child protective, child care licensing, and other services to children and their families.

"Complaints office" or **"constituent relations"** means the office within the children's administration responsible for handling complaints regarding child welfare services.

"Division of children and family services" (DCFS) means the division within the children's administration responsible for administering child welfare services programs.

"Division of licensed resources" (DLR) means the division within the children's administration responsible for licensing or certifying child care homes and facilities under the authority of chapter 74.15 RCW.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-010, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-030 How does the children's administration resolve complaints? Constituent relations staff assist clients, foster parents, and other affected individuals in resolving complaints and grievances regarding children's administration (CA) policies and procedures, or the application of a policy or procedure related to CA programs. Under RCW 74.13.045, constituent relations staff may inquire into, determine fact, and facilitate the resolution of disputes and complaints.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-030, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-035 What is the process for resolving complaints? (1) After making a reasonable effort to resolve a complaint with a social worker or licensor, a client, foster parent, or community member may contact the CA constituent relations office to request assistance.

(2) Constituent relations staff will assist the complainant in reviewing the complaint with the assigned social worker or licensor to arrive at a resolution.

(3) If the complaint cannot be resolved with the social worker or licensor, constituent relations staff will assist the complainant in reviewing it with the supervisor of the social worker or licensor for resolution.

(4) If the complaint cannot be resolved with the supervisor, constituent relations staff will assist the complainant in reviewing the complaint with the supervisor's area manager or regional manager for resolution.

(5) If the complaint cannot be resolved with the area manager or regional manager, constituent relations staff will assist the complainant in reviewing it with the area manager's regional administrator or the regional manager's office chief.

(6) If CA constituent relations staff determines at any time during the complaint resolution process that the administration's actions were consistent with agency policy and procedures based on complete and correct information regarding the complainant's situation, the constituent relations staff will terminate the resolution process and will close the complaint.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-035, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-040 What happens if the complaint is not resolved at the regional level? (1) When constituent relations staff and local CA staff have made a reasonable attempt to resolve the complaint, the regional administrator, the office chief, or the constituent relations supervisor may convene a panel to review the complaint and make recommendations to the CA assistant secretary for resolution.

(2) The regional administrator or office chief and the constituent relations supervisor will determine the membership of the panel.

(3) The panel must consist of the following members:

(a) The regional administrator's or office chief's designee who must not be from the administrative unit where the complaint originated;

(b) A constituent relations staff person;

(c) A person who is not a CA employee; and

(d) If the complainant is a foster parent, a foster parent who is not involved in the complaint.

(4) The panel may examine the complaint, the complainant's file, and any additional relevant information, including information from the complainant, CA staff, or others.

(5) The panel must submit written findings and recommendations to the CA assistant secretary who will issue a final, written decision.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-040, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-045 Does the complaint resolution process apply to all complaints? (1) The complaint resolution process does not apply to complaints for which the complainant has the right to seek resolution through judicial review or an adjudicative proceeding under Title 13, 26, or 74 RCW.

(2) The process also does not apply to contract rate setting, contested rate payments, exceptional cost rates, disputes or decisions regarding written personal service contracts, or financial agreements.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-045, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-050 Is the complaint resolution process the only way to resolve a complaint? Participation in the complaint resolution process does not affect the right of any person to seek other remedies.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-050, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-055 What rights do complainants have under the complaint resolution process? (1) Under RCW 74.13.045, the complaint resolution process does not create substantive or procedural rights for any person.

(2) Participation in the complaint resolution process does not entitle any person to an adjudicative proceeding under chapter 34.05 RCW or to superior court review.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-055, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-060 Do constituent relations staff only handle complaints? In addition to complaint resolution, CA constituent relations staff also provide information about children's administration programs, policies, and procedures and information about other complaint resolution resources, including the office of the family and children's ombudsman.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-060, filed 3/5/01, effective 4/5/01.]

Chapter 388-46 WAC
RECIPIENT FRAUD

WAC

388-46-010 through 388-46-120 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-46-010 Fraud—Criminal prosecution. [Order 801, § 388-46-010, filed 5/25/73; Order 540, § 388-46-010, filed 3/31/71, effective 5/1/71; Regulation 17.10, filed 1/24/64.] Repealed by 01-06-044, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.510, 74.04.057, and 74.04.050.

388-46-100 Fraud—Federal food coupons and commodities. [Order 801, § 388-46-100, filed 5/25/73; Order 540, § 388-46-100, filed 3/31/71, effective 5/1/71; Regulation 17.90, filed 1/24/64.] Repealed by 01-06-044, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.510, 74.04.057, and 74.04.050.

388-46-110 Disqualification period for recipients convicted of unlawfully obtaining assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.290 and Public Law 104-193, Section 103 (a)(1)(1996). 97-10-038, § 388-46-110, filed 4/30/97, effective 5/1/97. Statutory Authority: RCW 74.08.331, 74.08.290 and 1995 c 379. 95-19-003 (Order 3892), § 388-46-110, filed 9/6/95, effective 10/7/95.] Repealed by 01-06-044, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.510, 74.04.057, and 74.04.050.

388-46-120 Disqualification period for temporary assistance to needy families (TANF) applicants or recipients convicted of misrepresenting residence to obtain assistance in two or more states. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.290 and Public Law 104-193, Section 103 (a)(1)(1996). 97-10-038, § 388-46-120, filed 4/30/97, effective 5/1/97.] Repealed by 01-06-044, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.510, 74.04.057, and 74.04.050.

WAC 388-46-010 through 388-46-120 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-60 WAC
DOMESTIC VIOLENCE PERPETRATOR TREATMENT PROGRAM STANDARDS

WAC

388-60-0015 What definitions apply to this chapter?
388-60-0025 What is the purpose of this chapter?
388-60-0035 Must domestic violence perpetrator treatment programs be certified?
388-60-0045 What must be the focus of a domestic violence perpetrator treatment program?
388-60-005 Repealed.
388-60-0055 What must be a treatment program's primary goal?
388-60-0065 What steps must a treatment program take to address victim safety?
388-60-0075 What must a treatment program require of its participants?
388-60-0085 What requirements apply to group treatment sessions?
388-60-0095 May a participant be involved in more than one type of treatment while enrolled in a domestic violence perpetrator treatment program?
388-60-0105 What requirements does the department have for treatment programs regarding nondiscrimination?
388-60-0115 Does a program have the authority to screen referrals?
388-60-0125 What rights do participants in a treatment program have?
388-60-0135 What information about the participant must the treatment program keep confidential?
388-60-0145 What releases must a program require a participant to sign?
388-60-0155 Must a treatment program keep information provided by or about the victim confidential?
388-60-0165 What information must the treatment program collect and discuss with the client during the intake process or assessment interview?
388-60-0175 Who may complete the intake process or conduct the assessment interview?
388-60-0185 Must the program compile a written document based on information gathered in the intake/assessment process?
388-60-0195 Must the treatment program develop an individual treatment plan for each participant?
388-60-0205 What must a treatment program consider when developing an individual treatment plan for a participant?
388-60-0215 Must a program require a participant to sign a contract for services with the treatment program?
388-60-0225 What must the treatment program include in the contract for each participant's treatment?
388-60-0235 Must a treatment program follow an educational curriculum for each participant?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-60-005 Scope. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-005, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-005, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.

388-60-120 Treatment focus. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-120, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-120, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.

388-60-130 Treatment modality. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-130, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-130, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.

388-60-140 Program policies and procedures. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-140, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-140, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.

388-60-150 Treatment staff qualifications. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-150, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-150, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.

388-60-160 Orientation and continuing professional education requirements. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-160, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-160, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.

388-60-170	Cooperation with domestic violence victim programs. [Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-170, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-180	Knowledge of law and justice system practices. [Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-180, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-190	Program certification process. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-190, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-200	Certification maintenance. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-200, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-210	Advisory committee. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-210, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-220	Complaint. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-220, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-230	Investigation. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-230, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-240	Results of investigation. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-240, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-250	Notification of results. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-250, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
388-60-260	Appeal. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-260, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.

WAC 388-60-0015 What definitions apply to this chapter? The following definitions are important to understand these rules:

"Corrective action" means the denial or suspension or revocation of certification, or the issuance of a written warning.

"Department" or **"DSHS"** means the department of social and health services.

"Participant" or **"perpetrator"** means the client enrolled in the domestic violence perpetrator treatment program. This client may be court-ordered to attend treatment or someone who chooses to voluntarily attend treatment.

"Program" or **"treatment program"** means a domestic violence perpetrator treatment program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0015, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0025 What is the purpose of this chapter? (1) This chapter establishes minimum standards for programs that treat perpetrators of domestic violence.

(2) These standards apply to any program that:

(a) Advertises that it provides domestic violence perpetrator treatment; or

(b) Defines its services as meeting court orders that require enrollment in and/or completion of domestic violence perpetrator treatment.

(3) These programs provide treatment only to perpetrators of domestic violence, including clients who are self-referred or those who are court-ordered to attend treatment.

(4) An agency may administer other service programs in addition to domestic violence perpetrator treatment services; however, the domestic violence perpetrator treatment program must be considered a separate and distinct program from all other services the agency provides.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0025, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0035 Must domestic violence perpetrator treatment programs be certified? All programs providing domestic violence perpetrator treatment services must:

(1) Be certified by the department; and

(2) Comply with the standards outlined in this chapter.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0035, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0045 What must be the focus of a domestic violence perpetrator treatment program? (1) A domestic violence perpetrator treatment program must focus treatment primarily on ending the participant's physical, sexual, and psychological abuse.

(2) The program must hold the participant accountable for:

(a) The abuse that occurred; and

(b) Changing the participant's violent and abusive behaviors.

(3) The program must base all treatment on strategies and philosophies that do not blame the victim or imply that the victim shares any responsibility for the abuse which occurred.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0045, filed 3/30/01, effective 4/30/01.]

WAC 388-60-005 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-0055 What must be a treatment program's primary goal? The primary goal of a domestic violence perpetrator treatment program must be to increase the victim's safety by:

(1) Facilitating change in the participant's abusive behavior; and

(2) Holding the participant accountable for changing the participant's patterns of behaviors, thinking, and beliefs.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0055, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0065 What steps must a treatment program take to address victim safety? (1) Each treatment program must have written policies and procedures that adequately assess the safety of the victims of the perpetrators enrolled in the treatment program.

(2) The treatment program must take the following steps to protect victims:

(a) Notify the victim of each program participant within fourteen days of the participant being accepted or denied entrance to the program that the participant has enrolled in or has been rejected for treatment services;

(b) Inform victims of specific outreach, advocacy, emergency and safety planning services offered by a domestic violence victim program in the victim's community;

(c) Encourage victims to make plans to protect themselves and their children;

(d) Give victims a brief description of the domestic violence perpetrator treatment program, including the fact that the victim is not expected to do anything to help the perpetrator complete any treatment program requirements; and

(e) Inform victims of the limitations of perpetrator treatment.

(3) The program must document in writing the program's efforts to notify the victim of the above requirements.

(4) The program cannot invite or require the victims of participants to attend perpetrator treatment program counseling sessions or education groups which the program requires participants to attend as a condition of their contracts.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0065, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0075 What must a treatment program require of its participants? (1) All participants must attend consecutive, weekly group treatment sessions. A program may develop policies which allow excused absences to be made up with the program director's approval.

Exception: Another type of intervention may be approved for certain documented clinical reasons, such as psychosis or other conditions that make the individual not amenable to treatment in a group setting.

(2) The program must assign each participant to a home group and the participant must be required to attend the same scheduled group each week. The program's director must authorize any exceptions to this requirement and document the reason for the exception.

(3) Each participant must sign all releases of information required by the treatment program, including those specified in WAC 388-60-0145.

(4) Each participant must sign a contract for services with the treatment program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0075, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0085 What requirements apply to group treatment sessions? (1) The group sessions must be single gender.

(2) The group size is limited to a maximum of twelve participants, and a minimum of two participants.

(3) Group sessions must be at least ninety minutes in length.

(4) Group sessions must be closed to all persons other than participants, group facilitators, and others specifically invited by the group leaders. Others specifically invited by group leaders may include:

(a) Professionals in related fields;

(b) Persons offering interpretation services for the deaf and/or hearing impaired or language translation/interpretation; and

(c) Others bringing specific information critical to the group.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0085, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0095 May a participant be involved in more than one type of treatment while enrolled in a domestic violence perpetrator treatment program? (1) A program may allow a client to participate in other types of therapy during the same period the client is participating in the required weekly group treatment sessions.

(2) Any other type of therapy must support the goal of victim safety by facilitating change in the participant's abusive behavior without blaming the victim for the perpetrator's abuse.

(3) The program must determine that the participant is stable in the participant's other treatments before allowing the participant to participate in treatment for domestic violence.

(4) Other therapies including the following list may not be substituted for the required domestic violence perpetrator treatment sessions:

(a) Individual therapy;

(b) Marital or couples' therapy;

(c) Family therapy;

(d) Substance abuse evaluations or treatment; or

(e) Anger management.

(5) A program may recommend marital or couples' therapy only after:

(a) The participant has completed at least six months of domestic violence perpetrator treatment services; and

(b) The victim has reported that the participant has ceased engaging in violent and/or controlling behaviors. However, this therapy may not take the place of domestic violence perpetrator treatment session.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0095, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0105 What requirements does the department have for treatment programs regarding nondiscrimination? (1) A domestic violence perpetrator treatment program may not discriminate against any participant based on:

(a) Race;

(b) Age;

(c) Gender;

(d) Disability;

(e) Religion;

(f) Marital status or living arrangements;

(g) Political affiliation;

(h) Educational attainment;

(i) Socio-economic status;

(j) Ethnicity;

(k) National origin; or

(l) Sexual orientation.

(2) Program materials, publications, and audio-visual materials must be culturally sensitive and nondiscriminatory.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0105, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0115 Does a program have the authority to screen referrals? (1) A treatment program has the authority to accept or reject any referral for its program.

(2) The program must base acceptance and rejection of a client on written criteria the program has developed to screen potential participants.

(3) A treatment program may impose any conditions on participants that the program deems appropriate for the success of treatment.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0115, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0125 What rights do participants in a treatment program have? (1) A treatment program must provide each participant with the highest quality of service.

(2) Treatment program staff must establish a climate where all relationships with colleagues and participants are respectful.

(3) Each participant enrolled in a program must have the assurance that the program staff will conduct themselves professionally, as specified in RCW 18.130.180.

(4) Staff, board members, and volunteers working for a treatment program must not engage in or tolerate sexual harassment or exploitation of an employee, a program participant, or a victim of any program participant.

(5) Each participant must have a written contract signed by the participant and the treatment program staff which specifies the participant's rights and responsibilities while enrolled in the program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0125, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0135 What information about the participant must the treatment program keep confidential? (1) Treatment programs must follow the confidentiality requirements contained in chapter 18.19 RCW for registered counselors and certified professionals.

(2) All program participants and guests must agree in writing not to disclose the identity of group participants or personal information about the participants.

(3) A treatment program must keep all communications between the participant and direct treatment staff confidential unless:

(a) The participant has signed a release of information; or

(b) The program is legally required to release the information.

(4) The treatment program may audio or video tape group sessions only when all participants grant written consent that gives details about the specific uses for the tape. The program must obtain an additional consent statement from each participant to permit use of the tape for any purpose other than the purposes specified in the original consent.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0135, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0145 What releases must a program require a participant to sign? For a treatment program to conduct case monitoring and periodic safety checks, the program must require all participants to sign the following releases which must remain in effect for the duration of the client's treatment:

(1) A release allowing the treatment program to notify the victim and/or the victim's community and/or legal advocates that the perpetrator has been accepted or rejected for treatment;

(2) A release allowing the program to provide the victim with periodic reports about the perpetrator's participation in the program;

(3) A release allowing the current domestic violence perpetrator treatment program access to information held by all prior and concurrent treatment agencies, including domestic violence perpetrator treatment programs, mental health agencies, and drug and alcohol treatment programs;

(4) A release allowing the treatment program to provide relevant information regarding the participant to each of the following entities:

(a) Lawyers, including prosecutors;

(b) Courts;

(c) Parole officers;

(d) Probation officers;

(e) Child protective services, child welfare services, and other DSHS programs;

(f) Court-appointed guardians ad litem;

(g) DSHS certifying authorities; and

(h) Former treatment programs that the participant has attended.

(5) A release for the program to notify any person whose safety appears to be at risk due to the participant's potential for violence and lethality. This includes, but is not limited to:

(a) The victim;

(b) Any children;

(c) Significant others;

(d) The victim's community and legal advocates; or

(e) Police.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0145, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0155 Must a treatment program keep information provided by or about the victim confidential? (1) A treatment program must treat all information the victim provides to the program as confidential unless the victim gives written permission for the program to release the information.

(2) Information must be kept separate from any files for perpetrators.

(3) If a victim tells the treatment program that the participant has committed a new offense, the treatment program must encourage the victim to contact:

(a) Appropriate law enforcement agency; and

(b) The local domestic violence victim's program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0155, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0165 What information must the treatment program collect and discuss with the client during the intake process or assessment interview? (1) Treatment programs must conduct an individual, complete clinical intake and assessment interview with each perpetrator who has been accepted into the treatment program. The program staff must meet face-to-face with the program participant to conduct this intake and interview.

(2) During the intake interview, program staff must obtain the following information, at a minimum:

(a) Current and past violence history;

(b) A complete diagnostic evaluation;

(c) A substance abuse screening;

(d) History of treatment from past domestic violence perpetrator treatment programs;

(e) History of threats of homicide or suicide;

(f) History of ideation of homicide or suicide;

(g) History of stalking;

(h) Data to develop a lethality risk assessment;

(i) Possession of, access to, plans to obtain, or a history of use of weapons;

(j) Degree of obsessiveness and dependency on the perpetrator's victim;

(k) History of episodes of rage;

(l) History of depression and other mental health problems;

(m) History of having sexually abused the battered victim or others;

(n) History of the perpetrator's domestic violence victimization and/or sexual abuse victimization;

(o) Access to the battered victim;

(p) Criminal history and law enforcement incident reports;

(q) Reports of abuse of children, elderly persons, or animals;

(r) Assessment of cultural issues;

(s) Assessment of learning disabilities, literacy, and special language needs; and

(t) Review of other diagnostic evaluations of the participant.

(3) If the program cannot obtain the above information, the program client file must include documentation of the program's reasonable efforts to obtain the information.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0165, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0175 Who may complete the intake process or conduct the assessment interview? (1) Only treatment staff who meet the minimum qualifications for direct treatment staff stated in chapter 388-60 WAC may complete the intake process or conduct the assessment interview.

(2) A trainee may not have sole responsibility for conducting an intake or assessment. If the staff conducting the intake/assessment is a trainee, the trainee must work in conjunction with additional staff in their program, and the trainee's program supervisor must review and sign off on the trainee's work.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0175, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0185 Must the program compile a written document based on information gathered in the intake/assessment process? The program must compile a written document, which includes the information required to be gathered in the intake/assessment process.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0185, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0195 Must the treatment program develop an individual treatment plan for each participant? (1) The treatment program must develop a written treatment plan for each participant who is accepted into the domestic perpetrator treatment program.

(2) The treatment program must base the participant's treatment on the clinical intake/assessment which the program completed for the client.

(3) The treatment plan must adequately and appropriately address the needs of the individual participant.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0195, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0205 What must a treatment program consider when developing an individual treatment plan for a participant? (1) A treatment program must:

(a) Assess whether a participant should be required to engage in drug and alcohol, mental health, or other treatment services while they are participating in the treatment program;

(b) Decide which treatment gets priority for the participant if more than one treatment service is recommended;

(c) Determine the sequence of other services if concurrent treatment is not clinically appropriate; and

(d) Make appropriate referrals to outside agencies.

(2) A treatment program must consider issues relating to a participant's prior victimization when designing each treatment plan.

The program must consider the appropriateness of domestic violence victim services in lieu of perpetrator treatment for a participant who presents an extensive history of prior victimization.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0205, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0215 Must a program require a participant to sign a contract for services with the treatment program? A treatment program must require each participant to sign a formal contract for services.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0215, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0225 What must the treatment program include in the contract for each participant's treatment? The contract between each participant and the treatment program must include the following elements:

(1) A statement regarding the treatment program's philosophy that:

(a) The victim may not be blamed for the participant's abuse;

(b) The perpetrator must stop all forms of abuse;

(c) An abuser is to be held accountable for the abusers actions; and

(d) The program's primary concern is for the safety of victims.

(2) A statement requiring the participant to:

(a) Cooperate with all program rules;

(b) Stop violent and threatening behaviors;

(c) Be nonabusive and noncontrolling in relationships;

(d) Develop and adhere to a responsibility plan;

(e) Comply with all court orders;

(f) Cooperate with the rules for group participation; and

(g) Sign all required releases of information.

(3) A policy on attendance and consequences for inadequate attendance;

(4) A requirement that the perpetrator must actively participate in treatment, including sharing personal experiences, values, and attitudes, as well as completing all group activities and assignments;

(5) A policy regarding other program expectations, such as completion of written exams, concurrent treatment requirements, and possession of weapons as described under chapters 388-861 and 388-875 WAC;

(6) Written criteria for completion of treatment;

(7) A statement that group members must honor the confidentiality of all participants;

(8) A statement that the treatment program has the duty to warn and protect victims, law enforcement, and third parties of any risk of serious harm the program determines the participant poses to them;

(9) Requirements that the participant must either:

(a) Provide the program with the participant's arrest records, criminal history, and any information regarding treatment services previously received; or

(b) Identify the existence of and location of all service records, and authorize release of all such records to the domestic violence treatment program.

(10) The program's policy regarding the use of drugs and alcohol, including a provision that the participant must attend treatment sessions free of drugs and alcohol; and

(11) Fees and methods of payment for treatment.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0225, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0235 Must a treatment program follow an educational curriculum for each participant? A treatment program must follow a specific educational curriculum for all participants in the program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0235, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0245 What topics must the treatment program include in the educational curriculum? The curriculum of the treatment program must include the following topics:

(1) Belief systems that allow and support violence against women;

(2) Belief systems that allow and/or support the use or threat of violence to establish power and control over an intimate partner;

(3) Definitions of abuse, battering, and domestic violence;

(4) Forms of abuse, including:

(a) Physical abuse;

(b) Emotional and sexual abuse;

(c) Economic manipulation or domination;

(d) Physical force against property or pets;

(e) Stalking;

(f) Terrorizing someone or threatening him or her; and

(g) Acts that put the safety of battered partners, children, pets, other family members, or friends at risk.

(5) The impact of abuse and battering on children and the incompatibility of domestic violence and abuse with responsible parenting;

(6) The fact that a participant is solely responsible for the participant's violent behavior, and must acknowledge this fact;

(7) The need to avoid blaming a victim for the participant's abusive behavior;

(8) Techniques to be nonabusive and noncontrolling;

(9) Negative legal and social consequences for someone who commits domestic violence;

(10) Why it is necessary to meet financial and legal obligations to family members;

(11) Opportunities for a participant to develop a responsibility plan:

(a) The treatment program may assist the participant in developing the plan.

(b) In the plan, the participant must make a commitment to giving up power and control over the victim.

(12) Education regarding individual cultural and family dynamics of domestic violence; and

(13) Washington state laws and practices regarding domestic violence, as described in chapters 10.31, 10.99, and 26.50 RCW.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0245, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0255 What is the minimum treatment period for program participants? (1) The minimum treatment period is the time required for the participant to fulfill all conditions of treatment set by the treatment program. Satisfactory completion of treatment is not based solely on a perpetrator participating in the treatment program for a certain period of time or attending a certain number of sessions.

(2) The program must require participants to attend treatment and satisfy all treatment program requirements for at least twelve consecutive months.

(3) The program must require the participant to attend:

(a) A minimum of twenty-six consecutive weekly same gender group sessions, followed by:

(b) Monthly sessions with the treatment provider until the twelve-month period is complete. These sessions must be conducted face-to-face with the participant by program staff who meet the minimum qualifications set forth in this chapter.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0255, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0265 What criteria must be satisfied for completion of treatment? (1) A treatment program must have written criteria for satisfactory completion of treatment.

(2) A program must require a participant to meet all of the following conditions in order for the program to state that the participant has completed treatment:

(a) Attend treatment sessions for the minimum treatment period;

(b) Attend all other sessions required by the program;

(c) Cooperate with all group rules and program requirements throughout the duration of treatment services;

(d) Stop the use of all violent acts or threats of violence;

(e) Stop using abusive and controlling behavior;

(f) Adhere to the participant's responsibility plan;

(g) Comply with court orders; and

(h) Comply with other conditions of the contract for treatment services, such as chemical dependency treatment.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0265, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0275 What must the treatment program do when a participant satisfactorily completes treatment? (1) A treatment program must notify the following people when a participant satisfactorily completes treatment:

(a) The court having jurisdiction, if the participant has been court-mandated to attend treatment; and

(b) The victim, if feasible.

(2) The program must document in writing its efforts to contact the victim.

(3) The program may specify only that the perpetrator has completed treatment based on adequate compliance with the participant's contract with the treatment program and any court order.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0275, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0285 Must a treatment program have policies regarding any reoffenses during treatment? A treatment program must establish and implement written policies that include consequences if a perpetrator reoffends during treatment or does not comply with program requirements.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0285, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0295 Does a program need guidelines for discharging participants who do not complete treatment? (1) A treatment program must have guidelines for discharging participants who do not satisfactorily complete the program.

(a) Discharge decisions must be uniform and predictable.

(b) Discrimination may not occur against any participant.

(2) A program may terminate a participant from treatment prior to completion of the program if the participant has not complied with the requirements set forth in the participant's contract with the program.

(3) If a program discharges a participant who does not complete treatment, the treatment program must document in writing that the participant has not complied with:

(a) The participant's contract with the treatment program;

(b) A court order;

(c) A probation agreement; or

(d) Group rules.

(4) If a program chooses not to discharge a participant who has reoffended, committed other acts of violence or abuse, or has not complied with any of subsection (3)(a) through (d) of this section, the program must note the reoffense and/or noncompliance in the client's progress notes, reports to the court, and reports to the victim (if feasible).

(5) The program must state in the client's record the program's rationale for not terminating the participant, and state what corrective action was taken.

(6) A program may discharge a participant if the treatment program cannot provide adequate treatment services to the participant because of the treatment program's current development.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0295, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0305 Who must the program notify when the program discharges a participant because of failure to complete treatment? A treatment program must notify the following parties in writing when the program discharges a participant from the program because of failure to complete treatment:

(1) The court having jurisdiction, if the participant has been court-mandated to attend treatment;

(2) The participant's probation officer, if any;

(3) The victim of the participant, if feasible; and

(4) The program must notify the above parties within three days of terminating the client.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0305, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0315 What are the minimum qualifications for all direct treatment staff? (1) All staff with direct treatment contact with participants must be:

(a) Registered as counselors or certified as mental health professionals as required under chapter 18.19 RCW; and

(b) Free of criminal convictions involving moral turpitude.

(2) Each staff person providing direct treatment services to a participant must have a bachelor's degree.

(a) The department will review requests for an exception to this requirement on a case-by-case basis.

(b) In order to qualify for an exception, the employee must possess year-for-year professional level experience equivalent to a bachelor's degree. The department determines this equivalency at the discretion of the DSHS program manager responsible for monitoring domestic violence perpetrator treatment programs.

(3) Prior to providing any direct treatment services to program participants, each direct treatment staff person must have completed:

(a) A minimum of thirty hours of training about domestic violence from an established domestic violence victim program; and

(b) A minimum of thirty hours of training from an established domestic violence perpetrator treatment services program.

(i) If located within Washington state, the domestic violence perpetrator treatment program must be certified and meet the standards as outlined in this chapter.

(ii) If located out-of-state, the domestic violence perpetrator treatment program must meet the standards outlined in this chapter as well as chapter 26.50 RCW.

(4) All employees must complete all sixty hours of required training before the employee may begin to provide any direct services to group participants. Any work experience accrued prior to completion of the sixty hours of training will not count toward any requirement for work experience.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0315, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0325 Must a program notify the department when new direct treatment staff are added? (1) At the time that the program adds new direct treatment staff, the program must submit documentation to DSHS which proves that the staff meets the minimum qualifications for all treatment staff stated in WAC 388-60-0315.

(2) Direct treatment staff may not provide services to perpetrators until the treatment staff's qualifications have been reviewed and approved by the DSHS program manager responsible for certification of domestic violence perpetrator treatment programs.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0325, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0335 Who is considered a trainee for domestic violence perpetrator treatment programs? A trainee is a direct treatment staff person who has not accrued at least two hundred fifty hours of experience providing services to domestic violence perpetrators and domestic violence victims.

(1) At least one hundred twenty-five hours of this requirement must have been provision of supervised, direct treatment services to domestic violence perpetrators.

(2) The remainder of this requirement must have been provision of domestic violence victim advocacy services.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0335, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0345 May a trainee provide direct treatment services to participants? (1) A trainee may serve as a co-facilitator of groups, but may not have sole responsibility for the group at any time.

(2) A trainee may not have sole responsibility for conducting an intake or assessment, or for terminating a participant from treatment.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0345, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0355 Do treatment programs need a supervisor? Each treatment program must have at least one person providing supervision to paid and volunteer direct treatment staff.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0355, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0365 Who may provide supervision of direct treatment staff in a domestic violence perpetrator treatment program? (1) In addition to possessing the basic qualifications required for all direct treatment staff, a program's supervisor must meet **all** of the following requirements:

(a) Have a minimum of three years of experience providing direct treatment services to perpetrators of domestic violence;

(b) Have a minimum of one year of experience providing victim advocacy services to domestic violence victims (this may be concurrent with (a) of this subsection);

(c) Have a minimum of one year of experience in facilitating domestic violence perpetrator treatment groups;

(d) Has completed at least five hundred hours of supervised direct treatment contact with both perpetrators and domestic violence victims:

(i) At least three hundred hours of this requirement must have been the provision of supervised, direct treatment services to domestic violence perpetrators.

(ii) The remainder of this requirement must have been the provision of domestic violence victim advocacy services.

(2) Each staff person providing supervision to direct treatment staff within a program must have a master's degree.

(a) The department's program manger [manager] will review requests for an exception to this requirement on a case-by-case basis.

(b) In order to qualify for an exception, the employee must possess year-for-year professional level experience equivalent to a master's degree. The department determines this equivalency at the discretion of the DSHS program manager responsible for monitoring domestic violence perpetrator treatment programs.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0365, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0375 Must a supervisor always be on the premises of the treatment program? A supervisor may be located either on or off-site unless direct treatment services are being provided only by employees who are considered trainees, as defined in these rules. If no other direct treatment staff besides the supervisor possesses at least two hundred fifty hours of experience providing direct treatment services to perpetrators, the supervisor must be present at all times that direct treatment services are being provided.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0375, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0385 Must the treatment program have staff supervision policies? A treatment program must develop and follow policies, procedures, and supervision

schedules that provide adequate supervision for all treatment staff.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0385, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0395 What are the requirements for staff orientation? (1) A treatment program must have an orientation for any new staff, whether the staff are paid or volunteer.

(2) The purpose of the orientation must be to provide the staff with the program's philosophy, organization, curriculum, policies, procedures, and goals.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0395, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0405 What are the continuing professional education requirements for all direct treatment program staff? (1) All staff having direct treatment contact with participants must complete a minimum of twenty hours of continuing professional education each year after the program is certified, or each year after the staff person is added to the staff list. No more than five of those hours may be obtained by attending "in-house" training.

(2) Each staff person's continuing professional education must include four or more hours of training per year on issues of sexism, racism, and homophobia and their relationship to domestic violence.

(3) Continuing education training may be in the fields of alcohol/drug abuse, mental health, or other issues but all training must be related to the treatment of domestic violence perpetrators.

(4) The treatment staff may obtain continuing professional education through classes, seminars, workshops, video or audiotapes, or other self-study programs when approved in writing by the program supervisor. No more than five hours of video, audiotapes, or self-study program may be used toward the requirement of twenty hours of continuing education requirement. This includes correspondence courses.

(5) The staff must document all continuing education hours on DSHS approved forms.

(a) The form must be accompanied by completion certificates, course/workshop outline, and supervisor signature.

(b) The program must submit the form and documentation to the department at the time the program applies for recertification.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0405, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0415 Is a treatment program required to cooperate with local domestic violence victim programs? A treatment program must establish and maintain cooperative relationships with domestic violence victim services programs located in their community.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0415, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0425 Does a treatment program need knowledge of the domestic violence laws and justice system practices? A treatment program must show evidence of an understanding of the laws pertaining to domestic violence and the operation of the justice system. At a minimum, a program must be familiar with:

(1) State laws regulating the response to domestic violence by the criminal justice system;

(2) Relief available to victims of domestic violence offered by:

(a) Washington domestic violence law and civil protection orders;

(b) Criminal no-contact orders; and

(c) Civil restraining orders.

(3) Local law enforcement, prosecution, and court and probation policies regarding domestic violence cases.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0425, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0435 What is the process to apply for certification of a treatment program? (1) Any program wishing to provide treatment to perpetrators of domestic violence must request certification by completing an application available from the department. To request an application by mail, write to:

Domestic Violence Perpetrator Treatment Program
Department of Social and Health Services (DSHS)
Children's Administration
P.O. Box 45710
Olympia, Washington 98504-5710.

(2) The program must submit the application, application fee, and all documentation needed to prove that the program meets the requirements set forth in these standards.

(3) A program may not provide direct treatment services to domestic violence perpetrators without being certified by the department.

(4) If approved, the department grants certification for a two year period.

(5) The department considers each geographical location of a program an individual program, and must certify each program separately.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0435, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0445 What is the application fee for certification? (1) Application fee for either initial certification or recertification of a domestic violence perpetrator treatment program is one hundred dollars.

(2) The department publishes the application fee for certification of domestic violence perpetrator treatment programs in the application packet.

(3) If there is any change in the fee, the update will be done in July of each year.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0445, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0455 What documentation must a program submit before the department may certify the program? The program's director must submit the following documentation with the program's application:

(1) A written statement signed by the director that the program complies with the standards contained in this chapter;

(2) Results of current criminal history background checks conducted by the Washington state patrol for all current direct treatment program staff;

(3) A statement for each current paid or volunteer staff person whether or not the staff person has ever been a party to any civil proceedings involving domestic violence;

(4) Proof that each direct treatment staff is registered as a counselor or certified as a mental health professional with the department of health;

(5) Evidence that the program maintains cooperative relationships with agencies providing services related to domestic violence.

(a) This evidence must include, at a minimum:

(i) Three items of evidence that they have established and continue to maintain cooperative relationships with local domestic violence victim programs and other local agencies involved with domestic violence intervention.

(ii) Documentation that they have established a referral process between their program and the local domestic violence victim services programs.

(iii) Proof that they participate in a local domestic violence task force, intervention committee or workgroup if one exists in their community.

(b) The program may also submit evidence of the following:

(i) Participation in public awareness activities sponsored by the local domestic violence victim services agency.

(ii) Service agreements between the local domestic violence victim services agency(ies) and the treatment program.

(iii) Letters of support for the program from other agencies or parties involved in domestic violence intervention.

(6) Evidence that the program maintains cooperative relationships with agencies involved in domestic violence intervention.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0455, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0465 What happens after a program turns in an application to the department? (1) The department will review a certification application within thirty days after the application is received to decide if the domestic violence perpetrator program meets the program standards in this chapter.

(2) The department must notify the applicant whether or not the program meets these standards.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0465, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0475 Will a certificate be issued if the treatment program meets the standards? If a program meets the standards in this chapter, the department will issue the program a certificate of compliance.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0475, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0485 What happens if a treatment program does not meet the standards? (1) If a program does not meet the standards for certification or recertification, the department will provide the program with:

(a) A copy of the standards;

(b) A written notice containing the reasons for the determination of noncompliance; and

(c) The program standards relied upon for making the decision.

(2) Treatment programs have the right to a hearing if the program is denied certification under this chapter (chapter 388-02 WAC).

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0485, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0495 What records must the department keep regarding certified domestic violence perpetrator programs? The department must maintain the following information:

(1) A current record of all certified domestic violence perpetrator programs.

(2) A current record of programs that:

(a) Are in the process of applying for certification;

(b) Have been denied certification;

(c) Have been notified that the department is revoking or suspending certification;

(d) Have had their certification revoked; and

(e) Are being investigated.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0495, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0505 How often must a domestic violence perpetrator treatment program reapply for certification? Each program certified under this chapter must reapply for certification every two years.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0505, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0515 What must a program do to apply for recertification of their domestic violence perpetrator treatment program? In order to be recertified, a program must submit a completed application packet to the department at least forty-five days prior to the expiration date of the previous certification period.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0515, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0525 What must the application packet for renewal of the certification of a domestic violence perpetrator program include? The packet must include the following:

(1) A completed application form signed by the program director;

(2) Payment of the application fee;

(3) A listing of all direct treatment staff;

(4) A statement of qualifications for any staff added since the last certification period;

(5) Current results of criminal history background checks conducted by the Washington state patrol, and a state-

ment regarding any involvement in civil proceedings involving domestic violence for each employee providing direct treatment services;

(6) An update of continuing professional education hours for each direct treatment staff;

(7) Evidence that the program maintains cooperative relationships with agencies providing services related to domestic violence.

(a) This evidence must include, at a minimum:

(i) Three items of evidence that they have established and continue to maintain cooperative relationships with local domestic violence victim programs and other local agencies involved with domestic violence intervention.

(ii) Documentation that they have established a referral process between their program and the local domestic violence victim services programs.

(iii) Proof that they participate in a local domestic violence task force, intervention committee or workgroup if one exists in their community.

(b) The program may also submit evidence of the following:

(i) Participation in public awareness activities sponsored by the local domestic violence victim services agency.

(ii) Service agreements between the local domestic violence victim services agency(ies) and the treatment program.

(iii) Letters of support for the program from other agencies or parties involved in domestic violence intervention.

(8) Evidence that the program maintains cooperative relationships with agencies involved in domestic violence intervention; and

(9) All documentation needed to prove that the program continues to meet the standards for certification.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0525, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0535 How does the department decide that a program should continue to be certified? The department will continue to certify a program, or will review its certification, if:

(1) The department determines, based on the completed application, that the program continues to meet the standards and qualifications as outlined in this chapter; and

(2) The department determines that any complaint investigations from the previous certification period have been satisfactorily resolved.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0535, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0545 Is there a formal process if a treatment program wishes to appeal a denial of certification or recertification? If the department denies certification or recertification, the domestic violence perpetrator treatment program has a right to an administrative hearing under chapter 388-08 WAC.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0545, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0555 Does the department have an advisory committee for domestic violence perpetrator treatment? The department will establish and appoint a volunteer group to serve as the Washington domestic violence perpetrator treatment program standards advisory committee.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0555, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0565 What is the role of the advisory committee? The role of the advisory committee is to:

(1) Advise the department regarding recommended changes to the program standards; and

(2) Provide technical assistance on program standards, implementation, and certification and recertification criteria.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0565, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0575 Who are the advisory committee members and how are they chosen? The advisory committee must include the following members:

(1) Four persons representing the perspective of victims of domestic violence. They will be chosen with input from the Washington State Coalition Against Domestic Violence (WSCADV);

(2) Four persons representing the perspective of state-certified domestic violence perpetrator treatment programs. They will be chosen with input from the Washington Association of Domestic Violence Intervention Professionals (WADVIP);

(3) Four persons representing the perspective of adult misdemeanant probation and Washington state courts of limited jurisdiction. They will be chosen with input from the Misdemeanant Corrections Association and the Washington State District and Municipal Court Judges Association;

(4) One person representing the department of corrections; and

(5) One person representing the office of the administrator for the courts.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0575, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0585 How long is the appointed term for an advisory committee member? Advisory committee members are appointed for two-year terms.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0585, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0595 May advisory committee members be replaced before their term expires? The department may replace committee members if the member misses two consecutive committee meetings.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0595, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0605 Are expenses for advisory committee members reimbursed? (1) If funds are available, the department will reimburse advisory committee members for travel and meal expenses related to service on the committee.

(2) Advisory committee members may not receive any other compensation for service on the committee.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0605, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0615 Does the department investigate complaints about domestic violence perpetrator treatment programs? DSHS investigates complaints regarding domestic violence perpetrator treatment programs.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0615, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0625 Who may request an investigation of a certified domestic violence perpetrator treatment program? Any person may submit a written complaint to DSHS if the person has the following concerns about a certified program:

(1) The program has acted in a way that places victims at risk; or

(2) The program has failed to follow standards in this chapter.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0625, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0635 Does the department notify a treatment program that the department has received a complaint? Once it receives a complaint about a certified program, the department will:

(1) Determine that the complaint includes sufficient information to be deemed valid;

(2) Notify the program within fourteen days of the complaint being determined valid that the department has received a complaint about the program; and

(3) Notify the program that an investigation has been initiated.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0635, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0645 May DSHS begin an investigation of a treatment program without receiving a complaint? DSHS may begin an investigation of a domestic violence perpetrator treatment program without a written complaint if the department believes that the program:

(1) Has placed victims at risk; or

(2) Failed to follow the standards outlined in this chapter.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0645, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0655 What is included in an investigation? The investigation of a complaint against a domestic violence perpetrator treatment program may include:

(1) Contact with:

(a) The person making the complaint;

(b) Other persons involved in the complaint; or

(c) The treatment program.

(2) A request for written documentation of evidence; and/or

(3) An on-site visit to the program to interview program staff.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0655, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0665 Is there a time limit for the department to complete its investigation of a complaint? The department must complete its investigation within forty-five days of beginning the investigation, unless circumstances warrant a longer period of time.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0665, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0675 Does the department put the results of the investigation in writing? (1) The department will prepare written results of the complaint investigation.

(2) If the department decides that the treatment program behaved in a way that placed victims at risk or failed to meet the standards outlined in this chapter, the written results must include a decision regarding the status of the program's certification.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0675, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0685 What action may the department take regarding a program's certification if a complaint is founded? If the department determines that a complaint against a domestic violence perpetrator treatment program is founded, the department may:

(1) Revoke the treatment program's certification;

(2) Suspend the treatment program's certification; or

(3) Send a written warning to the treatment program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0685, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0695 Does DSHS notify a treatment program of its decision to take corrective action? DSHS must send the written results of its investigation to the program by certified mail, return receipt requested, within twenty days after completing the investigation.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0695, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0705 What information must the department give a program if it takes action that affects the program's certification status? (1) If DSHS revokes a program's certification, the department must provide the program with:

(a) The specific reasons for the revocation;

(b) The WAC standards the revocation is based on; and

(c) The effective date of the revocation.

(2) If DSHS suspends a treatment program's certification, DSHS must provide the treatment program with:

(a) The specific reasons for the corrective action;

(b) The WAC standards that the suspension is based on;

(c) The effective date of the suspension;

(d) Any remedial steps which the program must complete to the satisfaction of the department before the department will reinstate the program's certification and lift the suspension; and

(e) The deadline for completion of any remedial steps.

(3) If DSHS issues a written warning to a program, DSHS must provide the treatment program with:

(a) The specific reasons for the written warning;

(b) The WAC standards that the written warning is based on; and

(c) Any remedial steps which the program must complete to the satisfaction of the department.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0705, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0715 What happens if a treatment program refuses to remedy the problems outlined in the complaint findings? If the treatment program refuses or fails to remedy the problems outlined in the written warning, DSHS may revoke or suspend the certification of the program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0715, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0725 What if the director of a domestic violence perpetrator treatment program disagrees with the corrective action decision? (1) When DSHS revokes or suspends a program's certification, issues a written warning, or imposes corrective action, the department will notify the program director in writing of the program's right to request a hearing.

(2) The program director may request an administrative hearing from the office of administrative hearings pursuant to chapter 388-02 WAC.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0725, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0735 Does the department notify the person that made the complaint of the results of the investigation? DSHS will mail a copy of the written results of the investigation to the person who made the complaint against the domestic violence perpetrator treatment program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0735, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0745 What must the treatment program do after notification that its certification has been suspended or revoked? If DSHS revokes or suspends a program's certification, the program must:

(1) Take immediate steps to notify and refer current clients to other certified domestic violence perpetrator treatment programs;

Note: This must be done prior to the effective date of revocation or suspension.

(2) Cease accepting perpetrators of domestic violence into its treatment program;

(3) Notify victims, current partners of the participants, and any relevant agencies about the client referral; and

(4) Notify, in writing, the presiding judge and chief probation officer of each judicial district from which the treatment program receives court referrals.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0745, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0755 What happens if the program has other licenses or certificates? If a program also holds a license or certification from the state of Washington for other treatment modalities, DSHS may notify the appropriate licensing or certifying authority that the program's certification has been suspended or revoked.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0755, filed 3/30/01, effective 4/30/01.]

WAC 388-60-120 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-130 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-140 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-150 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-160 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-170 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-180 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-190 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-200 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-210 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-220 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-230 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-240 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-250 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-60-260 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-61A WAC
SHELTERS FOR VICTIMS OF DOMESTIC VIOLENCE

(Formerly chapter 284-554 WAC)

WAC

WAC 388-61A-0005 What is the legal basis for the domestic violence shelter program? Chapter 70.123 RCW authorizes us to establish minimum standards for agencies that receive funding from the department of social and health services (DSHS) to provide domestic violence shelter and services.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0005, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0010 What is the purpose of having minimum standards for domestic violence shelters and services? The purpose of these rules is to have uniform statewide standards for domestic violence shelters and services funded by us. Minimum standards are necessary to provide rules for agencies that contract with us to provide shelter and services for domestic violence victims. These standards address issues such as adequate food, clothing, housing, safety, security, advocacy, and counseling for victims.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0010, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0015 Is DSHS required to provide funding to any domestic violence service that requests funding? We are not obligated to disburse funds to all domestic violence services that may comply with the minimum standards set forth in this chapter. The goal of this program is to provide funding and support for the statewide development, stability, and expansion of shelter and services for victims of domestic violence. In support of that goal, if an agency applies to receive funding we will consider such things as:

(1) Geographic location;

(2) Population ratios;

(3) Population need for services;

(4) An agency's ability to provide services that comply with these minimum standards;

(5) The availability of other domestic violence services in a community; and

(6) The amount of funding we have available to support domestic violence services.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0015, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0020 What are the facility and service requirements for domestic violence services? In order for us to contract with an agency for domestic violence services, the agency must provide shelter and supportive services to victims of domestic violence. The agency must comply with the:

(1) General facility requirements for shelters; and

(2) Specific additional requirements for safe homes; or

(3) Specific additional requirements for shelter homes; and

(4) Requirements for supportive services and agency administration.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0020, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0025 What definitions apply to domestic violence shelters and services? "Advocacy-based counseling" means that the client is involved with an advocate counselor in individual, family, or group sessions with the primary focus on safety planning, empowerment, and education of the client through reinforcing the client's autonomy and self-determination.

"Advocate counselor" means a trained staff person who works in a domestic violence service and provides advo-

cacy-based counseling, counseling, and supportive temporary shelter services to clients.

"Client" means a victim of domestic violence or dependent child of the victim.

"Cohabitant" means a person who is married or is living with a person as a husband or wife at the present time or at some time in the past. Any person who has one or more children in common with another person, regardless of whether they have been married or have lived together at any time, is considered a cohabitant.

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

"Domestic violence" includes, but is not limited to, the criminal offenses defined in RCW 10.99.020 when committed by one cohabitant against another.

"Domestic violence service" means an agency that provides shelter, advocacy, and counseling for domestic violence clients in a safe, supportive environment.

"Lodging unit" means one or more rooms used for a victim of domestic violence including rooms used for sleeping or sitting.

"Program" means the DSHS domestic violence program.

"Safe home" means a shelter that has two or less lodging units and has a written working agreement with a domestic violence service.

"Secretary" means the DSHS secretary or the secretary's designee.

"Shelter" means a safe home or shelter home that provides temporary refuge and adequate food and clothing offered on a twenty-four-hour, seven-day-per-week basis to victims of domestic violence and their children.

"Shelter home" means a shelter that has three or more lodging units and either is a component of or has a written working agreement with a domestic violence service.

"Staff" means persons who are paid or who volunteer services and are a part of a domestic violence service.

"Victim" means a cohabitant who has been subjected to domestic violence.

"We, us and our" refers to the department of social and health services and its employees.

"You, I and your" refers to the domestic violence service or shelter.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0025, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0030 What safety requirements is the shelter required to meet? You must keep your equipment and the physical structures in the shelter safe and clean for the clients you serve. You must:

(1) Maintain the shelter, premises, equipment, and supplies in a clean, safe and sanitary condition, free of hazards, and in good repair;

(2) Provide guard or handrails, as necessary, for stairways, porches and balconies used by clients;

(3) Maintain swimming pools, wading pools, bathtubs, hot tubs, spas, and bathing beaches in a safe manner and in such a way that does not present a health hazard, safety problem, or nuisance;

(4) Have a method for securing all windows, doors, and other building accesses to prevent the entry of intruders;

(5) Provide a way for staff to enter any area occupied by clients should there be an emergency; and

(6) Secure all unused refrigerators and freezers accessible to children in such a way that prevents them from climbing in and becoming trapped.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0030, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0035 What are the general requirements for bedrooms? Shelters must meet the following requirements for bedrooms:

(1) You must provide a bed in good condition, with a clean and comfortable mattress to shelter residents.

(2) If the shelter provides cribs or bassinets for infants, the shelter must follow each of these requirements:

(a) Cribs and bassinets must have clean, firm mattresses covered with waterproof material that is easily sanitized;

(b) Crib mattresses must fit snugly to prevent the infant from being caught between the mattress and crib side rails;

(c) Cribs must be made of wood, metal, or approved plastic with secure latching devices;

(d) Cribs must have no more than two and three-eighths inches space between vertical slats when used for infants under six months of age; and

(e) Bumper pad ties must be no longer than twelve inches in length.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0035, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0040 What kind of diaper changing area must I provide? You must provide a sanitary diaper changing area. In addition, you must develop and provide to clients, hygiene procedures for handling and storing diapers and sanitizing the changing area.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0040, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0045 What are the kitchen requirements? The following are the minimum general requirements for kitchen facilities:

(1) A sink for dishwashing;

(2) A refrigerator or other storage equipment capable of maintaining a temperature of forty-five degrees Fahrenheit or lower;

(3) A range, stove, or hot plate;

(4) Covered garbage container;

(5) Eating and cooking utensils that are clean and in good repair; and

(6) Counter surfaces that are clean and resistant to moisture.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0045, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0050 Are there any restrictions on food preparation? Food and beverages prepared by and for

clients must be prepared, served and stored safely and in a sanitary manner. You must not serve home-canned, low-acid foods (e.g., meats and vegetables) to clients residing in a shelter.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0050, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0055 What are the requirements for providing food and clothing to shelter residents? (1) The domestic violence service must provide appropriate food and beverages for the basic sustenance of shelter residents, unless other resources are immediately available.

(2) You should store appropriate food, including infant formula, at the shelter to provide to residents when other resources are not immediately available.

(3) Whenever possible, the shelter should provide food that is culturally appropriate.

(4) You must provide shelter residents with access to clean, adequate clothing. Clothing that you provide must be clean and have been stored in a sanitary manner.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0055, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0060 What are the requirements for toilets, sinks, and bathing facilities? You must meet these requirements for toilets, sinks, and bathing facilities.

(1) You must provide at least one indoor flush-type toilet, one nearby hand-washing sink with hot and cold running water, and a bathtub or shower facility. These facilities must be located within the shelter building premises.

(2) You must comply with all of the following requirements for toilet and bathing facilities:

(a) Toilet and bathing facilities must allow for privacy of shelter residents.

(b) Toilets, urinals, and hand-washing sinks must be the appropriate height for the children served, or have a safe and easily cleaned step stool or platform that is water resistant.

(c) Hand-washing and bathing facilities must be provided with hot and cold running water; the hot water must not exceed one hundred twenty degrees.

(d) Potty chairs and toilet training equipment for toddlers must be regularly maintained and kept in a sanitary condition. You must put potty chairs, when in use, on washable, water resistant surfaces.

(e) You must provide soap and clean washcloths and towels, disposable towels or other approved hand-drying devices to residents.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0060, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0065 What types of linen do I need to provide to clients? (1) You must provide the following to clients residing in shelter:

(a) Bed linen, towels and washcloths that are clean and in good repair. After use by a client, bed linen, towels and washcloths must be laundered prior to use by another client.

(b) A clean liner for a sleeping bag unless the bag is cleaned between use by different clients.

(2) Clients residing in shelter must be provided with changes of clean bed linen, towels and washcloths upon their request.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0065, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0070 What are the requirements for laundry facilities? We have specific requirements for laundry facilities at your shelter.

(1) You must provide adequate laundry and drying equipment, or make other arrangements for getting laundry done on a regular basis.

(2) You must handle and store laundry in a sanitary manner.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0070, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0075 Are there requirements for drinking water? Water supplies to be used for human consumption must be from an approved public water system. If it is an individual system, the local health department must approve it as safe for human consumption.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0075, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0080 What are the requirements for sewage and liquid wastes? You must discharge sewage and liquid wastes into a public sewer system or into a functioning septic system, approved by the local health authority or department.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0080, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0085 What kind of heating system is required? (1) Rooms used by clients in a shelter must be equipped with a safe and adequate source of heat that can keep the room at a healthful temperature during the time the room is occupied.

(2) Gas-fired or oil-fired space heaters and water heaters must be safely vented to the outside.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0085, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0090 How must I ventilate the shelter? (1) You must ensure that your shelter is ventilated for the health and comfort of the shelter residents. A mechanical exhaust to the outside must ventilate toilets and bathrooms that do not have windows opening to the outside.

(2) Bedrooms and communal living areas must have a window or opening to the outdoors that can be locked or secured from the inside.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0090, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0095 How much lighting is required in the shelter? You must locate light fixtures and provide lighting that promotes good visibility and comfort for shelter residents.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0095, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0100 Are there any requirements about pets in the shelter? Pets are prohibited from the kitchen during food preparation.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0100, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0105 What first-aid supplies must I provide? You must keep first-aid supplies on hand for immediate use, including unexpired syrup of ipecac that is to be used only when advised by the poison control center. First-aid supplies must include at least the following: First aid manual, band-aids, gauze, and adhesive tape.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0105, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0110 What are the requirements for storing medications? (1) All medications, including pet medications and herbal remedies, must be stored in a way that is inaccessible to children.

(2) Pet and human medications must be stored separately.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0110, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0115 What measures must I take for pest control? You must make reasonable attempts to keep the shelter free from pests, such as rodents, flies, cockroaches, fleas and other insects.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0115, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0120 What are the requirements for labeling and storing chemicals and toxic materials? (1) Containers of chemical cleaning agents and other toxic materials must:

(a) Be clearly labeled with the contents; and

(b) Bear the manufacturer's instructions and precautions for use.

(2) You must store the following items in a place that is not accessible to children:

(a) Chemical cleaning supplies;

(b) Toxic substances;

(c) Poisons;

(d) Aerosols; and

(e) Items with warning labels.

(3) You must store chemical cleaning supplies and toxic substances separately from food items, clothing, and bedding in order to prevent contamination.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0120, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0125 Where do I keep firearms and other dangerous weapons? (1) You must keep firearms and other dangerous weapons in a locked storage container, gun safe, or another storage area made of strong, unbreakable material.

(2) If the storage cabinet has a glass or another breakable front, you must secure the firearms with a locked cable or chain placed through the trigger guards.

(3) You must store ammunition in a place that is separate from the firearms or locked in a gun safe.

(4) You must allow access to firearms, weapons and ammunition only to authorized persons.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0125, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0130 What are the additional requirements for a safe home? Safe homes must meet the following additional requirements in order for a domestic violence service to contract with us:

(1) A safe home must complete a written application to a domestic violence service. The domestic violence service must approve the application and give training to the safe home staff before the home may receive clients.

(2) The domestic violence service must maintain a written record of all safe homes. The record must include:

(a) The name and address of the person operating the safe home or an identification code for the safe home;

(b) A written safe home application;

(c) Documentation that the safe home complies with the general facility and additional requirements for safe homes; and

(d) Verification that safe home staff received initial basic training as outlined in this WAC by the domestic violence service.

(3) You must have at least one telephone at the safe home for incoming and outgoing calls. You must provide the following information to residents:

(a) Emergency telephone numbers; and

(b) Instructions on how residents can access domestic violence service staff.

(4) When clients are residing in a safe home at least one domestic violence service staff member must be on-call to go to the safe home twenty-four-hours a day, seven-days-per-week.

(5) Safe homes must comply with the following general fire safety requirements:

(a) Every room used by children in the safe home must have easy entry and exit, including one of these features:

(i) Two separate doors;

(ii) One door leading directly to the outside; or

(iii) A window that opens to the outside and is large enough for emergency escape or rescue.

(b) Every occupied area must have access to at least one exit that does not pass through rooms or spaces the can be locked or blocked from the opposite side.

(c) No space may be lived in by a client that is accessible only by a ladder, folding stairs, or a trap door.

(d) Every bathroom door used by clients must be designed to permit the opening of the locked door from the outside.

(e) Every closet door latch must be designed to be opened from the inside.

(f) Stoves or heaters must not block escape or exit routes.

(g) Flammable, combustible, or poisonous material must be stored away from exits and away from areas that are accessible to children.

(h) Open-flame devices and fireplaces, heating and cooking appliances, and products capable of igniting clothing must not be left unattended or used incorrectly.

(i) Fireplaces, wood stoves and other heating systems that have a surface hot enough to cause harm must have gates or protectors around them when in use.

(j) Multi-level dwellings must have a means of escape from an upper floor. If a fire ladder is needed to escape from an upper story window, it must be stored in a location that is easily accessible to the clients who may need it.

(k) You must place a smoke detector in good working condition in each bedroom or in areas close to where children sleep, such as a hallway. If the smoke detector is mounted on the wall, it must be twelve inches from the ceiling and a corner.

(l) If questions arise concerning fire danger, the local fire protection authority must be consulted.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0130, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0135 What are the additional requirements for a shelter home? Shelter homes must meet the following additional requirements in order for a domestic violence service to contract with us:

(1) When a shelter home is not a component of a domestic violence service, the shelter home and domestic violence service must have a written working agreement before the shelter home receives clients from the domestic violence service. The written working agreement must include:

(a) Confirmation that the domestic violence service has inspected the shelter home and that the shelter home complies with the general facility and additional requirements for shelter homes;

(b) How the domestic violence service will provide supportive services to shelter home residents; and

(c) Verification that shelter home staff received initial basic training as outlined in this rule by the domestic violence service.

(2) Shelter homes must provide at least one toilet, sink, and bathing facility for each fifteen clients or fraction of this number. The floors of all toilet and bathing facilities must be resistant to moisture.

(3) You must have at least one telephone at the shelter for incoming and outgoing calls. Next to the telephone in shelter homes you must post:

(a) Emergency telephone numbers; and

(b) Instructions on how residents can access domestic violence service staff.

(4) In shelter homes all bathrooms, toilet rooms, laundry rooms, and janitor closets containing wet mops and brushes must have natural or mechanical ventilation in order to prevent objectionable odors and condensation.

(5) When staff serve food to clients in shelter homes, the staff must prepare the food in compliance with WAC 246-215-190, Temporary food service establishment.

(6) Shelter homes must develop and post hygiene procedures for handling and storing diapers and sanitizing the changing area.

(7) Shelter homes must comply with the fire and life safety requirements as outlined in chapter 51-40 WAC.

(8) Shelter homes must meet the following requirements for bedrooms:

(a) Bedrooms must have a minimum ceiling height of seven and half feet;

(b) Bedrooms must provide at least fifty square feet of usable floor area per bed; and

(c) Floor area where the ceiling height is less than five feet cannot be considered as usable floor area.

(9) When clients are residing in a shelter home at least one domestic violence service staff
member must be present or on-call to go to the shelter home twenty-four-hours a day, seven-days-per-week.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0135, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0140 What supportive services am I required to provide to clients? You must give clients an opportunity to receive supportive services and assistance during their stay in the shelter. Clients are not required to participate in these services as a condition of residing in the shelter. Supportive services must include:

(1) Twenty-four-hour, seven-day-per-week access to advocacy-based counseling;

(2) A safe, supportive environment that offers clients the opportunity to examine the events that led to the need for domestic violence services;

(3) A private area for counseling;

(4) Advocacy-based counseling with, and on behalf of, the client;

(5) Safety planning, problem solving and crisis intervention;

(6) Assistance with child care during individual and group counseling sessions;

(7) A minimum ratio of one group facilitator to eight group participants;

(8) Planned activities for children who are residents of the shelter;

(9) A day program or drop-in center to assist victims of domestic violence who have found other shelter but who have a need for supportive services; and

(10) Referrals to other appropriate services or domestic violence services when:

(a) Shelter homes or safe homes are full;

(b) A client must be transferred to another domestic violence service for reasons of safety of the client; or

(c) An inappropriate referral has been made to a domestic violence service; or

(d) The client has problems that require services of another agency or agencies before receiving domestic violence services.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0140, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0145 What is advocacy-based counseling? Advocacy-based counseling means the involvement

of a client with an advocate counselor in an individual, family, or group session with the primary focus on safety planning and on empowerment of the client through reinforcing the client's autonomy and self-determination. Advocacy-based counseling uses nonvictim blaming problem-solving methods that include:

(1) Identifying the barriers to safety;

(2) Developing safety checking and planning skills;

(3) Clarifying issues;

(4) Providing options;

(5) Solving problems;

(6) Increasing self-esteem and self-awareness; and

(7) Improving and implementing skills in decision making, parenting, self-help, and self-care.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0145, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0150 What type of training is required for staff of the domestic violence service? All staff providing direct services to domestic violence clients, and supervisors of direct service staff, must meet the following minimum training requirements.

(1) A minimum of twenty hours of initial basic training that covers at least the following topics:

(a) Theory and implementation of advocacy-based counseling;

(b) The history of domestic violence;

(c) Legal, medical, social service, and systems advocacy;

(d) Confidentiality and ethics;

(e) Client safety assessment;

(f) Planning, problem-solving, and crisis intervention;

(g) Providing services and advocacy to individuals from diverse communities;

(h) Policies and procedures of the domestic violence service; and

(i) Referrals and shelter resident transfers.

(2) In the year following the year in which they received their initial basic training, and every year thereafter, staff providing direct services, and supervisors of direct service staff, must attend a minimum of thirty hours of continuing education as follows:

(a) At least fifteen hours of continuing education must be training on advocacy-based counseling directly related to serving victims of domestic violence and their children.

(b) At least five hours of continuing education must be training on services and advocacy to individuals from diverse communities.

(c) Staff must devote not more than ten hours to video, audiotapes, or self-study as part of the overall thirty-hour continuing education requirement.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0150, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0155 Must supervisors of domestic violence service staff have specific experience and training? Supervisors of staff providing direct services to domestic violence clients must meet the following minimum experience and training requirements.

(1) At least two years' counseling experience with a domestic violence service; and

(2) Fifty hours of training on domestic violence issues and advocacy-based counseling within three years prior to providing staff supervision.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0155, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0160 What written policies and procedures do you need to have? The domestic violence service must have written policies and procedures that cover the following issues:

(1) Victims in immediate danger or at risk will receive first priority for shelter;

(2) Confidentiality of client records and communication;

(3) Nondiscrimination relating to staff, clients, and provision of services;

(4) The provision of bilingual and interpreter services to clients;

(5) Recruitment, hiring, periodic performance evaluation, promotion and termination of staff. Agencies must recruit, to the extent feasible, persons who are former victims of domestic violence to work as paid or volunteer staff;

(6) Job descriptions for all staff positions including volunteers;

(7) Reporting of child abuse as legally mandated;

(8) Clients access to their files;

(9) Grievance procedures for staff and clients;

(10) Procedures for making referrals to other community resources such as medical, community service offices, pastoral care, legal representation, and client transfers to another domestic violence service for reasons of safety of the client;

(11) Emergency procedures for fire, disaster, first aid, medical and police intervention;

(12) Appropriate documentation of domestic violence services and client files;

(13) Protection of agency and client records;

(14) Records retention;

(15) Appropriate accounting procedures;

(16) Personnel policies and procedures; and

(17) Administrative policies and procedures.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0160, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0165 Will DSHS do an evaluation of the domestic violence service? (1) To measure compliance with our requirements we will conduct a biennial evaluation of each agency under contract with us to provide domestic violence service.

(2) We will inspect a random number of safe homes during biennial evaluations of domestic violence services to measure compliance with our requirements.

(3) If a lodging unit is occupied at the time of an evaluation, the domestic violence service must give the client an opportunity to leave the unit.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0165, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0170 What will happen if I am out of compliance with my contract? (1) If we find that the domestic violence service, safe home, or shelter home is out of compliance with the standards specified in this chapter or the contract, we will give you written notice of the deficiencies. You must correct the deficiencies according to a plan of correction we approve.

(2) We may suspend or revoke the funding of a domestic violence service where a safe home, shelter home, or the domestic violence service itself is out of compliance with this chapter or the DSHS contract.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0170, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0175 What will happen if there is a complaint to DSHS about the domestic violence service? (1) If we receive a complaint that your domestic violence service is out of compliance with this chapter or the DSHS contract, we will notify you and we will initiate an investigation.

(2) If the investigation requires that we be on-site at your domestic violence service, you must give clients residing in lodging units an opportunity to leave the unit during the inspection.

(3) If we find that the domestic violence service, safe home, or shelter home has not complied with the standards specified in this chapter or the terms of the DSHS contract, we will give you written notice of the deficiencies. You must correct the deficiencies according to a plan of correction we approve.

(4) We may suspend or revoke the funding of a domestic violence service where a safe home, shelter home, or the service itself is out of compliance with this chapter or the DSHS contract.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0175, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0180 Can DSHS waive any of the minimum standards of this chapter? Under certain conditions we may waive some of the rules contained in this chapter if you submit a written request that satisfactorily demonstrates that:

(1) The waiver will not place the client's safety or health in jeopardy and that:

(a) The domestic violence service is unable to meet the requirements of this chapter without the waiver; or

(b) The absence of the waiver will have a detrimental effect on the provision of services.

(2) Any substitutions of procedures, materials, or equipment from those specified in this chapter are at least equivalent to those required.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0180, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0185 What are my rights if DSHS suspends, revokes, or denies funding? If we suspend, revoke or deny funding you may request an agency hearing.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0185, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0190 Will I be notified if my funding has been suspended, revoked, or denied? We will notify you in writing if:

(1) Your funding has been suspended or revoked and we will state our reasons for making that decision; or

(2) Your request for funding has been denied and we will state our reasons for making that decision.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0190, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0195 How do I request an agency hearing? In order to request an agency hearing you must:

(1) Notify the office of administrative hearings within twenty-eight days from the date of the letter that notified you of our decision;

(2) Include in your letter a statement of your reasons why you disagree with our decision; and

(3) Attach a copy of our letter to your request for an agency hearing.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0195, filed 3/16/01, effective 4/16/01.]

Chapter 388-70 WAC

CHILD WELFARE SERVICES—FOSTER CARE—ADOPTION SERVICES—SERVICES TO UNMARRIED PARENTS

WAC

388-70-010	Repealed.
388-70-012	Repealed.
388-70-013	Repealed.
388-70-022	Repealed.
388-70-024	Repealed.
388-70-031	Repealed.
388-70-032	Repealed.
388-70-033	Repealed.
388-70-034	Repealed.
388-70-035	Repealed.
388-70-036	Repealed.
388-70-037	Repealed.
388-70-041	Repealed.
388-70-042	Repealed.
388-70-044	Repealed.
388-70-048	Repealed.
388-70-051	Repealed.
388-70-054	Repealed.
388-70-058	Repealed.
388-70-062	Repealed.
388-70-066	Repealed.
388-70-068	Repealed.
388-70-069	Repealed.
388-70-075	Repealed.
388-70-078	Repealed.
388-70-080	Repealed.
388-70-082	Repealed.
388-70-084	Repealed.
388-70-170	Repealed.
388-70-410	Repealed.
388-70-420	Repealed.
388-70-430	Repealed.
388-70-440	Repealed.
388-70-460	Repealed.
388-70-470	Repealed.
388-70-480	Repealed.
388-70-510	Repealed.
388-70-520	Repealed.
388-70-530	Repealed.
388-70-540	Repealed.
388-70-550	Repealed.
388-70-560	Repealed.
388-70-570	Repealed.
388-70-580	Repealed.
388-70-590	Repealed.

388-70-595 Repealed.
388-70-700 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-70-010 Foster care—Legal basis. [Statutory Authority: 1982 c 118. 82-23-006 (Order 1901), § 388-70-010, filed 11/4/82. Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-010, filed 9/1/78; Order 965, § 388-70-010, filed 8/29/74; Order 913, § 388-70-010, filed 3/1/74; Order 623, § 388-70-010, filed 10/27/71; Regulation 70.010, filed 3/22/60.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-012 Foster care—Definitions. [Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-012, filed 9/1/78; Order 1123, § 388-70-012, filed 6/7/76; Order 913, § 388-70-012, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-013 Authorization for foster care placement. [Statutory Authority: RCW 74.08.090. 88-17-059 (Order 2669), § 388-70-013, filed 8/17/88; 86-04-030 (Order 2337), § 388-70-013, filed 1/29/86. Statutory Authority: RCW 74.12.340. 82-16-064 (Order 1849), § 388-70-013, filed 7/30/82. Statutory Authority: RCW 74.08.090. 82-06-001 (Order 1764), § 388-70-013, filed 2/18/82. Statutory Authority: RCW 74.13.109 and 74.08.090. 81-18-031 (Order 1686), § 388-70-013, filed 8/27/81. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-70-013, filed 9/10/79. Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-013, filed 9/1/78; Order 1186, § 388-70-013, filed 2/3/77; Order 1123, § 388-70-013, filed 6/7/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-022 Payment of foster care. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-70-022, filed 9/10/79. Statutory Authority: RCW 74.08.090. 79-04-062 (Order 1384), § 388-70-022, filed 3/28/79; 78-09-098 (Order 1335), § 388-70-022, filed 9/1/78; Order 1260, § 388-70-022, filed 12/29/77, effective 2/1/78; Order 1123, § 388-70-022, filed 6/7/76; Order 913, § 388-70-022, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-024 Payment of foster care—Effective date. [Statutory Authority: RCW 74.12.340. 82-16-064 (Order 1849), § 388-70-024, filed 7/30/82. Statutory Authority: RCW 74.08.090. 82-04-070 (Order 1753), § 388-70-024, filed 2/3/82; 78-09-098 (Order 1335), § 388-70-024, filed 9/1/78; Order 1123, § 388-70-024, filed 6/7/76; Order 1040, § 388-70-024, filed 8/7/75; Order 1020, § 388-70-024, filed 4/29/75; Order 913, § 388-70-024, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-031 Foster parent liability fund. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-031, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-032 Period of coverage. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-032, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-033 Persons eligible for coverage. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-033, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-034 Limits of coverage. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-034, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-035 Exclusions. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-035, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-036 Subrogation. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-036, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-037 Investigation of claims. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-037, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-041 Payment standards—Foster family care. [Order 913, § 388-70-041, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-042 Payment standards—Regular foster family care. [Statutory Authority: RCW 74.08.090. 86-04-030 (Order 2337), § 388-70-042, filed 1/29/86; 85-13-062 (Order 2242), § 388-70-042, filed 6/18/85; 81-09-042 (Order 1634), § 388-70-042, filed 4/15/81; 79-11-085 (Order 1445), § 388-70-042, filed 10/24/79; Order 1260, § 388-70-042, filed 12/29/77, effective 2/1/78; Order 1149, § 388-70-042, filed 8/26/76; Order 1052, § 388-70-042, filed 9/10/75; Order 963, § 388-70-042, filed 8/19/74; Order 913, § 388-70-042, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-044 Payment standards—Receiving home care—Standards for using. [Statutory Authority: RCW 74.08.090. 86-04-030 (Order 2337), § 388-70-044, filed 1/29/86; 85-13-062 (Order 2242), § 388-70-044, filed 6/18/85; 81-09-042 (Order 1634), § 388-70-044, filed 4/15/81; 79-11-085 (Order 1445), § 388-70-044, filed 10/24/79; 78-09-098 (Order 1335), § 388-70-044, filed 9/1/78; Order 1260, § 388-70-044, filed 12/29/77, effective 2/1/78; Order 1208, § 388-70-044, filed 4/29/77; Order 1149, § 388-70-044, filed 8/26/76; Order 1052, § 388-70-044, filed 9/10/75; Order 965, § 388-70-044, filed 8/29/74; Order 963, § 388-70-044, filed 8/19/74; Order 913, § 388-70-044, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-048 Payment standards—Specialized rate foster family care—Child with special needs. [Statutory Authority: RCW 74.08.090. 86-04-030 (Order 2337), § 388-70-048, filed 1/29/86; 85-13-062 (Order 2242), § 388-70-048, filed 6/18/85; 81-09-042 (Order 1634), § 388-70-048, filed 4/15/81; 79-11-085 (Order 1445), § 388-70-048, filed 10/24/79; 78-09-098 (Order 1335), § 388-70-048, filed 9/1/78; Order 1149, § 388-70-048, filed 8/26/76; Order 1052, § 388-70-048, filed 9/10/75; Order 963, § 388-70-048, filed 8/19/74; Order 913, § 388-70-048, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-051 Education related foster care. [Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-051, filed 9/1/78; Order 924, § 388-70-051, filed 4/15/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-054 Temporary absence of child from foster care. [Statutory Authority: RCW 74.08.090. 85-13-062 (Order 2242), § 388-70-054, filed 6/18/85; 79-11-105 (Order 1449), § 388-70-054, filed 10/31/79; Order 1123, § 388-70-054, filed 6/7/76; Order 965, § 388-70-054, filed 8/29/74; Order 913, § 388-70-054, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-058 Reimbursement for damage or loss caused by child in foster family care. [Statutory Authority: RCW 74.08.090. 85-13-062 (Order 2242), § 388-70-058, filed 6/18/85; 80-04-055 (Order 1495), § 388-70-058, filed 3/21/80.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-062 Payment for foster care to family receiving public assistance. [Order 913, § 388-70-062, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-066 Foster care out-of-state—Authorization—Payment. [Statutory Authority: RCW 74.08.090. 85-13-062 (Order 2242), § 388-70-066, filed 6/18/85; 78-09-098 (Order 1335), § 388-70-066, filed 9/1/78; Order 913, § 388-70-066, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-068 Earnings of foster child. [Statutory Authority: RCW 74.08.090. 83-04-061 (Order 1943), § 388-70-068, filed

2/2/83; Order 913, § 388-70-068, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-069 Resources and unearned income of foster child. [Statutory Authority: RCW 74.08.090. 83-04-061 (Order 1943), § 388-70-069, filed 2/2/83; Order 1123, § 388-70-069, filed 6/7/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-075 Parents' obligation to support child in foster care. [Order 1123, § 388-70-075, filed 6/7/76; Order 918, § 388-70-075, filed 3/14/74; Order 623, § 388-70-075, filed 10/27/71.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-078 Standards for parental participation in cost of foster care—Minimum scale recommended to court. [Order 1123, § 388-70-078, filed 6/7/76; Order 918, § 388-70-078, filed 3/14/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-080 Referral of child in foster care to department's office of support enforcement. [Statutory Authority: RCW 74.08.090. 83-17-003 (Order 1992), § 388-70-080, filed 8/5/83; Order 1123, § 388-70-080, filed 6/7/76; Order 1048, § 388-70-080, filed 8/29/75; Order 1016, § 388-70-080, filed 4/1/75; Order 918, § 388-70-080, filed 3/14/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-082 Parents' foster care payments to be remitted to department. [Order 1123, § 388-70-082, filed 6/7/76; Order 918, § 388-70-082, filed 3/14/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-084 Assignment of child support judgment and limited power of attorney. [Order 1123, § 388-70-084, filed 6/7/76; Order 918, § 388-70-084, filed 3/14/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-170 Veterans' benefits. [Order 913, § 388-70-170, filed 3/1/74; Regulation 70.170, filed 3/22/60.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-410 Adoption services for children—Legal basis—Purpose. [Order 1167, § 388-70-410, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-420 Definitions. [Order 1167, § 388-70-420, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-430 Eligibility for adoption service. [Order 1167, § 388-70-430, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-440 Adoption services for children. [Order 1167, § 388-70-440, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-460 Adoption services for families. [Order 1167, § 388-70-460, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-470 Interstate procedures. [Order 1167, § 388-70-470, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-480 Record confidentiality. [Order 1167, § 388-70-480, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-510 Adoption support for children—Legal basis—Purpose. [Statutory Authority: RCW 43.20A.550. 82-02-023 (Order 1744), § 388-70-510, filed 12/30/81; Order 1037, § 388-70-510, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-520 Adoption support for children—Definitions. [Statutory Authority: RCW 43.20A.550. 93-07-030 (Order 3524), § 388-70-520, filed 3/10/93, effective 4/10/93. Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-520, filed 11/20/90, effective 12/21/90; Order 1037, § 388-70-520, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-530 Adoption support for children—Eligible child. [Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-530, filed 11/20/90, effective 12/21/90. Statutory Authority: RCW 43.20A.550. 82-02-023 (Order 1744), § 388-70-530, filed 12/30/81; Order 1037, § 388-70-530, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-540 Adoption support for children—Application. [Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-540, filed 11/20/90, effective 12/21/90; Order 1037, § 388-70-540, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-550 Adoption support for children—Types and amounts of payments. [Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-550, filed 11/20/90, effective 12/21/90. Statutory Authority: RCW 43.20A.550. 82-02-023 (Order 1744), § 388-70-550, filed 12/30/81. Statutory Authority: RCW 74.13.109. 80-08-028 (Order 1516), § 388-70-550, filed 6/25/80; Order 1037, § 388-70-550, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-560 Adoption support for children—Criteria governing amount of payment. [Order 1037, § 388-70-560, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-570 Adoption support for children—Agreement for adoption support. [Statutory Authority: RCW 43.20A.550. 82-02-023 (Order 1744), § 388-70-570, filed 12/30/81; Order 1037, § 388-70-570, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-580 Adoption support for children—Review of support payment. [Order 1037, § 388-70-580, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-590 Adoption support for children—Appeal from secretary's decision—Hearing. [Statutory Authority: RCW 34.05.220 (1)(a) and 74.13.109. 90-04-072 (Order 2995), § 388-70-590, filed 2/5/90, effective 3/1/90; Order 1037, § 388-70-590, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-595 Reimbursement for nonrecurring adoption finalization costs. [Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-595, filed 11/20/90, effective 12/21/90.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

388-70-700 Juvenile records. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-70-700, filed 9/10/79. Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-700, filed 9/1/78.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

WAC 388-70-010 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-012 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-013 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-022 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-024 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-031 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-032 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-033 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-034 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-035 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-036 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-037 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-041 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-042 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-044 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-048 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-051 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-054 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-058 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-062 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-066 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-068 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-069 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-075 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-078 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-080 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-082 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-084 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-170 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-410 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-420 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-430 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-440 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-460 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-470 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-480 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-510 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-520 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-530 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-540 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-550 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-560 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-570 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-580 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-590 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-595 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-70-700 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-71 WAC
SOCIAL SERVICES FOR ADULTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-71-0545 Under what conditions will the department/AAA deny payment to or terminate the contract of an individual provider, or deny payment to a home care agency provider? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0545, filed 1/13/00, effective 2/13/00.] Repealed by 01-11-019, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095.

388-71-0550 Are there other conditions under which the department/AAA may deny payment, or deny or terminate a contract to an individual provider? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0550, filed 1/13/00, effective 2/13/00.] Repealed by 01-11-019, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095.

388-71-0555 When can the department/AAA summarily suspend an individual provider's contract? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0555, filed 1/13/00, effective 2/13/00.] Repealed by 01-11-019, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095.

WAC 388-71-0500 What is the purpose of WAC 388-71-0500 through 388-71-0580? A client/legal representative may choose an individual provider or a home care agency provider. The intent of WAC 388-71-0500 through 388-71-0580 is to describe the:

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

(2) Qualifications of a home care agency provider, as defined in WAC 388-15-202(2) and chapter 246-336 WAC;

(3) Conditions under which the department or the area agency on aging (AAA) will pay for the services of an individual provider or a home care agency provider.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0500, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0500, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0505 How does a client hire an individual provider? The client, or legal representative:

(1) Has the primary responsibility for locating, screening, hiring, supervising, and terminating an individual provider;

(2) Establishes an employer/employee relationship with the provider; and

(3) May receive assistance from the social worker/case manager or other resources in this process.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0505, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0505, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0510 How does a person become an individual provider? In order to become an individual provider, a person must:

(1) Be eighteen years of age or older;

(2) Provide the social worker/case manager/designee with:

(a) Picture identification; and

(b) A Social Security card; or

(c) Authorization to work in the United States.

(3) Complete and submit to the social worker/case manager/designee the department's criminal conviction back-

ground inquiry application, unless the provider is also the parent of the adult DDD client and exempted, per chapter 74.15 RCW;

(a) Preliminary results may require a thumb print for identification purposes;

(b) An FBI fingerprint-based background check is required if the person has lived in the state of Washington less than three years.

(4) Sign a home and community-based service provider contract/agreement to provide services to a COPES or Medicaid personal care client.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0510, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0510, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0513 Is a background check required of a home care agency provider? In order to be a home care agency provider, a person must complete the department's criminal conviction background inquiry application, which is submitted by the agency to the department. This includes an FBI fingerprint-based background check if the home care agency provider has lived in the state of Washington less than three years.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0513, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0515 What are the responsibilities of an individual provider or home care agency provider when employed to provide care to a client? An individual provider or home care agency provider must:

(1) Understand the client's service plan that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;

(2) Provide the services as outlined on the client's service plan, within the scope of practice in WAC 388-15-202(38) and 388-15-203;

(3) Accommodate client's individual preferences and differences in providing care, within the scope of the service plan;

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

(5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;

(6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;

(7) Notify the case manager immediately if the client dies;

(8) Notify the department or AAA immediately when unable to staff/serve the client; and

(9) Notify the department/AAA when the individual provider or home care agency will no longer provide services. Notification to the client/legal guardian must:

(a) Give at least two weeks' notice, and

(b) Be in writing.

(10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and

(11) Comply with all applicable laws and regulations.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0515, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0515, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0540 When will the department or AAA deny payment for services of an individual provider or home care agency provider? The department or AAA will deny payment for the services of an individual provider or home care agency provider who:

(1) Is the client's spouse, per 42 C.F.R 441.360(g), except in the case of an individual provider for a Chore services client. Note: For Chore spousal providers, the department pays a rate not to exceed the amount of a one-person standard for a continuing general assistance grant, per WAC 388-478-0030;

(2) Is the natural/step/adoptive parent of a minor client aged seventeen or younger receiving services under this chapter;

(3) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830;

(4) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW;

(5) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations;

(6) Does not successfully complete the training requirements within the time limits required in WAC 388-71-0520;

(7) Is already meeting the client's needs on an informal basis, and the client's assessment or reassessment does not identify any unmet need; and/or

(8) Is terminated by the client (in the case of an individual provider) or by the home care agency (in the case of an agency provider).

(9) In addition, the department or AAA may deny payment to or terminate the contract of an individual provider as provided under WAC 388-71-0546, 388-71-0551, and 388-71-0556.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0540, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0540, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0545 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-71-0546 When can the department or AAA reject the client's choice of an individual provider? The department or AAA may reject a client's request to have a family member or other person serve as his or her individual provider if the case manager has a reasonable, good faith belief that the person will be unable to appropriately meet the

client's needs. Examples of circumstances indicating an inability to meet the client's needs could include, without limitation:

(1) Evidence of alcohol or drug abuse;

(2) A reported history of domestic violence, no-contact orders, or criminal conduct (whether or not the conduct is disqualifying under RCW 43.43.830 and 43.43.842;

(3) A report from the client's health care provider or other knowledgeable person that the requested provider lacks the ability or willingness to provide adequate care;

(4) Other employment or responsibilities that prevent or interfere with the provision of required services;

(5) Excessive commuting distance that would make it impractical to provide services as they are needed and outlined in the client's service plan.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0546, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0550 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-71-0551 When can the department or AAA terminate or summarily suspend an individual provider's contract? The department or AAA may take action to terminate an individual provider's contract if the provider's inadequate performance or inability to deliver quality care is jeopardizing the client's health, safety, or well-being. The department or AAA may summarily suspend the contract pending a hearing based on a reasonable, good faith belief that the client's health, safety, or well-being is in imminent jeopardy. Examples of circumstances indicating jeopardy to the client could include, without limitation:

(1) Domestic violence or abuse, neglect, abandonment, or exploitation of a minor or vulnerable adult;

(2) Using or being under the influence of alcohol or illegal drugs during working hours;

(3) Other behavior directed toward the client or other persons involved in the client's life that places the client at risk of harm;

(4) A report from the client's health care provider that the client's health is negatively affected by inadequate care;

(5) A complaint from the client or client's representative that the client is not receiving adequate care;

(6) The absence of essential interventions identified in the service plan, such as medications or medical supplies; and/or

(7) Failure to respond appropriately to emergencies.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0551, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0555 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-71-0556 When can the department or AAA otherwise terminate an individual provider's contract? The department or AAA may otherwise terminate the individual provider's contract for default or convenience in accordance with the terms of the contract and to the extent that those terms are not inconsistent with these rules.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0556, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0560 What are the client's rights if the department denies, terminates, or summarily suspends an individual provider's contract? If the department denies, terminates, or summarily suspends the individual provider's contract, the client has the right to:

(1) A fair hearing to appeal the decision, per chapter 388-02 WAC, and

(2) Receive services from another currently contracted individual provider or home care agency provider, or other options the client is eligible for, if a contract is summarily suspended.

(3) The hearing rights afforded under this section are those of the client, not the individual provider.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0560, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0560, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0580 Self-directed care—Who must direct self-directed care? Self-directed care under chapter 74.39 RCW must be directed by an adult client for whom the health-related tasks are provided. The adult client is responsible to train the individual provider in the health-related tasks which the client self-directs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0580, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0580, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0605 Am I eligible for residential services? (1) If you apply for services, you may be eligible to have the department pay for your services through one of the programs listed below. The department assesses and determines your functional and financial eligibility for residential services under one of the following long-term care programs:

(a) Community options program entry system (COPES), described in WAC 388-71-0435; or

(b) Medicaid personal care funding (MPC), described in WAC 388-71-0440.

(2) If you are not eligible for services under one of the programs listed above, you may receive state-only funding for residential services if you meet eligibility requirements for general assistance unemployable, described in WAC 388-235-5000.

(3) If you are on:

(a) MPC, you can receive services in adult family homes and adult residential care facilities.

Note: If you are under eighteen, you may receive MPC services in a children's foster family home or a children's group care facility.

(b) COPES, you can receive services in adult family homes, enhanced adult residential care facilities, and assisted living facilities.

(c) GAU, you can receive state-funded services in adult family homes and adult residential care facilities.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, and 74.08.090. 01-14-055, § 388-71-0605, filed 6/29/01, effective 7/30/01. Statutory Authority: RCW 74.08.44 [74.08.044]. 00-04-056, § 388-71-0605, filed 1/28/00, effective 2/28/00.]

WAC 388-71-0613 For what days will the department pay the residential care facility? The department pays the residential care facility from the first day of service through the:

(1) Last day of service when the Medicaid resident dies in the facility; or

(2) Day of service before the day the Medicaid resident is discharged.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, and 74.08.090. 01-14-055, § 388-71-0613, filed 6/29/01, effective 7/30/01.]

WAC 388-71-0900 What is the intent of WAC 388-71-0900 through 388-71-0960? The intent of WAC 388-71-0900 through WAC 388-71-0960 is to:

(1) Describe the eligibility requirements under which an adult age eighteen and older may receive private duty nursing (PDN) services through aging and adult services;

(2) Assist clients and families to support clients in their own homes; and

(3) Describe the requirements applicants/clients families, home health agencies, and privately contracted registered nurses (RNs) and licensed practical nurses (LPNs) must meet in order for services to be authorized for PDN.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0900, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0905 What is private duty nursing (PDN) for adults? Private duty nursing (PDN):

(1) Is an optional community-based Medicaid service for adults eighteen or older with complex medical needs who require at least four continuous hours of skilled nursing care on a day to day basis;

(2) Provides an alternative to institutionalization in a hospital or nursing facility; and

(3) Is a resource of last resort and is not intended to supplant or replace other means of providing the services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0905, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0910 Am I financially eligible for Medicaid-funded private duty nursing services? In order to be financially eligible for Medicaid-funded PDN, you must:

(1) Meet Medicaid requirements under the:

(a) Categorically needy program; or

(b) Medically needy program.

(2) Use private insurance as first payer, per Medicaid rules. Private insurance benefits which cover hospitalization and in-home services must be ruled out as the first payment source to PDN.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0910, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0915 Am I medically eligible to receive private duty nursing services? In order to be medically eligible for PDN, the community nurse consultant (CNC) must assess you and determine that you:

(1) Be assessed by a CNC as requiring care in a hospital or meeting nursing facility level of care, as defined in WAC 388-71-0435(4).

(2) Have a complex medical need that requires four or more hours of continuous skilled nursing care which can be safely provided outside a hospital or nursing facility; and

(3) Are technology-dependent daily, which means you require at least one of the following:

(a) A mechanical ventilator or other respiratory support at least part of each day;

(b) Tracheostomy tube care/suctioning;

(c) Intravenous/parenteral administration of medications; and

(d) Intravenous administration of nutritional substances.

(4) Require services that are medically necessary.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0915, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0920 How is my eligibility determined? In order to be eligible for Medicaid-funded PDN services:

(1) A CNC must use the comprehensive assessment (CA) to assess:

(a) Unmet skilled care needs;

(b) Informal supports; and

(c) Other services paid for by the department.

(2) Your primary care physician must:

(a) Document your medical stability and appropriateness for PDN;

(b) Provide orders for medical services; and

(c) Document approval of the service provider's plan of care.

(3) You must also:

(a) Be able to supervise your care (provider) or your guardian must be available on the premises; and

(b) Have family or other appropriate support who is responsible for assuming a portion of your care.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0920, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0925 Am I required to pay participation toward PDN services? (1) Except as provided in subsection (2) of this section, you are not required to pay any participation toward PDN services.

(2) You may be required to pay participation if you are receiving home and community program services, as described in WAC 388-71-0405 and 388-71-0470.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0925, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0930 Are PDN costs subject to estate recovery? If you are receiving PDN services, the cost of services is subject to estate recovery when you reach the age of fifty-five, per chapter 388-527 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0930, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0935 Who can provide my PDN services? In addition to a family member(s) or a personal aide providing self-directed care under RCW 74.39.050:

(1) A Washington state licensed and contracted home health provider can provide your PDN services.

(2) With an approved exception to policy (ETP), a private (nonhome health agency) registered nurse (RN) or licensed practical nurse (LPN) under the direction of the physician can provide your PDN services only when:

(a) The geographic location precludes a contracted home health agency from providing services to you; or

(b) No contracted home health agency is willing to provide PDN services to you.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0935, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0940 Are there limitations or other requirements for PDN? The limits to PDN services are:

(1) Your PDN cannot exceed sixteen hours a day. The hours are determined through a CA completed by a CNC;

(2) Trained family must provide for any hours above your assessment determination, or you or your family must pay for these additional hours;

(3) In instances where your family is temporarily absent due to vacations, PDN must be:

(a) Paid for by you or your family; or

(b) Provided by other trained family. If this is not possible, you may need placement in a long-term care setting during their absence.

(4) You may use respite care if you and your unpaid family caregiver meet the eligibility criteria defined in WAC 388-71-1075.

(5) You may receive additional hours, up to thirty days only when:

(a) Your family is being trained in care and procedures;

(b) You have an acute episode that would otherwise require hospitalization;

(c) Your caregiver is ill or temporarily unable to provide care; or

(d) There is a family emergency.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0940, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0945 What requirements must a home health agency meet in order to provide and get paid for my PDN? A home health agency must:

(1) Be licensed and contracted by Washington state. A license is obtained through the department of health. A contract is obtained through aging and adult services administration;

(2) Have physician orders;

(3) Have a detailed service plan, including time sheets, that is reviewed at least every six months by the physician and CNC case manager;

(4) Submit timely and accurate invoices to the social services payment system (SSPS).

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0945, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0950 What requirements must a private RN or LPN meet in order to provide and get paid for my PDN services? In order to be paid by the department, a private RN or LPN must:

(1) Have a license in good standing;

(2) Complete a contract;

(3) Provide services according to the service plan under the supervision/direction of a physician;

(4) Complete a background inquiry application. This will require fingerprinting if the RN or LPN has lived in the state of Washington less than three years;

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

(6) Have no stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority, a court of law, or entered into a state registry with a finding of guilt for abuse, neglect, abandonment or exploitation;

(7) Complete time sheets monthly;

(8) Document notes regarding your services provided per the service plan, which are reviewed at least every six months by the CNC case manager; and

(9) Submit timely and accurate invoices to SSPS.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0950, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0955 Can I receive PDN in a licensed adult family home (AFH)? You may be eligible to receive PDN in a licensed adult family home (AFH). In order for you to receive these services, the AFH provider must:

(1) Have an approved exception to policy;

(2) Possess a WA state registered nurse license;

(3) Sign a contract amendment stating they will ensure twenty-four-hour personal care and nursing care services pursuant to the Nurse Practice Act;

(4) Provide the PDN services to you. Your service plan cannot exceed a maximum of eight PDN care hours per day;

(5) Have a nursing service plan prescribed by your primary physician that allows you to reside in an AFH. The physician is responsible for:

(a) Overseeing your plan of care;

(b) Monitoring your medical stability; and

(c) Supervising the safety of the AFH's nursing care services.

(6) Keep records and have your service plan reviewed at least every six months.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0955, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0960 Can I receive services in addition to PDN? In addition to PDN services, you may be eligible to receive personal care and other household services through COPES or Medicaid personal care (MPC), from a contracted home care agency or contracted individual provider (IP), for unmet personal care needs not performed by your family/informal support system.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0960, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0965 Can I choose to self-direct my care if I receive PDN? You may choose to self-direct your care, as outlined in RCW 74.39.050.

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0965, filed 5/4/01, effective 6/4/01.]

Chapter 388-73 WAC
CHILD CARE AGENCIES—MINIMUM LICENSING/ CERTIFICATION REQUIREMENTS

WAC

388-73-010 through 388-73-904 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-73-010 Authority. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-010, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-010, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-012 Definitions. [Statutory Authority: RCW 74.15.030 and 74.08.090. 99-01-059, § 388-73-012, filed 12/11/98, effective 1/11/99. Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-012, filed 4/24/96, effective 5/25/96. Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-012, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-012, filed 12/2/86; 84-06-030 (Order 2081), § 388-73-012, filed 2/29/84. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-012, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-012, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-014 Persons and organizations subject to licensing. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-014, filed 4/24/96, effective 5/25/96. Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-014, filed 11/8/95, effective 12/9/95. Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-014, filed 3/26/92, effective 4/26/92; 89-11-005 (Order 2796), § 388-73-014, filed 5/4/89; 86-24-059 (Order 2445), § 388-73-014, filed 12/2/86; 84-06-030 (Order 2081), § 388-73-014, filed 2/29/84; 83-02-060 (Order 1933), § 388-73-014, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-014, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-014, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-016 Exceptions to rules. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-016, filed 3/26/92, effective 4/26/92; 89-11-005 (Order 2796), § 388-73-016, filed 5/4/89; 78-10-006 (Order 1336), § 388-73-016, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-018 Persons and organizations not subject to licensing. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-018, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-018, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-019 Effect of local ordinances. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-019, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-01950 Fire standards. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-01950, filed 4/24/96, effective 5/25/96. Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-01950, filed 7/9/92, effective 8/9/92; 83-02-060 (Order 1933), § 388-73-01950, filed 1/5/83.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-020 Certification of juvenile detention facility and exempt agency. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-020, filed 4/24/96, effective 5/25/96. Statutory Authority: RCW 74.15.030. 83-02-060 (Order 1933), § 388-73-020, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-020, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-020, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-022 Application or reapplication for license or certification—Investigation. [Statutory Authority: RCW 74.15.030. 90-20-076 (Order 3069), § 388-73-022, filed 9/28/90, effective 10/29/90; 86-24-059 (Order 2445), § 388-73-022, filed 12/2/86. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-022, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-022, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-024 Licenses for homes supervised by licensed agency. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-024, filed 3/26/92, effective 4/26/92; 83-02-060 (Order 1933), § 388-73-024, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-024, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-024, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-026 Licensing of employees. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-026, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-026, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-028 Limitations on licenses and dual licensure. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-028, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-028, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-030 General qualifications of licensee, adoptive applicant, and persons on the premises. [Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-73-030, filed 4/26/96, effective 5/27/96; 92-08-056, § 388-73-030, filed 3/26/92, effective 4/26/92; 90-20-076 (Order 3069), § 388-73-030, filed 9/28/90, effective 10/29/90; 78-10-006 (Order 1336), § 388-73-030, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-032 Age of licensee. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-032, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-034 Posting of license. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-034, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-034, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-036 Licensure—Denial, suspension, or revocation. [Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-73-036, filed 4/26/96, effective 5/27/96; 92-08-056, § 388-73-036, filed 3/26/92, effective 4/26/92; 90-20-076 (Order 3069), § 388-73-036, filed 9/28/90, effective 10/29/90. Statutory Authority: RCW 34.05.220 (1)(a) and 74.15.030. 90-04-072 (Order 2995), § 388-73-036, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.15.030. 89-11-005 (Order 2796), § 388-73-036, filed 5/4/89; 86-24-059 (Order 2445), § 388-73-036, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-036, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-038 Licensed capacity. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-038, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-

038, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-040 Discrimination prohibited. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-040, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-042 Religious activities. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-042, filed 3/26/92, effective 4/26/92; 83-02-060 (Order 1933), § 388-73-042, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-042, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-044 Special requirements regarding American Indians. [Statutory Authority: RCW 74.15.030. 89-05-063 (Order 2743), § 388-73-044, filed 2/15/89; 81-20-011 (Order 1703), § 388-73-044, filed 9/25/81; 78-10-006 (Order 1336), § 388-73-044, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-046 Discipline. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-046, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-048 Corporal punishment. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-048, filed 4/24/96, effective 5/25/96. Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-048, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-048, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-050 Abuse, neglect, exploitation. [Statutory Authority: RCW 74.15.030. 83-02-060 (Order 1933), § 388-73-050, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-050, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-052 Interstate placement of children. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-052, filed 3/26/92, effective 4/26/92. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-052, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-052, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-054 Client records and information—All agencies. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-054, filed 4/24/96, effective 5/25/96. Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-054, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-054, filed 12/2/86; 84-06-030 (Order 2081), § 388-73-054, filed 2/29/84. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-054, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-054, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-056 Reporting of illness, death, injury, epidemic, child abuse, or unauthorized absence—All facilities. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-056, filed 3/26/92, effective 4/26/92; 89-11-005 (Order 2796), § 388-73-056, filed 5/4/89; 86-24-059 (Order 2445), § 388-73-056, filed 12/2/86. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-056, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-056, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-057 Reporting of circumstantial changes. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-057, filed 3/26/92, effective 4/26/92; 85-13-064 (Order 2244), § 388-73-057, filed 6/18/85; 78-10-006 (Order 1336), § 388-73-057, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-058 Earnings, allowances, personal belongings. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-058, filed 11/8/95, effective 12/9/95. Statutory Authority: RCW 74.15.030. 84-06-030 (Order 2081), § 388-73-058, filed 2/29/84; 83-02-060 (Order 1933), § 388-73-058, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-058, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-058, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-060 Work assignments. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-060, filed 7/9/92, effective 8/9/92; 92-08-056, § 388-73-060, filed 3/26/92, effective 4/26/92; 83-02-060 (Order 1933), § 388-73-060, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-060, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-062 Transportation. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-062, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-062, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-062, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-062, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-064 Clothing. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-064, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-064, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-066 Personal hygiene. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-066, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-068 Personnel policies. [Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-068, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-068, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-068, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-069 Consumption of alcoholic beverages. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-069, filed 7/9/92, effective 8/9/92; 86-24-059 (Order 2445), § 388-73-069, filed 12/2/86.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-070 Training. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-070, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-070, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-070, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-072 Education and vocational instruction. [Statutory Authority: RCW 74.15.030. 84-06-030 (Order 2081), § 388-73-072, filed 2/29/84. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-072, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-072, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-074 Social service staff. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-074, filed 11/8/95, effective 12/9/95. Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-074, filed 12/2/86. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-074, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-074, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-076 Social study—Treatment plans. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-076, filed 11/8/95, effective 12/9/95. Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-076, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-076, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-076, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-076, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-077 Multidisciplinary care plan for severely and multiply-handicapped children. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-077, filed 3/26/92, effective 4/26/92; 84-06-030 (Order 2081), § 388-73-077, filed 2/29/84.] Repealed by 01-18-037, filed

8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-078 Clerical, accounting and administrative services. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-078, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-078, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-080 Support and maintenance staff. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-080, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-080, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-100 Site and telephone. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-100, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-100, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-101 Wheeled baby walkers. [Statutory Authority: RCW 74.15.030 and 74.08.090. 99-01-059, § 388-73-101, filed 12/11/98, effective 1/11/99.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-102 Equipment, safety, and maintenance. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-102, filed 7/9/92, effective 8/9/92; 92-08-056, § 388-73-102, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-102, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-102, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-102, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-103 Water safety. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-103, filed 3/26/92, effective 4/26/92; 83-02-060 (Order 1933), § 388-73-103, filed 1/5/83.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-104 Firearms. [Statutory Authority: RCW 74.15.030 and 74.08.090. 99-01-059, § 388-73-104, filed 12/11/98, effective 1/11/99. Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-104, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-104, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-106 Storage. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-106, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-106, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-106, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-108 Bedrooms. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-108, filed 7/9/92, effective 8/9/92; 92-08-056, § 388-73-108, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-108, filed 12/2/86; 84-06-030 (Order 2081), § 388-73-108, filed 2/29/84; 83-02-060 (Order 1933), § 388-73-108, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-108, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-108, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-110 Special care room. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-110, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-110, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-112 Kitchen facilities. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-112, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-112, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-112, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-114 Housekeeping sink. [Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-114, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-114, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-116 Laundry. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-116, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-116, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-116, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-118 Toilets, handwashing sinks, and bathing facilities. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-118, filed 7/9/92, effective 8/9/92; 92-08-056, § 388-73-118, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-118, filed 12/2/86; 84-06-030 (Order 2081), § 388-73-118, filed 2/29/84; 83-02-060 (Order 1933), § 388-73-118, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-118, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-120 Lighting. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-120, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-120, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-120, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-122 Pest control. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-122, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-124 Sewage and liquid wastes. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-124, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-126 Water supply. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-126, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-126, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-128 Temperature. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-128, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-128, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-130 Ventilation. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-130, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-130, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-132 Health care plan. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-132, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-132, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-132, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-132, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-134 First aid. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-134, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-134, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-134, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-134, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-134, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-136 Medications controlled by licensee. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-136, filed 3/26/92, effective 4/26/92; 89-07-097 (Order 2778), § 388-73-136, filed 3/22/89; 86-24-059 (Order 2445), § 388-73-136, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-136, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-136, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-138 Self-administration of medications. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-138, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-138, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-138, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-140 Health history, physical examinations, immunizations. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-140, filed 3/26/92, effective 4/26/92; 85-18-063 (Order 2277), § 388-73-140, filed 9/4/85; 84-06-030 (Order 2081), § 388-73-140, filed 2/29/84; 83-02-060

(Order 1933), § 388-73-140, filed 1/5/83; 80-13-019 (Order 1540), § 388-73-140, filed 9/9/80. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-140, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-140, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-142 Infection control, communicable disease. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-142, filed 3/26/92, effective 4/26/92; 89-11-005 (Order 2796), § 388-73-142, filed 5/4/89; 86-24-059 (Order 2445), § 388-73-142, filed 12/2/86; 84-06-030 (Order 2081), § 388-73-142, filed 2/29/84; 83-02-060 (Order 1933), § 388-73-142, filed 1/5/83; 80-13-019 (Order 1540), § 388-73-142, filed 9/9/80; 78-10-006 (Order 1336), § 388-73-142, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-143 HIV/AIDS education and training. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-143, filed 3/26/92, effective 4/26/92; 89-22-134 (Order 2897), § 388-73-143, filed 11/1/89, effective 12/2/89.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-144 Nutrition. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-144, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-144, filed 12/2/86; 84-06-030 (Order 2081), § 388-73-144, filed 2/29/84; 83-02-060 (Order 1933), § 388-73-144, filed 1/5/83; 80-13-019 (Order 1540), § 388-73-144, filed 9/9/80; 78-10-006 (Order 1336), § 388-73-144, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-146 Care of younger or severely and multiply-handicapped children. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-146, filed 11/8/95, effective 12/9/95. Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-146, filed 3/26/92, effective 4/26/92; 89-11-005 (Order 2796), § 388-73-146, filed 5/4/89; 86-24-059 (Order 2445), § 388-73-146, filed 12/2/86; 84-06-030 (Order 2081), § 388-73-146, filed 2/29/84; 83-02-060 (Order 1933), § 388-73-146, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-146, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-200 Child-placing agency. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-200, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-202 Required personnel. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-202, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-202, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-202, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-204 Office space. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-204, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-206 Out-of-country, out-of-state agencies. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-206, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-208 Medical care. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-208, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-208, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-208, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-210 Foster care licensees. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-210, filed 7/9/92, effective 8/9/92; 92-08-056, § 388-73-210, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-210, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-212 Foster care placements. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-212, filed 7/9/92, effective 8/9/92; 92-08-056, § 388-73-212, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-212, filed 12/2/86. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-212, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-212, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-213 Certification to provide adoption services. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-213, filed 3/26/92, effective 4/26/92.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-214 Adoption procedures. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-214, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-214, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-214, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-216 Adoptive placements. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-216, filed 7/9/92, effective 8/9/92; 92-08-056, § 388-73-216, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-216, filed 12/2/86. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-216, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-216, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-300 Foster family homes. [Statutory Authority: RCW 74.15.030. 86-24-059 (Order 2445), § 388-73-300, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-300, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-302 Orientation and training. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-302, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-302, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-304 Capacity. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-304, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-304, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-304, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-304, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-304, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-306 Foster parents—Employment. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-306, filed 3/26/92, effective 4/26/92. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-306, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-306, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-308 Absence from home. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-308, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-308, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-310 Fire safety. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-310, filed 3/26/92, effective 4/26/92; 89-11-005 (Order 2796), § 388-73-310, filed 5/4/89; 86-24-059 (Order 2445), § 388-73-310, filed 12/2/86; 83-02-060 (Order 1933), § 388-73-310, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-310, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-312 Family foster homes—Services to person under care. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-312, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-312, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-351 Staffed residential homes for children or expectant mothers. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-351, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-353 Agency affiliation. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-353, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-355 Function of staffed residential home for children or expectant mothers. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-355, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-357 Capacity. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-357, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-361 Required positions. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-361, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-363 Nursing services. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-363, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-365 Required rooms, areas, and equipment. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-365, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-367 Staffed residential homes for children or expectant mothers—Services to person under care. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-367, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-369 Fire safety—Staffed residential child care home for children or expectant mothers. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-369, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-371 Location of care. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-371, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-373 Occupancy separations. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-373, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-375 Exits. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-375, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-377 Windows. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-377, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-379 Sprinklers. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-379, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-381 Accessibility of exits. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-381, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-383 Single station smoke detectors. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-383, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-385 Fire extinguishers. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-385, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-387 Fire prevention. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-387, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-389 Sprinkler system maintenance. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-389, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-391 Fire evacuation plan. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-391, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-393 Fire evacuation drill. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-393, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-395 Staff fire safety training. [Statutory Authority: Chapter 74.15 RCW. 95-23-033 (Order 3918), § 388-73-395, filed 11/8/95, effective 12/9/95.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-500 Day treatment center. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-500, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-502 Function of day treatment program. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-502, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-504 Personnel. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-504, filed 3/26/92, effective 4/26/92; 83-02-060 (Order 1933), § 388-73-504, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-504, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-506 Ratio of counselor and teaching staff to children. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-506, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-506, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-508 Program. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-508, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-510 Ill children. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-510, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-512 Play areas. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-512, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-512, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-600 Group care facilities. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-600, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-602 Function of group care facility. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-602, filed 3/26/92, effective 4/26/92; 84-06-030 (Order 2081), § 388-73-602, filed 2/29/84; 78-10-006 (Order 1336), § 388-73-602, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-604 Daily activity program. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-604, filed 3/26/92, effective 4/26/92; 83-02-060 (Order 1933), § 388-73-604, filed 1/5/83. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-604, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-604, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-606 Required positions. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-606, filed 4/24/96, effective 5/25/96. Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-606, filed 3/26/92, effective 4/26/92; 84-06-030 (Order

2081), § 388-73-606, filed 2/29/84. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-606, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-606, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-610 Required rooms, areas, and equipment—Group care facilities. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-610, filed 3/26/92, effective 4/26/92; 84-06-030 (Order 2081), § 388-73-610, filed 2/29/84. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-610, filed 9/10/79. Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-610, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-700 Maternity services. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-700, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-702 Types of maternity services. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-702, filed 3/26/92, effective 4/26/92; 86-24-059 (Order 2445), § 388-73-702, filed 12/2/86; 78-10-006 (Order 1336), § 388-73-702, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-704 Daily activities program. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-704, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-704, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-706 Eligibility for service—Required services. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-706, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-706, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-708 Required personnel. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-708, filed 3/26/92, effective 4/26/92; 83-02-060 (Order 1933), § 388-73-708, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-708, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-710 Services provided. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-710, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-710, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-712 Health education. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-712, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-712, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-714 Family life education. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-714, filed 3/26/92, effective 4/26/92; 83-02-060 (Order 1933), § 388-73-714, filed 1/5/83; 78-10-006 (Order 1336), § 388-73-714, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-718 Child care. [Statutory Authority: RCW 74.15.030. 78-10-006 (Order 1336), § 388-73-718, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-720 Medical service. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-720, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-720, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-722 Required rooms, areas, equipment. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-722, filed 3/26/92, effective 4/26/92; 78-10-006 (Order 1336), § 388-73-722, filed 9/8/78.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-800 Crisis residential centers. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-800, filed 4/24/96, effective 5/25/96. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-800, filed 9/10/79.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-802 Limitations on number of facilities. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-802, filed 9/10/79.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-803 Crisis residential center—Admission. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-803, filed 4/24/96, effective 5/25/96.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-804 Hours of operation. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-804, filed 3/26/92, effective 4/26/92. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-804, filed 9/10/79.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-805 Crisis residential center administrator requirements—Multidisciplinary teams. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-805, filed 4/24/96, effective 5/25/96.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-810 Group crisis residential centers. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-810, filed 9/10/79.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-815 Group crisis residential centers—Staffing. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-815, filed 4/24/96, effective 5/25/96. Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-815, filed 3/26/92, effective 4/26/92.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-820 Family crisis residential centers. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-820, filed 3/26/92, effective 4/26/92. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-73-820, filed 9/10/79.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-821 Behavior management—Secure crisis residential centers. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-821, filed 4/24/96, effective 5/25/96.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-822 Secure crisis residential centers—Staff training. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-822, filed 4/24/96, effective 5/25/96.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-823 Secure crisis residential centers—Program requirements. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-823, filed 4/24/96, effective 5/25/96.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-825 Secure crisis residential center—Physical facility. [Statutory Authority: Chapter 74.15 RCW and RCW 74.13.032. 96-10-032 (Order 3969), § 388-73-825, filed 4/24/96, effective 5/25/96.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-900 Facilities for severely and multiply-handicapped children. [Statutory Authority: RCW 74.15.030. 84-06-030 (Order 2081), § 388-73-900, filed 2/29/84.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-901 Multidisciplinary care plan for severely and multiply-handicapped children. [Statutory Authority: RCW 74.15.030. 92-15-043 (Order 3418), § 388-73-901, filed 7/9/92, effective 8/9/92; 92-08-056, § 388-73-901, filed 3/26/92, effective 4/26/92.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-902 Services provided. [Statutory Authority: RCW 74.15.030. 92-08-056, § 388-73-902, filed 3/26/92, effective 4/26/92; 84-06-030 (Order 2081), § 388-73-902, filed 2/29/84.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

388-73-904 Therapy room. [Statutory Authority: RCW 74.15.030. 84-06-030 (Order 2081), § 388-73-904, filed 2/29/84.] Repealed by 01-18-037, filed 8/28/01, effective 9/28/01. Statutory Authority: RCW 74.15.030.

WAC 388-73-010 through 388-73-904 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-74 WAC
CHILD WELFARE SERVICES—COMPLAINTS

WAC

388-74-010 through 388-74-030 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-74-010 Child welfare services complaint resolution definitions. [Statutory Authority: RCW 74.13.045 and chapter 74.13 RCW. 93-12-053 (Order 3558), § 388-74-010, filed 5/26/93, effective 6/26/93.] Repealed by 01-06-041, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.13.045.

388-74-030 Complaint procedure. [Statutory Authority: RCW 74.13.045 and chapter 74.13 RCW. 93-12-053 (Order 3558), § 388-74-030, filed 5/26/93, effective 6/26/93.] Repealed by 01-06-041, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.13.045.

WAC 388-74-010 through 388-74-030 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-86 WAC
MEDICAL CARE—SERVICES PROVIDED

WAC

388-86-071 through 388-86-100 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-86-071 Private duty nursing services. [Statutory Authority: RCW 74.08.090. 93-18-002 (Order 3612), § 388-86-071, filed 8/18/93, effective 9/18/93; 91-23-079 (Order 3281), § 388-86-071, filed 11/19/91, effective 12/20/91; 87-06-002 (Order 2469), § 388-86-071, filed 2/19/87; 83-01-056 (Order 1923), § 388-86-071, filed 12/15/82.] Repealed by 01-05-040, filed 2/14/01, effective 3/17/01. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-86-085 Transportation (other than ambulance). [Statutory Authority: RCW 74.08.090. 91-23-082 (Order 3284), § 388-86-085, filed 11/19/91, effective 12/20/91; 90-16-053 (Order 3044), § 388-86-085, filed 7/27/90, effective 8/27/90; 89-23-081 (Order 2899), § 388-86-085, filed 11/17/89, effective 12/18/89; 88-20-042 (Order 2702), § 388-86-085, filed 9/30/88; 88-06-083 (Order 2600), § 388-86-085, filed 3/2/88; 86-02-031 (Order 2321), § 388-86-085, filed 12/27/85; 85-05-024 (Order 2207), § 388-86-085, filed 2/14/85; 84-20-098 (Order 2155), § 388-86-085, filed 10/3/84; 82-02-022 (Order 1743), § 388-86-085, filed 12/30/81; 81-16-033 (Order 1685), § 388-86-085, filed 7/29/81; 81-10-015 (Order 1647), § 388-86-085, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-085, filed 10/9/80; 79-06-034 (Order 1402), § 388-86-085, filed 5/16/79; 79-01-002 (Order 1359), § 388-86-085, filed 12/8/78; Order 1230, § 388-86-085, filed 8/23/77; Order 1203, § 388-86-085, filed 4/1/77; Order 1154, § 388-86-085, filed 9/22/76; Order 1112, § 388-86-085, filed 4/15/76; Order 995, § 388-86-085, filed 12/31/74; Order 938, § 388-86-085, filed 5/23/74; Order 754, § 388-86-085, filed 12/14/72; Order 738, § 388-86-085, filed 11/22/72; Order 705, § 388-86-085, filed 8/11/72; Order 696, § 388-86-085, filed 6/29/72; Order 666, § 388-86-085, filed 3/23/72; Order 566, § 388-86-085, filed 5/19/71; Order 484, § 388-86-085, filed 10/13/70; Order 335, § 388-86-085, filed 2/3/69; Order 303, § 388-86-085, filed 9/6/68; Order 264 (part), § 388-86-085, filed 11/24/67.] Repealed by 01-06-029, filed 3/2/01, effective 4/2/01. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057.

388-86-086 Ambulance services. [Statutory Authority: RCW 74.08.090. 88-06-083 (Order 2600), § 388-86-086, filed 3/2/88.] Repealed by 01-03-084, filed 1/16/01, effective 2/16/01. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057.

388-86-100 Durable medical equipment, prosthetic devices, and disposable/nonreuseable medical supplies. [Statutory Authority: RCW 74.08.090. 89-08-052 (Order 2783), § 388-86-100, filed 3/31/89; 86-03-047 (Order 2329), § 388-86-100, filed 1/15/86; 82-17-072 (Order 1868), § 388-86-100, filed 8/18/82; 81-16-033 (Order 1685), § 388-86-100, filed 7/29/81; 81-06-003 (Order 1610), § 388-86-100, filed 2/19/81; 78-10-077 (Order 1346), § 388-86-100, filed 9/27/78; 78-02-024 (Order 1265), § 388-86-100, filed 1/13/78; Order 1233, § 388-86-100, filed 8/31/77; Order 1019, § 388-86-100, filed 4/30/75; Order 938, § 388-86-100, filed 5/23/74; Order 499, § 388-86-100, filed 12/2/70; Order 480, § 388-86-100, filed 9/22/70; Order 463, § 388-86-100, filed 6/23/70; Order 419, § 388-86-100, filed 12/31/69; Order 385, § 388-86-100, filed 8/27/69; Order 264 (part), § 388-86-100, filed 11/24/67.] Repealed by 01-06-028, filed 3/2/01, effective 4/2/01. Statutory Authority: RCW 74.08.090, 74.09.530.

WAC 388-86-071 through 388-86-100 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-87 WAC
MEDICAL CARE—PAYMENT

WAC

388-87-027 through 388-87-060 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-87-027 Services requiring prior approval. [Statutory Authority: RCW 74.08.090. 92-16-104 (Order 3432), § 388-87-027, filed 8/5/92, effective 9/5/92; 90-01-053 (Order 2916), § 388-87-027, filed 12/15/89, effective 1/15/90; 88-06-083 (Order 2600), § 388-87-027, filed 3/2/88; 86-02-031 (Order 2321), § 388-87-027, filed 12/27/85; 83-01-056 (Order 1923), § 388-87-027, filed 12/15/82; 82-01-001 (Order 1725), § 388-87-027, filed 12/3/81; 81-16-032 (Order 1684), § 388-87-027, filed 7/29/81; 81-10-016 (Order 1648), § 388-87-027, filed 4/27/81; 80-13-020 (Order 1542), § 388-87-027, filed 9/9/80; 79-09-053 (Order 1427), § 388-87-027, filed 8/24/79; 78-06-087 (Order 1301), § 388-87-027, filed 6/2/78; 78-02-024 (Order 1265), § 388-87-027, filed 1/13/78; Order 1233, § 388-87-027, filed 8/31/77; Order 1158, § 388-87-027, filed 10/6/76; Order 1098, § 388-87-027, filed 2/13/76; Order 1019, § 388-87-027, filed 4/30/75; Order 930, § 388-87-027, filed 4/25/74; Order 714, § 388-87-027, filed 9/14/72; Order 681, § 388-87-027, filed 5/10/72; Order 500, § 388-87-027, filed 12/2/70; Order 485, § 388-87-027, filed 10/13/70; Order 419, § 388-87-027, filed 12/31/69.] Repealed by 01-06-032, filed 3/2/01, effective 4/2/01. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-87-035 Payment—Transportation (other than ambulance). [Statutory Authority: RCW 74.08.090. 89-23-081 (Order 2899), § 388-87-035, filed 11/17/89, effective 12/18/89; 88-06-083 (Order 2600), § 388-87-035, filed 3/2/88; 85-05-024 (Order 2207) § 388-87-035, filed 2/14/85; 82-01-001 (Order 1725), § 388-87-035, filed

12/3/81; 80-13-020 (Order 1542), § 388-87-035, filed 9/9/80; Order 1244, § 388-87-035, filed 10/10/77; Order 755, § 388-87-035, filed 12/14/72; Order 706, § 388-87-035, filed 8/11/72; Order 336, § 388-87-035, filed 2/3/69; Order 304, § 388-87-035, filed 9/6/68; Order 264 (part), § 388-87-035, filed 11/24/67.] Repealed by 01-06-029, filed 3/2/01, effective 4/2/01. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057.

388-87-036 Payment—Ambulance services. [Statutory Authority: RCW 74.08.090. 88-06-083 (Order 2600), § 388-87-036, filed 3/2/88.] Repealed by 01-03-084, filed 1/16/01, effective 2/16/01. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057.

388-87-060 Payment—Extended care patient—Coinsurance. [Statutory Authority: RCW 74.08.090. 90-12-047 (Order 2989), § 388-87-060, filed 5/31/90, effective 7/1/90; 89-11-003 (Order 2792), § 388-87-060, filed 5/4/89; Order 1112, § 388-87-060, filed 4/15/76; Order 336, § 388-87-060, filed 2/3/69; Order 264 (part), § 388-87-060, filed 11/24/67.] Repealed by 01-06-033, filed 3/2/01, effective 4/2/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

WAC 388-87-027 through 388-87-060 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-96 WAC

NURSING FACILITY MEDICAID PAYMENT SYSTEM

WAC

WAC 388-96-010 Definitions. Unless the context indicates otherwise, the following definitions apply in this chapter.

"Accounting" means activities providing information, usually quantitative and often expressed in monetary units, for:

(1) Decision making;

(2) Planning;

(3) Evaluating performance;

(4) Controlling resources and operations; and

(5) External financial reporting to investors, creditors, regulatory authorities, and the public.

"Administration and management" means activities used to maintain, control, and evaluate the efforts and resources of an organization for the accomplishment of the objectives and policies of that organization.

"Allowable costs" means documented costs that are necessary, ordinary, and related to the care of Medicaid recipients, and are not expressly declared nonallowable by this chapter or chapter 74.46 RCW. Costs are ordinary if they are of the nature and magnitude that prudent and cost conscious management would pay.

"Allowable depreciation costs" means depreciation costs of tangible assets, whether owned or leased by the contractor, meeting the criteria specified in RCW 74.46.330.

"Assignment of contract" means:

(1) A new nursing facility licensee has elected to care for Medicaid residents;

(2) The department finds no good cause to object to continuing the Medicaid contract at the facility; and

(3) The new licensee accepts assignment of the immediately preceding contractor's contract at the facility.

"Capitalized lease" means a lease required to be recorded as an asset and associated liability in accordance with generally accepted accounting principles.

"Cash method of accounting" means a method of accounting in which revenues are recorded when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for those expenditures and assets.

"Change of ownership" means a substitution, elimination, or withdrawal of the individual operator or operating entity contracting with the department to deliver care services to medical care recipients in a nursing facility and ultimately responsible for the daily operational decisions of the nursing facility.

(1) Events which constitute a change of ownership include, but are not limited to, the following:

(a) Changing the form of legal organization of the contractor, e.g., a sole proprietor forms a partnership or corporation;

(b) Transferring ownership of the nursing facility business enterprise to another party, regardless of whether ownership of some or all of the real property and/or personal property assets of the facility are also transferred;

(c) Dissolving of a partnership;

(d) Dissolving the corporation, merging the corporation with another corporation, which is the survivor, or consolidating with one or more other corporations to form a new corporation;

(e) Transferring, whether by a single transaction or multiple transactions within any continuous twenty-four-month period, fifty percent or more of the stock to one or more:

(i) New or former stockholders; or

(ii) Present stockholders each having held less than five percent of the stock before the initial transaction;

(f) Substituting of the individual operator or the operating entity by any other event or combination of events that results in a substitution or substitution of control of the individual operator or the operating entity contracting with the department to deliver care services; or

(g) A nursing facility ceases to operate.

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

(a) A party contracts with the contractor to manage the nursing facility enterprise as the contractor's agent, i.e., subject to the contractor's general approval of daily operating and management decisions; or

(b) The real property or personal property assets of the nursing facility change ownership or are leased, or a lease of them is terminated, without a substitution of individual operator or operating entity and without a substitution of control of the operating entity contracting with the department to deliver care services.

"Charity allowance" means a reduction in charges made by the contractor because of the indigence or medical indigence of a patient.

"Component rate allocation(s)" means the initial component rate allocation(s) of the rebased rate for a rebase period effective July 1. If a month and a day, other than July 1, with a year precedes "component rate allocation(s)," it means the initial component rate allocation(s) of the rebased rate of the rebase period has been amended or updated effective the date that precedes it, e.g., October 1, 1999 direct care component rate allocation.

"Contract" means an agreement between the department and a contractor for the delivery of nursing facility services to medical care recipients.

"Cost report" means all schedules of a nursing facility's cost report submitted according to the department's instructions.

"Courtesy allowances" means reductions in charges in the form of an allowance to physicians, clergy, and others, for services received from the contractor. Employee fringe benefits are not considered courtesy allowances.

"Donated asset" means an asset the contractor acquired without making any payment for the asset either in cash, property, or services. An asset is not a donated asset if the contractor:

(1) Made even a nominal payment in acquiring the asset; or

(2) Used donated funds to purchase the asset.

"Equity capital" means total tangible and other assets which are necessary, ordinary, and related to patient care from the most recent provider cost report minus related total long-term debt from the most recent provider cost report plus working capital as defined in this section.

"Fiscal year" means the operating or business year of a contractor. All contractors report on the basis of a twelve-month fiscal year, but provision is made in this chapter for reports covering abbreviated fiscal periods. As determined by context or otherwise, **"fiscal year"** may also refer to a state fiscal year extending from July 1 through June 30 of the following year and comprising the first or second half of a state fiscal biennium.

"Gain on sale" means the actual total sales price of all tangible and intangible nursing facility assets including, but not limited to, land, building, equipment, supplies, goodwill, and beds authorized by certificate of need, minus the net book value of such assets immediately prior to the time of sale.

"Intangible asset" is an asset that lacks physical substance but possesses economic value.

"Interest" means the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user.

"Multiservice facility" means a facility at which two or more types of health or related care are delivered, e.g., a hospital and nursing facility, or a boarding home and nursing facility.

"Nonadministrative wages and benefits" means wages, benefits, and corresponding payroll taxes paid for nonadministrative personnel, not to include administrator, assistant administrator, or administrator-in-training.

"Nonallowable costs" means the same as **"unallowable costs."**

"Nonrestricted funds" means funds which are not restricted to a specific use by the donor, e.g., general operating funds.

"Nursing facility occupancy percentage" is determined by multiplying the number of calendar days for the cost report period by the number of licensed beds for the same cost report period. Then, the nursing facility's actual resident days for the same cost report period is divided by the product. When the nursing facility under chapter 70.38 RCW reinstates or reduces the number of licensed beds, then under WAC 388-96-708 or 388-96-709 the number of licensed beds after reinstatement or reduction will be used. In all determinations that require a nursing facility occupancy percentage, the department will use the greater of either a nursing facility's occupancy percentage or eighty-five percent.

"Per diem (per patient day or per resident day) costs" means total allowable costs for a fiscal period divided by total patient or resident days for the same period.

"Prospective daily payment rate" means the rate assigned by the department to a contractor for providing service to medical care recipients prior to the application of settlement principles.

"Recipient" means a Medicaid recipient.

"Related care" includes:

(1) The director of nursing services;

(2) Activities and social services programs;

(3) Medical and medical records specialists; and

(4) Consultation provided by:

(a) Medical directors; and

(b) Pharmacists.

"Relative" includes:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted child or adoptive parent;

(4) Stepparent, stepchild, stepbrother, stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law;

(6) Grandparent or grandchild; and

(7) Uncle, aunt, nephew, niece, or cousin.

"Start-up costs" means the one-time preopening costs incurred from the time preparation begins on a newly constructed or purchased building until the first patient is admitted. Start-up costs include:

(1) Administrative and nursing salaries;

(2) Utility costs;

(3) Taxes;

(4) Insurance;

(5) Repairs and maintenance; and

(6) Training costs.

Start-up costs do not include expenditures for capital assets.

"Total rate allocation" means the initial rebased rate for a rebase period effective July 1. If a month and a day, other than July 1, with a year precedes "total rate allocation," it means the initial rebased rate of the rebase period has been amended or updated effective the date that precedes it, e.g., October 1, 1999 direct care component rate allocation.

"Unallowable costs" means costs which do not meet every test of an allowable cost.

"Uniform chart of accounts" means a list of account titles identified by code numbers established by the department for contractors to use in reporting costs.

"Vendor number" means a number assigned to each contractor delivering care services to medical care recipients.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-010, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-010, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-010, filed 9/25/98, effective 10/1/98; 97-17-040, § 388-96-010, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-010, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-010, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-010, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-010, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-010, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-010, filed 12/23/87. Statutory Authority: RCW 74.09.120 and 74.46.800. 85-13-060 (Order 2240), § 388-96-010, filed 6/18/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-010, filed 12/4/84. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-010, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-010, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-010, filed 10/13/82; 81-22-081 (Order 1712), § 388-96-010, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-010, filed 2/25/81. Statutory Authority: RCW 74.09.120. 80-09-083 (Order 1527), § 388-96-010, filed 7/22/80; 79-04-061 (Order 1381), § 388-96-010, filed 3/28/79. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-010, filed 6/1/78; Order 1262, § 388-96-010, filed 12/30/77.]

WAC 388-96-218 Proposed, preliminary, and final settlements. (1) For each component rate, the department shall calculate a settlement at the lower of prospective payment rate or audited allowable costs, except as otherwise provided in this chapter.

(2) As part of the cost report, the proposed settlement report is due in accordance with RCW 74.46.040. In the proposed settlement report, a contractor shall compare the contractor's payment rates during a report period, weighted by the number of resident days reported for the period when each rate was in effect, to the contractor's allowable costs for the reporting period. The contractor shall take into account all authorized shifting, retained savings, and upper limits to rates on a cost center basis.

(a) The department will:

(i) Review the proposed settlement report for accuracy; and

(ii) Accept or reject the proposal of the contractor. If accepted, the proposed settlement report shall become the preliminary settlement report. If rejected, the department shall issue, by cost center, a preliminary settlement report fully substantiating disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

(b) When the department receives the proposed settlement report:

(i) By the due date, it will issue the preliminary settlement report within one hundred twenty days of the due date; or

(ii) After the due date, it will issue the preliminary settlement report within one hundred twenty days of the date received.

(c) In its discretion, the department may designate a date later than the dates specified in subsection (2)(b)(i) and (ii) of this section to issue preliminary settlements.

(d) A contractor shall have twenty-eight days after receipt of a preliminary settlement report to contest such report under WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight-day period, the department shall not review or adjust a preliminary settlement report. Any administrative review of a preliminary settlement shall be limited to calculation of the settlement, to the application of settlement principles and rules, or both, and shall not encompass rate or audit issues.

(3) The department shall issue a final settlement report to the contractor after the completion of the department audit process, including exhaustion or termination of any administrative review and appeal of audit findings or determinations requested by the contractor, but not including judicial review as may be available to and commenced by the contractor.

(a) The department shall prepare a final settlement by cost center and shall fully substantiate disallowed costs, refunds, underpayments, or adjustments to the cost report and financial statements, reports, and schedules submitted by the contractor. The department shall take into account all authorized shifting, savings, and upper limits to rates on a cost center basis. For the final settlement report, the department shall compare:

(i) The payment rate the contractor was paid for the facility in question during the report period, weighted by the number of allowable resident days reported for the period each rate was in effect to the contractor's;

(ii) Audited allowable costs for the reporting period; or

(iii) Reported costs for the nonaudited reporting period.

(b) A contractor shall have twenty-eight days after the receipt of a final settlement report to contest such report pursuant to WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight-day period, the department shall not review a final settlement report. Any administrative review of a final settlement shall be limited to calculation of the settlement, the application of settlement principles and rules, or both, and shall not encompass rate or audit issues.

(c) The department shall reopen a final settlement if it is necessary to make adjustments based upon findings resulting from a department audit performed pursuant to RCW 74.46.100. The department may also reopen a final settlement to recover an industrial insurance dividend or premium discount under RCW 51.16.035 in proportion to a contractor's Medicaid recipients.

(4) In computing a preliminary or final settlement, a contractor may shift savings and/or overpayment in the support services cost center to cover a deficit and/or underpayment in the direct care or therapy cost centers up to the amount of the savings as provided in RCW 74.46.165(4). The provider's payment rate is subject to the provisions of RCW 74.46.421.

(5) If an administrative or judicial remedy sought by the facility is not granted or is granted only in part after exhaustion or mutual termination of all appeals, the facility shall refund all amounts due the department within sixty days after the date of decision or termination plus interest as payment on judgments from the date the review was requested pursuant to WAC 388-96-901 and 388-96-904 to the date the repayment is made.

(6) In determining whether a facility has forfeited unused rate funds in its direct care, therapy care and support services component rates under authority of RCW 74.46.165(3), the following rules shall apply:

(a) Federal or state survey officials shall determine when a facility is not in substantial compliance or is providing substandard care, according to federal and state nursing facility survey regulations;

(b) Correspondence from state or federal survey officials notifying a facility of its compliance status shall be used to determine the beginning and ending dates of any period(s) of noncompliance; and

(c) Forfeiture shall occur if the facility was out of substantial compliance more than ninety days during the settlement period. The ninety-day period need not be continuous if the number of days of noncompliance exceed ninety days during the settlement period regardless of the length of the settlement period. Also, forfeiture shall occur if the nursing facility was determined to have provided substandard quality of care at any time during the settlement period.

(7)(a) For calendar year 1998, the department will calculate two settlements covering the following periods:

(i) January 1, 1998 through September 30, 1998; and

(ii) October 1, 1998 through December 31, 1998.

(b) The department will use Medicaid rates weighted by total patient days (i.e., Medicaid and non-Medicaid days) to divide 1998 costs between the two settlement periods identified in subsection (7)(a) of this section.

(c) The department will net the two settlements for 1998 to determine a nursing facility's 1998 settlement.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-218, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-218, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 9 and 10 and RCW 74.46.800. 98-20-023, § 388-96-218, filed 9/25/98, effective 10/1/98.]

WAC 388-96-369 The nursing facility shall maintain a subsidiary ledger with an account for each resident for whom the facility holds money. (1) The facility shall assure a full and complete separate accounting of each resident's personal funds. Each account record and related supporting information and documentation shall:

(a) Be maintained at the facility;

(b) Be kept current;

(c) Be balanced each month; and

(d) Show in writing and in detail, with supporting verification, all moneys received on behalf of the individual resident and the disposition of all moneys so received.

(2) Each account shall be reasonably accessible to the resident or the resident's guardian or legal representative and shall be available for audit and inspection by a department representative. Each account shall be maintained for a minimum of four years. A Medicaid provider shall notify each Title XIX Medicaid recipient or guardian and the home and community services office of the department that serves the area when the amount in the account of any Title XIX Medicaid recipient reaches two hundred dollars less than the applicable dollar resource limit for supplemental security income (SSI) eligibility set forth in Title XVI of the Social Security Act.

(3) When notice is given under subsection (2) of this section, the facility shall notify the recipient or guardian that if the amount in the account, in addition to the value of the recipient's other nonexempt resources, reaches the dollar resource limit determined under Title XVI, the recipient may lose eligibility for SSI medical assistance or benefits under Title XVI.

(4) Accumulation toward the Title XVI limit, after the recipient's admission to the facility, is permitted only from savings from the clothing and personal incidentals allowance and other income which the department specifically designates as exempt income.

(5) No resident funds may be overdrawn (show a debit balance). If a resident wants to spend an amount greater than the facility is holding for the resident, the home may provide money from its own funds and 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.

(6) The facility may not impose a charge against the personal funds of a Medicare or Medicaid recipient for any item or service for which payment is made under the Title XVIII Medicare program or the Title XIX Medicaid program. In order to ensure that Medicaid recipients are not charged for services provided under the Title XIX program, any charge for medical services otherwise properly made to a recipient's personal funds shall be supported by a written denial from the department.

(a) Mobility aids including walkers, wheelchairs, or crutches requested for the exclusive use by a Medicaid recip-

ient shall have a written denial from the department of social and health services before a recipient's personal funds may be charged.

(b) Requests for medically necessary services and supplies not funded under the provisions of chapter 388-96 WAC or chapter 388-86 WAC (reimbursement rate or coupon system) shall have a written denial from the department before a Medicaid recipient's personal funds may be charged.

(c) A written denial from the department is not required when the pharmacist verifies that 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. The pharmacist's notation to this effect is sufficient.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-369, filed 5/29/01, effective 6/29/01. Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-369, filed 9/28/90, effective 10/1/90. Statutory Authority: RCW 74.42.620 and 74.46.800. 85-17-070 (Order 2275), § 388-96-369, filed 8/21/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-369, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-369, filed 10/13/82; Order 1168, § 388-96-369, filed 11/3/76; Order 1114, § 388-96-369, filed 4/21/76.]

WAC 388-96-384 Liquidation or transfer of resident personal funds. (1) Upon the death of a resident, the facility shall promptly convey the resident's personal funds held by the facility with a final accounting of such funds to the department or to the individual or probate jurisdiction administering the resident's estate.

(a) If the deceased resident was a recipient of long-term care services paid for in whole or in part by the state of Washington then the personal funds held by the facility and the final accounting shall be sent to the state of Washington, department of social and health services, office of financial recovery (or successor office).

(b) The personal funds of the deceased resident and final accounting must be conveyed to the individual or probate jurisdiction administering the resident's estate or to the state of Washington, department of social and health services, office of financial recovery (or successor office) no later than the thirtieth day after the date of the resident's death.

(i) When the personal funds of the deceased resident are to be paid to the state of Washington, those funds shall be paid by the facility with a check, money order, certified check or cashiers check made payable to the secretary, department of social and health services, and mailed to the Office of Financial Recovery, Estate Recovery Unit, P.O. Box 9501, Olympia, Washington 98507-9501, or such address as may be directed by the department in the future.

(ii) The check, money order, certified check or cashier's check or the statement accompanying the payment shall contain the name and social security number of the deceased individual from whose personal funds account the monies are being paid.

(c) The department of social and health services shall establish a release procedure for use of funds necessary for burial expenses.

(2) In situations where the resident leaves the nursing home without authorization and the resident's whereabouts is unknown:

(a) The nursing facility shall make a reasonable attempt to locate the missing resident. This includes contacting:

(i) Friends,

(ii) Relatives,

(iii) Police,

(iv) The guardian, and

(v) The home and community services office in the area.

(b) If the resident cannot be located after ninety days, the nursing facility shall notify the department of revenue of the existence of "abandoned property," outlined in chapter 63.29 RCW. The nursing facility shall deliver to the department of revenue the balance of the resident's personal funds within twenty days following such notification.

(3) Prior to the sale or other transfer of ownership of the nursing facility business, the facility operator shall:

(a) Provide each resident or resident representative with a written accounting of any personal funds held by the facility;

(b) Provide the new operator with a written accounting of all resident funds being transferred; and

(c) Obtain a written receipt for those funds from the new operator.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-384, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-384, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-384, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-384, filed 9/28/90, effective 10/1/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-384, filed 12/23/87. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-384, filed 10/13/82; Order 1168, § 388-96-384, filed 11/3/76; Order 1114, § 388-96-384, filed 4/21/76.]

WAC 388-96-559 Cost basis of land and depreciation base. (1) For all partial or whole rate periods after December 31, 1984 unless otherwise provided or limited by this chapter or by this section, chapter 388-96 WAC or chapter 74.46 RCW, the total depreciation base of depreciable assets and the cost basis of land shall be the lowest of:

(a) The contractor's appraisal, if any;

(b) The department's appraisal obtained through the department of general administration of the state of Washington, if any; or

(c) The historical purchase cost of the contractor, or lessor if the assets are leased by the contractor, in acquiring ownership of the asset in an arm's-length transaction, and preparing the asset for use, less goodwill, and less accumulated depreciation, if applicable, incurred during periods the assets have been used in or as a facility by any and all contractors. Such accumulated depreciation is to be measured in accordance with WAC 388-96-561, 388-96-565, chapter 388-96 WAC, and chapter 74.46 RCW. Where the straight-line or sum-of-the-years digits method of depreciation is used the contractor:

(i) May deduct salvage values from historical costs for each cloth based item, e.g., mattresses, linen, and draperies; and

(ii) Shall deduct salvage values from historical costs of at least:

(A) Five percent of the historical value for each noncloth item included in moveable equipment; and

(B) Twenty-five percent of the historical value for each vehicle.

(2) Unless otherwise provided or limited by this chapter or by chapter 74.46 RCW, the department shall, in determining the total depreciation base of a depreciable real or personal asset owned or leased by the contractor, deduct depreciation relating to all periods subsequent to the more recent of:

(a) The date such asset was first used in the medical care program; or

(b) The most recent date such asset was acquired in an arm's-length purchase transaction which the department is required to recognize for Medicaid cost reimbursement purposes.

No depreciation shall be deducted for periods such asset was not used in the medical care program or was not used to provide nursing care.

(3) The department may have the fair market value of the asset at the time of purchase established by appraisal through the department of general administration of the state of Washington if:

(a) The department challenges the historical cost of an asset; or

(b) The contractor cannot or will not provide the historical cost of a leased asset and the department is unable to determine such historical cost from its own records or from any other source.

The contractor may allocate or reallocate values among land, building, improvements, and equipment in accordance with the department's appraisal.

If an appraisal is conducted, the depreciation base of the asset and cost basis of land will not exceed the fair market value of the asset. An appraisal conducted by or through the department of general administration shall be final unless the appraisal is shown to be arbitrary and capricious.

(4) If the land and depreciable assets of a newly constructed nursing facility were never used in or as a nursing facility before being purchased from the builder, the cost basis and the depreciation base shall be the lesser of:

(a) Documented actual cost of the builder; or

(b) The approved amount of the certificate of need issued to the builder.

When the builder is unable or unwilling to document its costs, the cost basis and the depreciation base shall be the approved amount of the certificate of need.

(5) For leased assets, the department may examine documentation in its files or otherwise obtainable from any source to determine:

(a) The lessor's purchase acquisition date; or

(b) The lessor's historical cost at the time of the last arm's-length purchase transaction.

If the department is unable to determine the lessor's acquisition date by review of its records or other records, the department, in determining fair market value as of such date, may use the construction date of the facility, as found in the state fire marshal's records or other records, as the lessor's purchase acquisition date of leased assets.

(6) For all rate periods past or future, where depreciable assets or land are acquired from a related organization, the contractor's depreciation base and land cost basis shall not exceed the base and basis the related organization had or would have had under a contract with the department.

(7) If a contractor cannot or will not provide the lessor's purchase acquisition cost of assets leased by the contractor and the department is unable to determine historical purchase cost from another source, the appraised asset value of land, building, or equipment, determined by or through the department of general administration shall be adjusted, if necessary, by the department using the *Marshall and Swift Valuation Guide* to reflect the value at the lessor's acquisition date. If an appraisal has been prepared for leased assets and the assets subsequently sell in the first arm's-length transaction since January 1, 1980, under subsection (9) of this section, the *Marshall and Swift Valuation Guide* will be used to adjust, if necessary, the asset value determined by the appraisal to the sale date. If the assets are located in a city for which the *Marshall and Swift Valuation Guide* publishes a specific index, or if the assets are located in a county containing that city, the city-specific index shall be used to adjust the appraised value of the asset. If the assets are located in a city or county for which a specific index is not calculated, the *Western District Index* calculated by Marshall and Swift shall be used.

(8) For new or replacement building construction or for substantial building additions requiring the acquisition of land and which commenced to operate on or after July 1, 1997, the department shall determine allowable land costs of the additional land acquired for the new or replacement construction or for substantial building additions to be the lesser of:

(a) The contractor's or lessor's actual cost per square foot; or

(b) The square foot land value as established by an appraisal that meets the latest publication of the *Uniform Standards of Professional Appraisal Practice (USPAP)* and the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA). The department shall obtain a USPAP appraisal that meets FIRREA first from:

(i) An arms'-length lender that has accepted the ordered appraisal; or

(ii) If the department is unable to obtain from the arms'-length lender a lender-approved appraisal meeting USPAP and FIRREA standards or if the contractor or lessor is unable or unwilling to provide or cause to be provided a lender-approved appraisal meeting USPAP and FIRREA standards, then:

(A) The department shall order such an appraisal; and

(B) The contractor shall immediately reimburse the department for the costs incurred in obtaining the USPAP and FIRREA appraisal.

(9) Except as provided for in subsection (8) of this section, for all rates effective on or after January 1, 1985, if depreciable assets or land are acquired by purchase which were used in the medical care program on or after January 1, 1980, the depreciation base or cost basis of such assets shall not exceed the net book value existing at the time of such acquisition or which would have existed had the assets continued in use under the previous Medicaid contract with the department; except that depreciation shall not be accumulated for periods during which such assets were not used in the medical care program or were not in use in or as a nursing care facility.

(10)(a) Subsection (9) of this section shall not apply to the most recent arm's-length purchase acquisition if it occurs ten years or more after the previous arm's-length transfer of ownership nor shall subsection (9) of this section apply to the first arm's-length purchase acquisition of assets occurring on or after January 1, 1980, for facilities participating in the Medicaid program before January 1, 1980. The depreciation base or cost basis for such acquisitions shall not exceed the lesser of the fair market value as of the date of purchase of the assets determined by an appraisal conducted by or through the department of general administration or the owner's acquisition cost of each asset, land, building, or equipment. An appraisal conducted by or through the department of general administration shall be final unless the appraisal is shown to be arbitrary and capricious. Should a contractor request a revaluation of an asset, the contractor must document ten years have passed since the most recent arm's-length transfer of ownership. As mandated by Section 2314 of the Deficit Reduction Act of 1984 (P.L. 98-369) and state statutory amendments, and under RCW 74.46.840, for all partial or whole rate periods after July 17, 1984, this subsection is inoperative for any transfer of ownership of any asset, including land and all depreciable or nondepreciable assets, occurring on or after July 18, 1984, leaving subsection (9) of this section to apply without exception to acquisitions occurring on or after July 18, 1984, except as provided in subsections (10)(b) and (11) of this section.

(b) For all rates after July 17, 1984, subsection (8)(a) shall apply, however, to transfers of ownership of assets:

(i) Occurring before January 1, 1985, if the costs of such assets have never been reimbursed under Medicaid cost reimbursement on an owner-operated basis or as a related party lease; or

(ii) Under written and enforceable purchase and sale agreements dated before July 18, 1984, which are documented and submitted to the department before January 1, 1988.

(c) For purposes of Medicaid cost reimbursement under this chapter, an otherwise enforceable agreement to purchase a nursing home dated before July 18, 1984, shall be considered enforceable even though the agreement contains:

(i) No legal description of the real property involved; or

(ii) An inaccurate legal description, notwithstanding the statute of frauds or any other provision of law.

(11)(a) In the case of land or depreciable assets leased by the same contractor since January 1, 1980, in an arm's-length lease, and purchased by the lessee/contractor, the lessee/contractor shall have the option to have the:

(i) Provisions of subsection (10) of this section apply to the purchase; or

(ii) Component rate allocations for property and financing allowance calculated under the provisions of chapter 74.46 RCW.Component rate allocations will be based upon provisions of the lease in existence on the date of the purchase, but only if the purchase date meets the criteria of RCW 74.46.360 (6)(c)(ii)(A) through (D).

(b) The lessee/contractor may select the option in subsection (11)(a)(ii) of this section only when the purchase date meets one of the following criteria. The purchase date is:

(i) After the lessor has declared bankruptcy or has defaulted in any loan or mortgage held against the leased property;

(ii) Within one year of the lease expiration or renewal date contained in the lease;

(iii) After a rate setting for the facility in which the reimbursement rate set, under this chapter and under chapter 74.46 RCW, no longer is equal to or greater than the actual cost of the lease; or

(iv) Within one year of any purchase option in existence on January 1, 1988.

(12) For purposes of establishing the property and financing allowance component rate allocations, the value of leased equipment, if unknown by the contractor, may be estimated by the department using previous department of general administration appraisals as a data base. The estimated value may be adjusted using the *Marshall and Swift Valuation Guide* to reflect the value of the asset at the lessor's purchase acquisition date.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-559, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-559, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.360. 97-17-040, § 388-96-559, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-559, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-559, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-559, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.46.800. 88-16-079 (Order 2660), § 388-96-559, filed 8/2/88; 86-10-055 (Order 2372), § 388-96-559, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-559, filed 8/19/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-559, filed 12/4/84; 81-22-081 (Order 1712), § 388-96-559, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-559, filed 2/25/81; Order 1262, § 388-96-559, filed 12/30/77.]

WAC 388-96-708 Reinstatement of beds previously removed from service under chapter 70.38 RCW—Effect on prospective payment rate. (1) After removing beds from service (banked) under the provisions of chapter 70.38 RCW, the contractor may bring back into service beds that were previously banked.

(2) When the contractor returns to service beds banked under the provisions of chapter 70.38 RCW, the department will recalculate the contractor's prospective Medicaid payment rate allocations using the greater of actual days from the cost report period on which the rate is based or days calculated by multiplying the new number of licensed beds times eighty-five percent times the number of calendar days in the cost report period on which the rate being recalculated is based.

(3) The effective date of the recalculated prospective rate for beds returned to service:

(a) Before the sixteenth of a month, shall be the first of the month in which the banked beds returned to service; or

(b) After the fifteenth of a month, shall be the first of the month following the month in which the banked beds returned to service.

(4) The recalculated prospective payment rate shall comply with all the provisions of rate setting contained in chapter

74.46 RCW or in this chapter, including all lids and maximums unless otherwise specified in this section.

(5) The recalculated prospective Medicaid payment rate shall be subject to adjustment if required by RCW 74.46.421.

(6) After the department recalculates the contractor's prospective Medicaid component rate allocations using the increased number of licensed beds, the department will use the increased number of licensed beds in all post unbanking rate settings, until under chapter 74.46 RCW and/or this chapter, the post unbanking number of licensed beds changes.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-708, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-708, filed 11/30/99, effective 12/31/99. Statutory Authority: 1998 c 322 § 19(11). 98-20-023, § 388-96-708, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-708, filed 7/16/96, effective 8/16/96.]

WAC 388-96-709 Prospective rate revisions—Reduction in licensed beds. (1) The department will recalculate a contractor's prospective Medicaid payment rate when the contractor reduces the number of its licensed beds and:

(a) Provides a copy of the new bed license and documentation of the number of beds sold, exchanged or otherwise placed out of service, along with the name of the contractor that received the beds, if any; and

(b) Requests a rate revision.

(2) The revised prospective Medicaid payment rate will comply with all the provisions of rate setting contained in chapter 74.46 RCW and in this chapter, including all lids and maximums, unless otherwise specified in this section.

(3) The revised prospective Medicaid payment rate will be effective the first of a month when the contractor complies with subsection (1)(a) and (b) of this section and the effective date of the licensed bed reduction falls:

(a) Between the first and the fifteenth of the month, then the revised prospective Medicaid payment rate is effective the first of the month in which the licensed bed reduction occurs; or

(b) Between the sixteenth and the end of the month, then the revised prospective Medicaid payment rate is effective the first of the month following the month in which the licensed bed reduction occurs.

(4) The department will recalculate a nursing facility's prospective Medicaid payment rate allocations using the greater of actual days from the cost report period on which the rate is based or days calculated by multiplying the new number of licensed beds times eighty-five percent times the number of calendar days in the cost report period on which the rate being recalculated is based.

(5) After the department recalculates the contractor's prospective Medicaid component rate allocations using the decreased number of licensed beds, the department will use the decreased number of licensed beds in all post banking rate settings, until under chapter 74.46 RCW and/or this chapter, the post banking number of licensed beds changes.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-709, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-709, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(11) and RCW 74.46.800. 98-20-023, § 388-96-709, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.510. 97-17-040, § 388-96-709, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-709, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-709, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-709, filed 5/26/93, effective 6/26/93.]

WAC 388-96-710 Prospective payment rate for new contractors. (1) The department will establish an initial prospective Medicaid payment rate for a new contractor as defined under WAC 388-96-026 within sixty days following the new contractor's application and approval for a license to operate the facility under chapter 18.51 RCW. The rate will take effect as of the effective date of the contract, except as provided in this section, and will comply with all the provisions of rate setting contained in chapter 74.46 RCW and in this chapter, including all lids and maximums set forth.

(2) Except for quarterly updates per RCW 74.46.501 (7)(c), the rate established for a new contractor as defined in WAC 388-96-026 (1)(a) or (b) will remain in effect for the nursing facility until the rate can be reset effective July 1 using the first cost report for that facility under the new contractor's operation containing at least six months' data from the prior calendar year, regardless of whether reported costs for facilities operated by other contractors for the prior calendar year in question will be used to cost rebase their July 1 rates. The new contractor's rate thereafter will be cost rebased only as provided in this chapter and chapter 74.46 RCW.

(3) To set the initial prospective Medicaid payment rate for a new contractor as defined in WAC 388-96-026 (1)(a) and (b), the department will:

(a) Determine whether the new contractor nursing facility belongs to the metropolitan statistical area (MSA) peer group or the non-MSA peer group using the latest information received from the office of management and budget or the appropriate federal agency;

(b) Select all nursing facilities from the department's records of all the current Medicaid nursing facilities in the new contractor's peer group with the same bed capacity plus or minus ten beds. If the selection does not result in at least seven facilities, then the department will increase the bed capacity by plus or minus five bed increments until a sample of at least seven nursing facilities is obtained;

(c) Based on the information for the nursing facilities selected under subsection (3)(b) of this section and available to the department on the day the new contractor began participating in the Medicaid payment rate system at the facility, rank from the highest to the lowest the component rate allocation in direct care, therapy care, support services, and operations cost centers and based on this ranking:

(i) Determine the middle of the ranking and then identify the rate immediately above the median for each cost center identified in subsection (3)(c) of this section. The rate immediately above the median will be known as the "selected rate" for each cost center;

(ii) Set the new contractor's nursing facility component rate allocation for therapy care, support services, and operations at the "selected rate";

(iii) Set the direct care rate using data from the direct care "selected" rate facility identified in (c) of this subsection as follows:

(A) The cost per case mix unit will be the rate base allowable case mixed direct care cost per patient day for the direct care "selected" rate facility, whether or not that facility is held harmless under WAC 388-96-728 and 388-96-729, divided by the facility average case mix index per WAC 388-96-741;

(B) The cost per case mix unit determined under (c)(iii)(A) of this subsection will be multiplied by the Medicaid average case mix index per WAC 388-96-740. The product will be the new contractors direct care rate under case mix; and

(C) The department will not apply RCW 74.46.506 (5)(k) to any direct care rate established under subsection (5)(e) or (f) of this section. When the department establishes a new contractor's direct care rate under subsection (5)(e) or (f) of this section, the new contractor is not eligible to be paid by a "hold harmless" rate as determined under RCW 74.46.506 (5)(k);

(iv) Set the property rate in accordance with the provisions of this chapter and chapter 74.46 RCW; and

(v) Set the financing allowance and variable return component rate allocations in accordance with the provisions of this chapter and chapter 74.46 RCW. In computing the variable return component rate allocation, the department will use for direct care, therapy care, support services and operations rate allocations those set pursuant to subsection (3)(c)(i), (ii) and (iii) of this section.

(d) Any subsequent revisions to the rate component allocations of the sample members will not impact a "selected rate" component allocation of the initial prospective rate established for the new contractor under this subsection.

(4) For the WAC 388-96-026 (1)(a) or (b) new contractor, the department will establish rate component allocations for:

(a) Direct care, therapy care, support services and operations based on the "selected rates" as determined under subsection (3)(c) of this section that are in effect on the date the new contractor began participating in the program;

(b) Property in accordance with the provisions of this chapter and chapter 74.46 RCW using for the new contractor as defined under:

(i) WAC 388-96-026 (1)(a), information from the certificate of need; or

(ii) WAC 388-96-026 (1)(b), information provided by the new contractor within ten days of the date the department requests the information in writing. If the contractor as defined under WAC 388-96-026 (1)(b), has not provided the requested information within ten days of the date requested, then the property rate will be zero. The property rate will remain zero until the information is received;

(c) Variable return in accordance with the provisions of this chapter and chapter 74.46 RCW using the "selected rates" established under subsection (3)(c) of this section that are in effect on the date the new contractor began participating in the program; and

(d) Financing allowance using for the new contractor as defined under:

(i) WAC 388-96-026 (1)(a), information from the certificate of need; or

(ii) WAC 388-96-026 (1)(b), information provided by the new contractor within ten days of the date the department requests the information in writing. If the contractor as defined under WAC 388-96-026 (1)(b), has not provided the requested information within ten days of the date requested, then the net book value of allowable assets will be zero. The financing allowance rate component allocation will remain zero until the information is received.

(5) The initial prospective payment rate for a new contractor as defined under WAC 388-96-026 (1)(a) or (b) will be established under subsections (3) and (4) of this section. If the WAC 388-96-026 (1)(a) or (b) contractor's initial rate is set:

(a) Between July 1, 2000 and June 30, 2001, the department will set the new contractor's rates for:

(i) July 1, 2001 using the July 1, 2001 rates for direct care, therapy care, support services, and operations of the sample facilities used to set the initial rate under subsections (3) and (4) of this section.

(A) Property and financing allowance component rates will remain the same as set for the initial rate.

(B) Variable return component rate using the rates determined under subsection (5)(a)(i) of this section;

(ii) July 1, 2002 rate using 2001 cost report data; and

(iii) All July 1 rates following July 1, 2002 in accordance with this chapter and chapter 74.46 RCW;

(b) Between July 1, 2001, and June 30, 2002, the department will set the new contractor's rates for:

(i) July 1, 2002 using July 1, 2002 rates for direct care, therapy care, support services, and operation of the sample facilities used to set the initial rate under subsections (3) and (4) of this section.

(A) Property and financing allowance component rates will remain the same as set for the initial rate.

(B) Variable return component rate using the rates determined under subsection (5)(b)(i) of this section;

(ii) July 1, 2003 rate by rebasing using 2002 cost report data in accordance with this chapter and chapter 74.46 RCW; and

(iii) All July 1 rates following July 1, 2003 in accordance with this chapter and chapter 74.46 RCW; or

(c) Between July 1, 2002, and June 30, 2003, the department will set the contractor's rates for:

(i) July 1, 2003 using July 1, 2003 rates for direct care, therapy care, support services, and operation of the sample facilities used to set the initial rate under subsection (3) and (4) of this section.

(A) Property and financing allowance component rates will remain the same as set for the initial rate.

(B) Variable return component rate using the rates determined under subsection (5)(c)(i) of this section;

(ii) July 1, 2004 by rebasing using 2003 cost report data; and

(iii) All July 1 rates following July 1, 2004 in accordance with this chapter and chapter 74.46 RCW.

(6) For the WAC 388-96-026 (1)(c) new contractor, the initial prospective payment rate will be the last prospective payment rate the department paid to the Medicaid contractor

operating the nursing facility immediately prior to the effective date of the new Medicaid contract or assignment. If the WAC 388-96-026 (1)(c) contractor's initial rate is set:

(a) Between October 1, 1998 and June 30, 1999, the department will not rebase the contractor's rate for:

(i) July 1, 1999; and

(ii) July 1, 2000;

(b) Between July 1, 1999 and June 30, 2000, the department will for:

(i) July 1, 2000 not rebase the new contractor's rate;

(ii) July 1, 2001 rebase the new contractor's rate using twelve months of cost report data derived from the old contractor's and the new contractor's 1999 cost reports; and

(iii) July 1, 2002 not rebase the new contractor's rate; and

(iv) July 1, 2003 not rebase the new contractor's rate;

(c) Between July 1, 2000 and June 30, 2001, the department will for:

(i) July 1, 2001 rebase the new contractor's rate using the old contractor's 1999 twelve month cost report;

(ii) July 1, 2002 not rebase the new contractor's rate;

(iii) July 1, 2003 not rebase the new contractor's rate; or

(d) Between July 1, 2001 and June 30, 2002, the department will for:

(i) July 1, 2002 not rebase the new contractor's rate;

(ii) July 1, 2003 not rebase the new contractor's rate; and

(iii) July 1, 2004 rebase the new contractor's rate using the new contractor's 2002 cost report containing at least six month's data.

(7) A prospective payment rate set for all new contractors will be subject to adjustments for economic trends and conditions as authorized and provided in this chapter and in chapter 74.46 RCW.

(8) For a WAC 388-96-026 (1)(a), (b) or (c) new contractor, the Medicaid case mix index and facility average case mix index will be determined in accordance with this chapter and chapter 74.46 RCW.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-710, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-710, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(11) and RCW 74.46.800. 98-20-023, § 388-96-710, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-710, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-710, filed 5/26/94, effective 6/26/94; 93-17-033 (Order 3615), § 388-96-710, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-710, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-710, filed 7/23/92, effective 8/23/92. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-710, filed 12/23/87. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-710, filed 4/20/87. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-710, filed 9/16/83; 78-02-013 (Order 1264), § 388-96-710, filed 1/9/78.]

WAC 388-96-713 Rate determination. (1) Each nursing facility's Medicaid payment rate for services provided to medical care recipients will be determined, adjusted and updated prospectively as provided in this chapter and in chapter 74.46 RCW. The department will calculate any limit, lid, and/or median only when it rebases each nursing facility's July 1 Medicaid payment rate in accordance with chapter 74.46 RCW and this chapter.

(2) If the contractor participated in the program for less than six months of the prior calendar year, its rates will be determined by procedures set forth in WAC 388-96-710.

(3) Contractors submitting correct and complete cost reports by March 31st, shall be notified of their rates by July 1st, unless circumstances beyond the control of the department interfere.

(4) In setting rates, the department will use the greater of actual days from the cost report period on which the rate is based or days calculated at eighty-five percent occupancy.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-713, filed 5/29/01, effective 6/29/01; 98-20-023, § 388-96-713, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-713, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-713, filed 9/14/93, effective 10/15/93; 90-09-061 (Order 2970), § 388-96-713, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-713, filed 9/16/83; 81-15-049 (Order 1669), § 388-96-713, filed 7/15/81; 80-06-122 (Order 1510), § 388-96-713, filed 5/30/80, effective 7/1/80; 78-02-013 (Order 1264), § 388-96-713, filed 1/9/78.]

WAC 388-96-714 Nursing facility Medicaid rate allocations—Economic trends and conditions adjustment factors. (1)(a) For July 1, 1999, the department will increase the following component rate allocations for each nursing facility by two percent:

(i) Direct care based on case mix requirements of RCW 74.46.506 (5)(g);

(ii) Therapy care;

(iii) Support services; and

(iv) Operations.

(b) For direct care based on case mix, the department will apply the two percent increase allowed under subsection (1)(a)(i) of this section to the total of the component rate allocations identified in subsection (1)(a) of this section after the direct care component rate allocation is adjusted for case-mix changes and before application of any reductions required by RCW 74.46.421.

(c) For July 1, 1999, the department will increase by one percent the direct care component rate allocation based on the requirements of RCW 74.46.506 (5)(k)(i).

(2) For July 1, 2000, the department will increase each nursing facility's component rate allocations in the same manner as described in subsection (1) of this section. The department will base the direct care component rate allocation of subsection (1)(c) of this section on the requirements of RCW 74.46.506 (5)(k)(ii).

(3)(a) After applying subsection (1) of this section, for rate determinations through March 2000 only, the department will determine whether a nursing facility's July 1 total rate allocation will be adjusted by an additional economic trends and conditions factor. The department will adjust a nursing facility's July 1 total rate allocation set pursuant to this chapter and chapter 74.46 RCW when it is less than its April 1, 1999 total rate allocation adjusted for case mix changes. Whether the April 1, 1999 or July 1 direct care rate allocation is determined by case mix under RCW 74.46.506 (a) through (j) or a hold harmless rate under RCW 74.46.506(k), the department will determine whether the July 1 total rate allo-

cation is less than the April 1, 1999 total rate allocation adjusted for case mix changes by:

(i) Calculating the nursing facility's April 1, 1999 direct care component rate allocation by applying the case mix index (CMI) used to set the nursing facility's July 1 direct care component rate allocation;

(ii) Comparing the April 1, 1999 direct care component rate allocation determined by applying the CMI used to determine the nursing facility's July 1 direct care component rate allocation with its direct care component rate allocation of September 30, 1998.

(iii) Adding the higher of the April 1, 1999 direct care component rate allocation based on the CMI used to set the July 1 direct care component rate allocation or the nursing facility's September 30, 1998 direct care component rate allocation to the remaining April 1, 1999 component rate allocations to establish the April 1, 1999 total rate allocation adjusted for case mix changes;

(iv) Comparing the April 1, 1999 total rate allocation adjusted for case mix changes pursuant to subsection (3)(a)(i), (ii), and (iii) of this section with the July 1 total rate allocation set pursuant to this chapter and chapter 74.46 RCW; and

(v) Determining an additional economic trends and conditions factor for the nursing facility when its April 1, 1999 total rate allocation adjusted for case mix changes pursuant to subsection (3)(a)(i), (ii), and (iii) of this section is greater than the facility's July 1 total rate allocation.

(b) The department will determine the additional economic trends and conditions factor by determining the percentage that the April 1, 1999 total rate allocation determined pursuant to subsection (3)(a)(i), (ii), and (iii) of this section is greater than the July 1 total rate allocation. The percentage is the additional economic trends and condition factor.

(c) For each nursing facility whose April 1, 1999 total rate allocation adjusted for case mix changes pursuant to subsection (3)(a) of this section is greater than its July 1 total rate allocation, the department will increase each of its July 1 component rate allocations by the nursing facility's additional economic trends and condition factor determined pursuant to subsection (3)(a) and (b) of this section. A nursing facility's additional economic trends and condition factor will be reduced proportionately by the percentage by which total supplemental payments to all nursing facilities would exceed the funds provided for such payments in the biennial appropriations act.

(d) The department will adjust by an additional economic trends and conditions factor determined pursuant to subsection (3)(a) and (b) of this section only the amount of a nursing facility's total rate allocation or its amended or updated total rate allocation that has not resulted from the nursing facility, under WAC 388-96-708, reinstating beds that were previously removed from service (i.e., banked) under chapter 70.38 RCW.

(4) For rate determinations through March 2000 only, after the initial determination under subsection (3) of this section of whether a nursing facility's July 1 total rate allocation will be adjusted by an additional economic trends and conditions factor, the department may amend or update a nursing facility's April 1, 1999 total rate allocation including any or all component rate allocations and/or its July 1 total rate allocation including any or all component rate allocations. If any amendments or updates occur, then the department will apply subsection (3) using the newly amended or updated April 1, 1999 total rate allocation and/or component rate allocation(s) and/or the amended or updated total rate allocation and/or component rate allocation(s).

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-714, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-714, filed 11/30/99, effective 12/31/99.]

WAC 388-96-723 How often will the department compare the statewide weighted average payment rate for the capital and noncapital portions of the rate for all nursing facilities with the statewide weighted average payment rate for the capital and noncapital portions of the rate identified in the Biennial Appropriations Act? (1) On a quarterly basis, the department will compare the statewide weighted average payment rate for the capital and noncapital portions of the rate for all nursing facilities with the statewide weighted average payment rate for the capital and noncapital portions of the rate identified in the biennial appropriations act.

(2) To determine the statewide weighted average payment rate for the capital and/or noncapital portion of the rate, the department will use total billed Medicaid days incurred in the calendar year immediately preceding the current fiscal year for the purpose of weighting the July 1 capital and/or noncapital rates that have been adjusted, or updated pursuant to chapter 74.46 RCW and this chapter.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-723, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-723, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-723, filed 9/25/98, effective 10/1/98.]

WAC 388-96-732 How will the department determine whether its notice pursuant to WAC 388-96-724 was timely? The department will deem the contractor to have received the department's notice five calendar days after the date on the notification letter, unless proof of the date of receipt of the department's notification letter exists, in which case the actual date of receipt will be used to determine timeliness of the notice.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-732, filed 5/29/01, effective 6/29/01.]

WAC 388-96-740 What will the department use as the Medicaid case mix index when a facility does not meet the ninety percent minimum data set (MDS) threshold as identified in RCW 74.46.501? (1) If the nursing facility is newly Medicaid certified after the quarter which will serve as the basis for the Medicaid case mix index, then the department must use the industry average Medicaid case mix index for the quarter specified in RCW 74.46.501 (7)(c) as the facility's Medicaid average case mix index.

(2) If the nursing facility does not meet the ninety percent MDS threshold for any other reason, then the department will use one as the Medicaid case mix index.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-740, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-740, filed 9/25/98, effective 10/1/98.]

WAC 388-96-776 Add-ons to the payment rate—Capital improvements. (1) The department shall grant an add-on to a payment rate for any capitalized additions or replacements made as a condition for licensure or certification; provided, the net rate effect is ten cents per patient day or greater.

(2) The department shall grant an add-on to a prospective rate for capitalized improvements done under RCW 74.46.431(12); provided, the legislature specifically appropriates funds for capital improvements for the biennium in which the request is made and the net rate effect is ten cents per patient day or greater. Physical plant capital improvements include, but are not limited to, capitalized additions, replacements or renovations made as a result of an approved certificate of need or exemption from the requirements for certificate of need for the replacement of existing nursing facility beds pursuant to RCW 70.38.115 (13)(a) or capitalized additions or renovations for the removal of physical plant waivers.

(3) Rate add-ons granted pursuant to subsection (1) or (2) of this section shall be limited in total amount each fiscal year to the total current legislative appropriation, if any, specifically made to fund the Medicaid share of such rate add-ons for the fiscal year. Rate add-ons are subject to the provisions of RCW 74.46.421.

(4) When physical plant improvements made under subsection (1) or (2) of this section are completed in phases, the department shall not grant a rate add-on for any addition, replacement or improvement until each phase is completed and fully utilized for the purpose for which it was intended. The department shall limit rate add-on to only the actual cost of the depreciable tangible assets meeting the criteria of RCW 74.46.330 and as applicable to that specific completed and fully utilized phase.

(5) When the construction class of any portion of a newly constructed building will improve as the result of any addition, replacement or improvement occurring in a later, but not yet completed and fully utilized phase of the project, the most appropriate construction class, as applicable to that completed and fully utilized phase, will be assigned for purposes of calculating the rate add-on. The department shall not revise the rate add-on retroactively after completion of the portion of the project that provides the improved construction class. Rather, the department shall calculate a new rate add-on when the improved construction class phase is completed and fully utilized and the rate add-on will be effective in accordance with subsection (9) of this section using the date the class was improved.

(6) The department shall not add on construction fees as defined in WAC 388-96-747 and other capitalized allowable fees and costs as related to the completion of all phases of the project to the rate until all phases of the entire project are completed and fully utilized for the purpose it was made. At that time, the department shall add on these fees and costs to the rate, effective no earlier than the earliest date a rate add-on was established specifically for any phase of this project. If the fees and costs are incurred in a later phase of the project, the add-on to the rate will be effective on the same date as the rate add-on for the actual cost of the tangible assets for that phase.

(7) The contractor requesting an adjustment under subsection (1) or (2) shall submit a written request to the office of rates management separate from all other requests and inquiries of the department, e.g., WAC 388-96-904 (1) and (5). A complete written request shall include the following:

(a) A copy of documentation requiring completion of the addition or replacements to maintain licensure or certification for adjustments requested under subsection (1) of this section;

(b) A copy of the new bed license, whether the number of licensed beds increases or decreases, if applicable;

(c) All documentation, e.g., copies of paid invoices showing actual final cost of assets and/or service, e.g., labor purchased as part of the capitalized addition or replacements;

(d) Certification showing the completion date of the capitalized additions or replacements and the date the assets were placed in service per RCW 74.46.360;

(e) A properly completed depreciation schedule for the capitalized additions or replacement as provided in this chapter;

(f) A written justification for granting the rate increase; and

(g) For capitalized additions or replacements requiring certificate of need approval, a copy of the approval and description of the project.

(8) The department's criteria used to evaluate the request may include, but is not limited to:

(a) The remaining functional life of the facility and the length of time since the facility's last significant improvement;

(b) The amount and scope of the renovation or remodel to the facility and whether the facility will be better able to serve the needs of its residents;

(c) Whether the improvement improves the quality of living conditions of the residents;

(d) Whether the improvement might eliminate life safety, building code, or construction standard waivers;

(e) Prior survey results; and

(f) A review of the copy of the approval and description of the project.

(9)(a) No rate add-on shall take effect more than sixty days before the office of rates management receives the initial written request and no earlier than the first of the month in which the physical plant improvements are completed and fully utilized.

(b) The following table indicates the effective date of an approved rate add-on in relation to the month in which the sixtieth day falls and the month that the project is completed and fully utilized:

The sixtieth day before the initial written request falls in:	The project is completed and fully utilized:	The effective date of the approved rate add-on:
(i) Any month before the month in which the project is completed and fully utilized.	In any month following the month in which the sixtieth day falls.	(A) When the project is completed and fully utilized before the sixteenth of the month, the effective date is the first of that month; or (B) When the project is completed and fully utilized after the fifteenth of the month, the effective date is the first of the month following the month in which the project is completed and fully utilized.
(ii) Any month after the month in which the project is completed and fully utilized.	In any month before the month in which the sixtieth day falls.	The first of the month following the month in which the sixtieth day falls unless the sixtieth day falls on the first of the month, then apply subsection (9)(b(i)(A) and (B).
(iii) The same month in which the project is completed and fully utilized.	In the same month in which the sixtieth day falls.	The first of the month following the month in which the sixtieth day and the project completion and utilization falls, unless the sixtieth day falls on the first of the month, then apply subsection (9)(b)(i)(A) and (B).

(10) If the initial written request is incomplete, the department will notify the contractor of the documentation and information required. The contractor shall submit the requested information within fifteen calendar days from the date the contractor receives the notice to provide the information. If the contractor fails to complete the add-on request by providing all the requested documentation and information within the fifteen calendar days from the date of receipt of notification, the department shall deny the request for failure to complete.

(11) If, after the denial for failure to complete, the contractor submits a written request for the same project, the date of receipt for the purpose of applying subsection (9) of this section will depend upon whether the subsequent request for the same project is complete, i.e., the department does not have to request additional documentation and information in order to make a determination. If a subsequent request for funding of the same project is:

(a) Complete, then the date of the first request may be used when applying subsection (9) of this section; or

(b) Incomplete, then the date of the subsequent request must be used when applying subsection (9) of this section even though the physical plant improvements may be completed and fully utilized prior to that date.

(12) The department shall respond, in writing, not later than sixty calendar days after receipt of a complete request.

(13) If the contractor does not use the funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

(14) When any physical plant improvements made under subsection (1) or (2) of this section results in a change in licensed beds, any rate add-on granted will be subject to the provisions regarding the number of licensed beds, patient days, occupancy, etc., included in this chapter and chapter 74.46 RCW.

(15) All rate components to fund the Medicaid share of nursing facility new construction or refurbishing projects costing in excess of one million two hundred thousand dollars, or projects requiring state or federal certificate of need approval, shall be based upon a minimum facility occupancy of eighty-five percent for the direct care, therapy care, support services, operations, property, financing allowance, and variable return component rate allocations, during the initial rate period in which the adjustment is granted. These same component rate allocations shall be based upon a minimum facility occupancy of eighty-five percent for all rate periods after the initial rate period.

(16) When a capitalized addition or replacement results in an increased licensed bed capacity during the calendar year following the capitalized addition or replacement:

(a) The department shall for:

(i) Property, use the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity; and

(ii) The financing allowance, multiply the net invested funds in accordance with WAC 388-96-748(3) and divide by the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity; and

(b) The anticipated resident occupancy for the increased number of beds must be at or above eighty-five percent. In all cases the department shall use at least eighty-five percent occupancy of the facility's increased licensed bed capacity.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-776, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-776, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(12) and RCW 74.46.800. 98-20-023, § 388-96-776, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.465. 97-17-040, § 388-96-776, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-776, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-776, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-776, filed 5/26/94, effective 6/26/94.]

WAC 388-96-777 Add-ons to the prospective rate—Initiated by the department. (1) The department shall initiate all rate add-ons granted under this section. Contractors may not request and be approved a rate add-on under this section.

(2) Rate add-ons the department grants under the authority of this section shall be for costs to implement:

(a) Program changes that the director of residential care services, aging and adult services administration determines a rate add-on is necessary to accomplish the purpose of the change and announces same in a written directive to the chief of the office of rates management; or

(b) Changes in either the state or federal statutes or regulations or directives that the director of management services, aging and adult services administration determines requires a

rate add-on to implement and directs in writing the chief of the office of rates management to implement.

(3) Changes made under this section are subject to review under WAC 388-96-901 and 388-96-904; provided, the issue is not whether a rate add-on should have been granted.

(4) If the contractor does not use the funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-777, filed 5/29/01, effective 6/29/01; 94-12-043 (Order 3737), § 388-96-777, filed 5/26/94, effective 6/26/94.]

WAC 388-96-780 Exceptional therapy care—Covered Medicaid residents. (1) The department will pay an exceptional therapy care rate to a nursing facility (NF) for a Medicaid resident who:

(a) Is less than sixty-five years of age;

(b) Does not qualify for Medicare;

(c) Has a functional need associated with a diagnosis of:

(i) Traumatic brain injury,

(ii) Stroke/cerebrovascular accident (CVA),

(iii) Paraplegia,

(iv) Quadriplegia, or

(v) Major multiple fractures;

(d) Resides in a NF that under WAC 388-96-779 is approved to provide exceptional therapy care; and

(e) Is assessed by a department case manager to be:

(i) Medically stable;

(ii) Physically and cognitively able to participate in the rehabilitation program;

(iii) Willing and able to participate in the rehabilitation program averaging a minimum of two hours per day, five days per week; and

(iv) Has an impairment in two or more of the following areas:

(A) Mobility and strength;

(B) Self-care/ADLs (activities of daily living);

(C) Communication;

(D) Continence-evacuation of bladder and/or bowel;

(E) Kitchen/food preparation-safety and skill;

(F) Cognitive/perceptual functioning; or

(G) Pathfinding skills and safety.

(2)(a) If a NF designated under WAC 388-96-779 wants exceptional therapy care payments for a Medicaid resident, then the NF will submit a request for exceptional therapy care payments on a department-supplied application. A complete exceptional therapy care payment application will include documentation that the Medicaid resident meets the criteria of subsection (1)(a) through (c) of this subsection. The department will:

(i) Review only complete applications; and

(ii) Return incomplete applications to the NF within five days of receipt.

(b) The department will respond to a NF requesting exceptional therapy care payments for a resident, in writing, no later than five working days after receipt of a complete application.

(i) If the department approves exceptional therapy care payments for a resident, the department will:

(A) Authorize five days of exceptional therapy care payments for observation of the resident's response to the intensive therapy;

(B) Conduct an on-site review during the five days of observation to determine whether the resident is an appropriate candidate for intensive therapy and that the NF has a viable plan to provide therapy averaging a minimum of two hours a day, five days per week; and

(C) Extend, when the department is unable to complete the on-site review during the five-day observation period, the exceptional therapy care payments until the department is able to complete the on-site review.

(ii) When the department determines a resident is:

(A) An appropriate candidate and the NF has a viable plan to meet the minimum hours and days of therapy, the department will authorize continuing exceptional therapy care payments; or

(B) An inappropriate candidate or the NF lacks a viable plan to meet the minimum hours and days of therapy, the department will discontinue the authorized days of payment per subsection (2)(b)(i) of this section effective the day after the on-site review and deny continuing exceptional therapy care payments beyond the day of the on-site review.

(iii) Before the conclusion of the on-site visit, the department will give the NF written confirmation of approval or denial of continuing exceptional therapy care payments.

(iv) All exceptional therapy care payments are contingent upon the resident being eligible for Medicaid. A NF may provide exceptional therapy care and/or seek approval for exceptional therapy care payments on residents for whom it does not have a Medicaid award letter because the determination of the resident's Medicaid eligibility is pending. If the resident is denied Medicaid coverage, then the department will not pay for any exceptional therapy care, including the authorized days per subsection (2)(b)(i) of this section.

(3)(a) For the Medicaid resident receiving exceptional therapy care, a NF must complete a FIM or department approved functional assessment measure for each exceptional therapy care Medicaid resident within:

(i) Five calendar days of initiation of the exceptional therapy care;

(ii) Fourteen calendar days of initiation of the exceptional therapy care;

(iii) Thirty calendar days of initiation of the exceptional therapy care;

(iv) Sixty calendar days of initiation of the exceptional therapy care;

(v) Ninety calendar days of initiation of the exceptional therapy care; and

(vi) At discharge or termination of the exceptional therapy care.

(b) The department case manager will review the FIM or the department approved functional assessment measure to determine whether the exceptional therapy care rate continues to be necessary. The department will terminate the exceptional therapy care rate for a Medicaid resident who has:

(i) Made no measurable improvement in rehabilitation as demonstrated by his/her assessments; or

(ii) Not participated in a rehabilitation program averaging a minimum of two hours per day, five days per week.

(c) The NF will notify the department of the date it discontinues exceptional therapy care to the Medicaid resident. If the NF discontinues the exceptional therapy care because it discharged the Medicaid resident, the NF will provide the department with the discharge disposition and date.

(4) The department will pay an exceptional therapy care rate up to a maximum of one hundred calendar days per episode. After one hundred calendar days per episode, the department will pay for any therapy treatment the Medicaid resident may receive under RCW 74.46.511.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-780, filed 5/29/01, effective 6/29/01. Statutory Authority: RCW 74.46.800, 74.46.508. 00-12-098, § 388-96-780, filed 6/7/00, effective 7/8/00.]

WAC 388-96-802 May the nursing facility (NF) contractor bill the department for a Medicaid resident's day of death, discharge, or transfer from the NF? No, the NF contractor may bill the department for the first day of a Medicaid resident's stay but not the last day.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-802, filed 5/29/01, effective 6/29/01.]

WAC 388-96-803 When a nursing facility (NF) contractor becomes aware of a change in the Medicaid resident's income and/or resources, must he or she report it? Yes, within seventy-two hours of becoming aware of a change in the Medicaid resident's income and/or resources, the NF contractor will report the change in writing to the home and community services office serving the area in which the NF is located. When reporting the change, the NF contractor will include copies of any available documentation of the change in the Medicaid resident's income and/or resources.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-803, filed 5/29/01, effective 6/29/01.]

WAC 388-96-901 Disputes. (1) If a contractor wishes to contest the way in which a statute or department rule relating to the nursing facility Medicaid payment system was applied to the contractor by the department, the contractor shall pursue the administrative review process prescribed in WAC 388-96-904.

(a) Adverse actions taken under the authority of this chapter or chapter 74.46 RCW subject to administrative review under WAC 388-96-904 include but are not limited to:

(i) Determining a nursing facility payment rate;

(ii) Calculating a nursing facility settlement;

(iii) Imposing a civil fine on the nursing facility;

(iv) Suspending payment to a nursing facility; or

(v) Refusing to contract with a nursing facility.

(b) Adverse actions taken under the authority of this chapter or chapter 74.46 RCW not subject to administrative review under WAC 388-96-904 include but are not limited to those taken under the authority of RCW 74.46.421 and sections of this chapter implementing RCW 74.46.421.

(2) The administrative review process prescribed in WAC 388-96-904 shall not be used to contest or review unrelated or ancillary department actions, whether review is sought to obtain a ruling on the merits of a claim or to make a record for subsequent judicial review or other purpose. If an issue is raised that is not subject to review under WAC 388-96-904, the presiding officer shall dismiss such issue with prejudice to further review under the provisions of WAC 388-96-904, but without prejudice to other administrative or judicial review as may be provided by law. Unrelated or ancillary actions not eligible for administrative review under WAC 388-96-904 include but are not limited to:

(a) Challenges to the adequacy or validity of the public process followed by department in proposing or making a change to the nursing facility Medicaid payment rate methodology, as required by 42 U.S.C. 1396a (a)(13)(A) and WAC 388-96-718;

(b) Challenges to the nursing facility Medicaid payment system that are based in whole or in part on federal laws, regulations, or policies;

(c) Challenges to a contractor's rate that are based in whole or in part of federal laws, regulations, or policies;

(d) Challenges to the legal validity of a statute or regulation;

(e) Issues relating to case mix accuracy review of minimum data set (MDS) nursing facility resident assessments, which shall be limited to separate administrative review under the provisions of WAC 388-96-905;

(f) Quarterly rate updates to reflect changes in a facility's resident case mix;

(g) Issues relating to any action of the department affecting a Medicaid beneficiary or provider that were not commenced by the office of rates management, aging and adult services administration, for example, entitlement to or payment for durable medical equipment or other services;

(h) Issues relating to exceptional therapy care and exceptional direct care programs codified at WAC 388-96-779 through 388-96-782; and

(i) Department actions taken under WAC 388-96-218 (2)(c).

(3) If a contractor wishes to challenge the legal validity of a statute or regulation relating to the nursing facility Medicaid payment system, or wishes to bring a challenge based in whole or in part on federal law, it must bring such action de novo in a court of proper jurisdiction as may be provided by law.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-901, filed 5/29/01, effective 6/29/01. Statutory Authority: RCW 74.46.800, 74.46.508. 00-12-098, § 388-96-901, filed 6/7/00, effective 7/8/00. Statutory Authority: RCW 74.46.780 as amended by 1998 c 322 § 41. 98-20-023, § 388-96-901, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-901, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 74.09.120. 91-12-026 (Order 3185), § 388-96-901, filed 5/31/91, effective 7/1/91. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-901, filed 10/13/82; Order 1262, § 388-96-901, filed 12/30/77.]

Chapter 388-105 WAC

MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICE RATES

WAC

WAC 388-105-0005 What are the daily Medicaid payment rates for contracted adult family home (AFH), adult residential care (ARC), and enhanced adult residential care (EARC) services? For contracted AFH, ARC, and EARC services, the department pays the following daily rates for care of a Medicaid resident:

Four level payment system rates for AFHs, ARCs, & EARCs			
Care Levels	Non-metropolitan	Metropolitan*	King Co.
Level 1	$44.94	$43.68	$43.68
Level 2	$47.84	$50.05	$55.42
Level 3	$55.40	$57.80	$63.96
Level 4	$66.66	$70.52	$76.67

*Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima Counties.

[Statutory Authority: 2001 c 7 § 206. 01-21-077, § 388-105-0005, filed 10/18/01, effective 11/18/01. Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0005, filed 6/29/01, effective 7/30/01.]

WAC 388-105-0010 What are care levels? The care levels correspond to the amount of assistance a Medicaid resident needs in performing unmet activities of daily living (ADL) and to meet additional unmet care needs. Level 1 represents minimal assistance with level 4 representing maximum assistance.

[Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0010, filed 6/29/01, effective 7/30/01.]

WAC 388-105-0015 How does the department determine whether the Medicaid resident needs assistance in completing ADLs and/or has unmet care needs? The department completes a comprehensive assessment (CA) to identify the assistance needed with unmet ADLs and other care needs of a Medicaid resident.

[Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0015, filed 6/29/01, effective 7/30/01.]

WAC 388-105-0020 How does the department determine at which care level the Medicaid resident will be placed? (1) The department assigns:

(a) Values from zero to three to any of the following unmet activities of daily living (ADL) that the Medicaid resident needs either minimal, substantial, or total assistance to complete: eating, toileting, ambulation, transfer, positioning, and bathing; and

(b) Points to the resident's health, psychological, social, behavioral and/or cognitive status.

(2) A Medicaid resident's total:

(a) ADL values can range from zero to sixteen; and

(b) Points can range from zero to three hundred fifty.

(3) The department determines the Medicaid resident's care level by combining his/her total ADL values and total points.

[Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0020, filed 6/29/01, effective 7/30/01.]

WAC 388-105-0025 How many ADL values and unmet care need points correspond to the four care levels? The following table illustrates the number of ADL values and points that the Medicaid resident's assessment must demonstrate to be assigned to one of the four levels of care:

Level	ADL values	Unmet care needs points
1	0	0-59
1	1	0-59
1	2	0-49
1	3	0-39
1	4	0-29
2	0	60-109
2	1	60-109
2	2	50-109
2	3	40-109
2	4	30-99
2	5-10	no points required
3	0-3	110+
3	4	100+
3	5	90+
3	6	80+
3	7	70+
3	8	60+
3	9	50-99
3	10	40-89
3	11-16	no points required
4	9	100+
4	10	90+
4	11	80+
4	12	70+
4	13	60+
4	14	50+
4	15	40+
4	16	30+

[Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0025, filed 6/29/01, effective 7/30/01.]

Chapter 388-148 WAC

LICENSING REQUIREMENTS FOR CHILD FOSTER HOMES, STAFFED RESIDENTIAL HOMES, GROUP CARE PROGRAMS/FACILITIES, AND AGENCIES

WAC

WAC 388-148-0005 What is the purpose of this chapter? The department issues or denies a license or certification on the basis of compliance with licensing requirements. This chapter defines general and specific licensing requirements for foster homes, staffed residential homes, group facilities, and child-placing agencies. We include licensing requirements for people who operate foster homes, group care programs and facilities, staffed residential homes, and child-placing agencies. In addition, we describe our requirements for specialized services offered in these homes and facilities, including: maternity services, day treatment services, crisis residential centers, services for children with severe developmental disabilities and programs for medically fragile children. Unless noted otherwise, these requirements apply to people who want to be licensed, certified, relicensed and recertified.

The department is committed to ensuring that the children who receive care experience health, safety, and well-being. We want these children's experiences to be beneficial to them not only in the short run, but also in the long term. Our licensing requirements reflect our commitment to children.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0005, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0010 What definitions do I need to know to understand this chapter? The following definitions are important to understand these rules:

"Abuse or neglect" means the injury, sexual abuse, sexual exploitation, negligent treatment or mistreatment of a child where the child's health, welfare and safety are harmed.

"Capacity" means the maximum number of children that a home or facility is licensed to care for at a given time.

"Care provider" means any licensed or certified person or organization that provides twenty-four-hour care for children.

"Case manager" means the private agency employee who coordinates the planning efforts of all the persons working on behalf of a child. They are responsible for implementing the child's case plan, assisting in achieving those goals, and assisting with day-to-day problem solving.

"Certification" means:

(1) Department approval of a person, home, or facility that does not legally need to be licensed, but wishes to have evidence that they met the minimum licensing requirements; or

(2) Department licensing of a child-placing agency to certify a foster home and/or a group care program meets licensing requirements.

"Children" or **"youth,"** means individuals who are:

(1) Under eighteen years old, including expectant mothers under eighteen years old; or

(2) Up to twenty-one years of age and enrolled in high school, equivalent course of study, GED, or educational program;

(3) Up to twenty-one years of age with developmental disabilities; or

(4) Up to twenty-one years of age if under the custody of the Washington state juvenile rehabilitation administration.

"Child-placing agency" means an agency licensed to place children for temporary care, continued care or adoption.

"Crisis residential center (CRC)" means an agency under contract with DSHS that provides temporary, protective care to children in a foster home, regular (semisecure) or secure group setting.

"Compliance agreement" means a written licensing improvement plan to address specific skills, abilities or other issues of a fully licensed home or facility to maintain and/or increase the safety and well-being of children in their care.

"DCFS" means the division of children and family services.

"DDD" means division of developmental disabilities.

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

"Developmental disabilities" means the language used by DSHS, division of developmental disabilities as defined in RCW 71A.10.020.

"DLR" means the division of licensed resources.

"Firearms" means guns or weapons, including but not limited to the following: BB guns, pellet guns, air rifles, stun guns, antique guns, bows and arrows, handguns, rifles, and shotguns.

"Foster-adopt" means placement of a child with a foster parent(s) who intends to adopt the child, if possible.

"Foster home or foster family home" means person(s) regularly providing care on a twenty-four-hour basis to one or more children in the person's home.

"Full licensure" means an entity meets the requirements established by the state for licensing or approved as meeting state licensing requirements.

"Group care facility for children" means a location maintained and operated for a group of children on a twenty-four-hour basis.

"Hearing" means the department's administrative review process.

"I" refers to anyone who operates or owns a foster home, staffed residential home, and group facilities, including group homes, child-placing agencies, maternity homes, day treatment centers, and crisis residential centers.

"Infants" means children under one year of age.

"License" means a permit issued by the department affirming that a home or facility meets the licensing requirements.

"Licensor" means:

(1) A division of licensed resources (DLR) employee at DSHS who:

(a) Approves licenses or certifications for foster homes and group facilities; and

(b) Monitors homes and facilities to ensure that they continue to meet health and safety requirements.

(2) An employee of a child-placing agency who:

(a) Attests that a foster home and/or group home facility supervised by the child-placing agency meets licensing requirements; and

(b) Monitors the homes and facilities to ensure they continue to meet the licensing standards for the health and safety of the children in care.

"Maternity service" means an individual, program or facility providing or arranging for care for:

(1) Expectant mothers before and during pregnancy; and

(2) Mothers and their infants after pregnancy.

These services are provided to mothers who are under eighteen years of age.

"Medically fragile" means the condition of a child who has a chronic illness or severe medical disabilities requiring regular nursing visits, regular medical check-ups, or under a physician's care.

"Multidisciplinary teams (MDT)" means groups formed to assist children who are considered at-risk youth or children in need of services, and their parents.

"Nonambulatory" means not able to walk.

"Nonmobile" refers to children who are not yet walking, are unable to walk, or unable to use a wheelchair or other device to move about freely.

"Out-of-home placement" means a child's placement in a home or facility other than the child's parent, guardian, or legal custodian.

"Premises" means a facility's buildings and adjoining grounds that are managed by a person or agency in charge.

"Probationary license" means a license issued as a disciplinary measure to an individual or agency that has previously been issued a full license but is out of compliance with licensing standards.

"Psychotropic medication" means a type of medicine that is prescribed to affect or alter thought processes, mood, sleep, or behavior. These include anti-psychotic, antidepressants and anti-anxiety medications.

"Relative" means a person who is related to the child as defined in RCW 74.15.020 (4)(a)(i), (ii), (iii), and (iv) only.

"Respite" means brief, relief care provided to foster parents with the respite provider fulfilling some or all of the functions of the care-taking responsibilities of the foster parent.

"Secure facilities" means a crisis residential center that has locking doors and windows, or secured perimeters intended to prevent children from leaving without permission.

"Severe developmental disabilities" means significant disabling, physical and/or mental condition(s) that cause a child to need external support for self-direction, self-support and social participation.

"Social service staff" means child placing agency or group care program staff who is an employee of the agency or hired to provide consultation on developing and implementing the child's individual service and treatment plans.

"Staffed residential home" means a licensed home providing twenty-four-hour care for six or fewer children or expectant mothers. The home may employ staff to care for children or expectant mothers. It may or may not be a family residence.

"We" or **"our"** refers to the department of social and health services, including DLR licensors and DCFS social workers.

"You" refers to anyone who operates a foster home, staffed residential home, and group facilities, including group homes, maternity programs, day treatment programs, crisis residential centers, and child-placing agencies.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0010, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0015 Am I required to have a license to provide care to children? (1) If you regularly provide care to a child who is not related to you, you must be licensed.

(2) The types of homes or facilities that need a license include:

(a) Foster homes;

(b) Group care programs;

(c) Programs for medically fragile children and children with severe developmental disabilities;

(d) Maternity services;

(e) Day treatment programs;

(f) Crisis residential centers;

(g) Staffed residential homes; and

(h) Child-placing agencies.

Note: Homes and facilities offering maternity services, day treatment, crisis residential centers, services to medically fragile children and/or children with severe developmental disabilities will need to follow the specific program requirements outlined in this chapter as well.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0015, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0020 When is a license not required if I provide care to children? The department does not require licenses for people providing care in any of the situations as defined in RCW 74.15.020(2).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0020, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0025 How do you decide how many children I may serve in my home or facility? (1) The department approves the number of children that a home or facility may serve, based on an evaluation of these factors:

(a) Physical accommodations in your home or facility;

(b) The number of staff, family members and volunteers available for providing care;

(c) Your skills and the skills of your staff; and

(d) The ages and characteristics of the children you are serving.

(2) Based on the evaluation, the department may license you for the care of fewer children than you normally would serve in your category of care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0025, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0030 How old do I have to be to apply for a license to provide care to children? You must be at least twenty-one years old to apply for a license to provide care to children.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0030, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0035 What personal characteristics do I need to provide care to children? If you are requesting a license, certification, or a position as an employee, volunteer, intern, or contractor in a foster home, group care facility, staffed residential home, or child-placing agency you must have the following specific personal characteristics:

(1) You must demonstrate that you have the understanding, ability, physical health, emotional stability and personality suited to meet the physical, mental, emotional, and social needs of the children under your care.

(2) You must not have been disqualified by our background check (chapter 388-06 WAC) prior to having unsupervised access to children.

(3) You must have the ability to furnish the child with a nurturing, respectful, supportive, and responsive environment.

(4) The department may require you to give additional information. We may request this information at any time and it may include, but is not limited to:

(a) Substance and alcohol abuse evaluations and/or documentation of treatment;

(b) Psychiatric evaluations;

(c) Psycho-sexual evaluations; and

(d) Medical evaluations and/or medical records.

(5) Any evaluation requested under WAC 388-148-0035 (4)(a)-(d) will be at the applicant/licensees expense.

(6) The licensor must be given permission to speak with the evaluator/provider prior to and after the evaluation.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0035, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0040 What first aid training is required? You and your staff must have the following first-aid training:

(1) If you have a home or facility that provides care, the care givers must have current training in:

(a) Basic standard first aid; and

(b) Age-appropriate cardiopulmonary resuscitation (CPR).

(2) Approved first aid and CPR training must be in accordance with a nationally recognized standard such as the American Red Cross or American Heart Association.

(3) For any facilities other than foster homes, the person with first aid and CPR training must be on the premises at all times when children are present.

(4) The requirement for CPR training may be waived for persons with a statement from their physician that the training is not advised for medical reasons.

(5) You must keep records in your home or facility showing who has completed current first aid and CPR training.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0040, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0045 What HIV/AIDS training is required? (1) You must provide or arrange for training for yourself and any of your staff on the prevention, transmission, and treatment of HIV and AIDS. Such training must include infection control requirements.

(2) You must use infection control requirements and educational material consistent with the approved curriculum *Know - HIV/AIDS Prevention Education for Health Care Facility Employees*, published by the department of health, office on HIV/AIDS.

(3) The staff of group care programs are required to complete blood borne pathogen training.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0045, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0050 How do I apply for a license? To apply for a license, the person or legal entity responsible for your home or facility must follow these procedures:

(1) You must send the application form to your licensor at DLR or a child-placing agency.

(2) With the application form, you must send the following information:

(a) Written verification for each applicant of:

(i) A tuberculosis test or x-ray unless you can demonstrate religious reasons prohibiting the test;

(ii) First-aid and cardio-pulmonary resuscitation (CPR) training appropriate to the age of the children in care; and

(iii) HIV/AIDS training including infection control standards.

(b) A completed background check form for each applicant, family member, staff person, board member, intern or volunteer who:

(i) Is at least sixteen years old;

(ii) Is not a foster child; and

(iii) Has unsupervised access to children (see chapter 388-06 WAC).

(c) If you have lived in Washington state less than three years, you must provide us with a completed FBI fingerprint form.

(d) We may require additional information from you including, but not limited to:

(i) Substance and alcohol abuse evaluations and/or documentation of completed treatment;

(ii) Psychiatric evaluations;

(iii) Psycho-sexual evaluations; and

(iv) Medical evaluations and/or medical records.

(3) Except foster homes, if you are applying for a license renewal, you must send the application form to your licensor

at least ninety days prior to the expiration of your current license.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0050, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0055 How long do I have to complete the licensing application packet? You must complete your licensing application with supporting documents, such as training certificates, within ninety days of first applying for your license. If you fail to meet this deadline and have not contacted your licensor, your licensor may consider your application withdrawn.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0055, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0060 When am I not allowed to receive a license from a child-placing agency? (1) You or your relatives, are not allowed to be certified by a child-placing agency if you or your relative is in an administrative or supervisory role or directly involved in certification, placement, or authorization of payment to yourself or your relative for that same child-placing agency.

(2) You or your relative may apply to a different child-placing agency for a license.

(3) Licensed foster parents who become employed by the department or a child-placing agency must be relicensed through an agency other than their employer within six months of employment.

Note: Relative as defined under RCW 74.15.020 (4)(i) through (iv).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0060, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0065 When may I be certified to provide care to children? You may apply for certification of your home or facility by the department rather than a license, if you:

(1) Are exempt from needing a license (per chapter 74.15 RCW);

(2) Meet the licensing requirements; and

(3) Wish to serve department-funded children.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0065, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0070 Is there a difference between licensing and certification? (1) The department has the sole legal authority to license or approve homes and facilities for the care of children in out-of-home placement.

(2) The department may license a child-placing agency, including a Tribal CPA, to operate foster home and/or group care facilities.

(3) The child-placing agency is only authorized to "certify" or attest to the department that the home or facility meets the licensing requirements.

(4) The licensing and certification requirements are the same and are contained in this chapter.

(5) The department has the final approval for licensing the home or facility that the CPA will be supervising.

(6) The department's representative signs the license of the home or facility.

(7) A home "certified" by a child-placing agency (CPA) and licensed by the department must be supervised by that CPA to have a valid license to care for children.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0070, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0075 May I be licensed with the department and a child-placing agency at the same time? You may not be licensed to provide care to children at the same time by both the department and a child-placing agency.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0075, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0080 What may I do if I disagree with the decision of a child-placing agency that I do not meet the licensing requirements? If you disagree with the child-placing agency's decision, you must abide by the child-placing agency's grievance process to challenge the decision.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0080, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0085 Will the department license or continue to license a home or facility if the home or facility does not meet the licensing requirements? (1) At its discretion, the department may make exceptions and license or continue to license a home or facility that does not meet the minimum licensing requirements.

(2) Exceptions are approved for nonsafety requirements only.(3) The safety and well-being of the children receiving care must not be compromised.

(4) The request for an exception to the licensing requirements must be in writing.

(5)You must keep a copy of the approved exception to the licensing requirements for your files.

(6) Along with an exception to the licensing requirements, the department may limit or restrict a license issued to you and/or require you to enter into a compliance agreement to ensure the safety and well-being of the children in your care.

(7) You do not have appeal rights if the department denies your request for an exception to our requirements.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0085, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0090 Does the department issue probationary license? (1) The department may issue a probationary license as part of a corrective action plan with a licensed provider.

(2) The department must base its decision as to whether a probationary license will be issued on the following:

(a) Intentional or negligent noncompliance with the licensing rules;

(b) A history of noncompliance with the rules;

(c) Current noncompliance with the rules;

(d) Evidence of a good faith effort to comply; and

(e) Any other factors relevant to the specific situation.

(3) A probationary license may be issued for up to six months. At its discretion, the department may extend the probationary license for an additional six months.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0090, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0095 When are licenses denied, suspended or revoked? (1) A license must be denied, suspended or revoked if the department decides that you cannot provide care for children in a way that ensures their safety, health and well-being.

(2) The department must, also, disqualify you for any of the reasons that follow.

(a) You have been disqualified by your background check (see chapter 388-06 WAC).

(b) You have been found to have committed child abuse or neglect or you treat, permit or assist in treating children in your care with cruelty, indifference, abuse, neglect, or exploitation, unless the department determines that you do not pose a risk to a child's safety, well-being, and long-term stability.

(c) You or anyone living on the premises had a license denied or revoked from an agency that provided care to children or vulnerable adults.

(d) You try to get a license by deceitful means, such as making false statements or leaving out important information on the application.

(e) You commit, permit or assist in an illegal act on the premises of a home or facility providing care to children.

(f) You are using illegal drugs, or excessively using alcohol and/or prescription drugs.

(g) You knowingly allowed employees or volunteers who made false statements on their applications to work at your agency.

(h) You repeatedly lack qualified or an adequate number of staff to care for the number and types of children under your care.

(i) You have refused to allow our authorized staff and inspectors to have requested information or access to your facility, child and program files, and/or your staff and clients.

(j) You are unable to manage the property, fiscal responsibilities, or staff in your agency.

(k) You have failed to comply with the federal and state laws for any Native American children that you have under care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0095, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0100 Are there any other reasons that might cause me to lose my license? (1) The department may suspend or revoke your license if you exceed the conditions of your home or facility license by:

(a) Having more children than the license allows;

(b) Having children with ages different than the license allows;

(c) Failing to provide a safe, healthy and nurturing environment for children under your care;

(d) Failing to comply with any of our other licensing requirements; or

(e) Failing to meet the health and safety requirements to receive a certificate of compliance as required by the department of health and/or office of the state Fire Marshal.

(2) The department must suspend your license to provide care to children, if we receive a notice from the division of child support that you are not in compliance with a support order.

Note: The governing authority is RCW 43.20A.205 and 74.20A.320.

(3) The suspension of your license for noncompliance of a support order would be effective the date you receive a notice that we received the certificate of noncompliance from the division of child support.

(4) Your license would remain suspended until you provide proof that you are in compliance with the child support order.

(5) You would not have a right to an administrative hearing based on a suspension of your license due to noncompliance of a child support order.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0100, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0105 How do you notify me if you have modified, denied, suspended, or revoked my license? The department sends you a certified letter informing you of the decision to modify, deny, suspend or revoke your license. In the letter, the department also tells you what you need to do if you disagree with the decision.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0105, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0110 What may I do if I disagree with your decision to modify, deny, suspend or revoke my license? You have the right to appeal any decision the department makes to deny, modify, suspend, or revoke your license.

(1) You may request a department administrative hearing to disagree with the department's decision to modify, suspend, revoke or deny your license.

(2) You must request a department administrative hearing within twenty-eight days of receiving a certified letter with the department's decision (see chapter 34.05 RCW).

(3) You must send a letter to the office of administrative hearings, P.O. Box 42489, Olympia, Washington 98504-2489, 1-800-583-8271 requesting an administrative hearing. The letter must have the following attachments:

(a) A specific statement of your reasons for disagreeing with the department decision and any laws that relate to your reasons; and

(b) A copy of the certified letter from the department that you are disputing.

(4) The administrative hearing will take place before an employee of the office of administrative hearings.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0110, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0115 May I appeal the decision of the office of administrative hearings' administrative law judge? (1) The decision of the administrative law judge

(ALJ) will become the final decision of the department, unless either you or the department files a petition for review with DSHS board of appeals within twenty-one days after the administrative law judge's initial decision is mailed to the parties.

(2) The procedure for requesting, or responding to, a petition for review with the board of appeals is in WAC 388-02-0560 through 388-02-0635.

(3) If either party asks for a review, the decision of the board of appeals review judge will be the department's final decision.

(4) If you disagree with the decision of the board of appeals, you may file a petition in superior court and ask for judicial review. The procedure for judicial review is in RCW 34.05.510 to 34.05.598.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0115, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0120 What incidents involving children must I report? (1) You or your staff must report any of the following incidents immediately and in no instance later than forty-eight hours to your local children's administration intake staff:

(a) Any reasonable cause to believe that a child has suffered child abuse or neglect;

(b) Any violations of the licensing or certification requirements;

(c) Death of a child;

(d) Any child's suicide attempt that results in injury requiring medical treatment or hospitalization;

(e) Any use of physical restraint that is alleged improper or excessive;

(f) Sexual contact between two or more children that is not considered typical play between preschool age children;

(g) Any disclosures of sexual or physical abuse by a child in care;

(h) Physical assaults between two or more children that result in injury requiring off-site medical treatment or hospitalization;

(i) Unexpected health problems that require off-site medical treatment;

(j) Any medication that is given incorrectly and requires off-site medical treatment;

(k) Serious property damage that is a safety hazard and is not immediately corrected; or

(l) Any emergent medical care.

(2) You or your staff must report immediately or in no instance later than forty-eight hours, any of the following incidents to the child's social worker, if the child is in the department's custody:

(a) Suicidal/homicidal ideations, gestures, or attempts that do not require professional medical treatment;

(b) Unexpected health problems that do not require professional medical treatment;

(c) Any incident of medication incorrectly administered;

(d) Physical assaults between two or more children that result in injury but did not require professional medical treatment;

(e) Runaways; and

(f) Use of physical restraints for routine behavior management.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0120, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0125 What are your requirements for keeping client records? (1) Any identifying and personal information about a child and the child's family must be kept confidential.

(2) You must keep records about children and their families in a secure place. If the child is in the department's custody, at the end of the child's placement, reports written by others about the child or the child's family must be returned to the child's social worker.

(3) During a placement in your foster home, your records must be kept at your home and contain, if available, at a minimum, the following information:

(a) The child's name, birth date, and legal status;

(b) Name and telephone number of the social worker for each child in care;

(c) Names, address and telephone numbers of parents or persons to be contacted in case of emergency;

(d) Information on specific cultural needs of the child;

(e) Medical history including any medical problems, name of doctor, type of medical coverage and provider;

(f) Mental health history and any current mental health and behavioral issues, including medical and psychological reports when available;

(g) Other pertinent information related to the child's health;

(h) Record of immunizations. Receiving and interim care homes and facilities do not need to keep records of immunizations for children in their care less than thirty days. Crisis residential centers do not need to keep records of immunizations for children in their care;

(i) Child's school records, report cards, school pictures, and individual education plans (IEP);

(j) Special instructions including supervision requirements and suggestions for managing problem behavior;

(k) Inventory of personal belongings at the time of placement; and

(l) The child's visitation plan.

(4) During a child's placement in a staffed residential home or a group care program, your records must be kept at your site and contain, at a minimum, the following information in addition to the information in subsection (3)(a) through (l) of this section:

(a) Written consent from the child placing agency, if any, for providing medical care and emergency surgery (unless that care is authorized by a court order);

(b) Names, addresses, and telephone numbers of persons authorized to take the child under care out of the facility;

(c) A copy of the court order or voluntary placement agreement that gives approval to place the child;

(d) Case plans, such as children's administration's "individual service and safety plan;" and

(e) Daily logs of therapy treatment received by children with the signature of the person making the entry in the log.

(5) If you operate a group care program, staffed residential home, or child-placing agency and have client files with

information not returned to the department, you must keep them for six years following the termination or expiration of any contract you have with the department.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0125, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0130 What information may I share about a child or a child's family? (1) Information about a child or the child's family is confidential and must only be shared with people directly involved in the case plan for a child. Confidential information must not be shared with:

(a) Friends,

(b) Relatives,

(c) Neighbors.

(2) You may discuss information about the child, the child's family and the case plan only with:

(a) A representative of the department, including staff from DCFS and DLR; department of health and the office of the state fire marshal;

(b) A child-placing agency case manager assigned to the child;

(c) The child's assigned guardian ad litem or court-appointed special advocate; or

(d) Others designated by the child's social worker.

(3) You may check with your child's social worker for guidance about sharing information with the child's teacher, counselor or doctor, respite care provider or any other professional.

(4) Child-placing agencies and the department must share with the child's care provider any information about the child and child's family related to the case plan.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0130, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0135 What changes to my home or facility must I report to my licensor? (1) You must report to your licensor immediately any changes in the original licensing application. Changes include any of the following:

(a) Changes in your location or designated space, including address;

(b) Changes in your phone number;

(c) Changes in the maximum number, age ranges, and sex of children you wish to serve;

(d) Changes in the structure of your facility or premises from events causing damage, such as a fire, or from remodeling;

(e) Addition of any new staff person, employee, intern, contractor, or volunteer, who might have unsupervised contact with the children in care; or

(f) Changes in household composition, such as:

(i) A marriage, separation or divorce;

(ii) Incapacity or serious illness of a foster parent or member of the household;

(iii) The death of anyone in the household;

(iv) A change in employment status or significant change in income; or

(v) A change in who resides in the household or is on the premises for more than fourteen days.

(2) A license is valid only for the person or organization named on the license at a specific address. If you operate a group facility or child-placing agency, you must also report any of the following changes to your licensor:

(a) A change of your agency's executive director or any staff changes;

(b) The death, retirement, or incapacity of the person who holds the license;

(c) A change in the name of a licensed corporation, or the name by which your facility is commonly known; or

(d) Changes in an agency's articles of incorporation and bylaws.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0135, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0140 What personnel policies must I have? You must follow the personnel requirements listed below, at any home or facility we license.

(1) Each employee, intern, contractor, or volunteer who has unsupervised access to children must have completed an application for employment and signed a form enabling us to do a background check (chapter 388-06 WAC).

(2) Misrepresentation by the prospective employee, interns, or volunteer will be grounds for termination or denial of employment or volunteer service.

(3) If you have five or more staff, volunteers, or interns you must have written policies covering qualifications, training, and duties for employees, interns, and volunteers.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0140, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0145 Where do I post my license? (1) Foster home parents do not need to post their license.

(2) If you operate any other kind of home, facility, or agency you must post your license where the public can easily view it.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0145, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0150 Are local ordinances part of your licensing requirements? (1) Local ordinances (laws), such as zoning regulations and local building codes, fall outside the scope of our licensing requirements.

(2) We may require you to provide proof that you have met local ordinances.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0150, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0155 What physical structure safety requirements must my home or facility meet? You must keep the equipment and the physical structures in your home or facility safe and clean for the children you serve. You must:

(1) Maintain your buildings, premises, and equipment in a clean and sanitary condition, free of hazards, and in good repair;

(2) Provide handrails for steps, stairways, and ramps; if required by the department;

(3) Have emergency lighting devices available and in operational condition;

(4) Furnish your home or facility appropriately, based on the age and activities of the children under care.

(5) Have washable, water-resistant floors in your home or facility bathrooms, kitchens, and any other rooms exposed to moisture. The department may approve washable, short-pile carpeting that is kept clean and sanitary for your home or facility's kitchens.

(6) All homes and facilities must provide tamper proof or tamper resistant electrical outlets or blank covers installed in areas accessible to children under the age of six or other persons with limited mental capacity or who might be endangered by access to them.

(7) Have easy access to rooms occupied by children in case an emergency arises. Some examples are bedrooms, toilet rooms, shower rooms, and bathrooms.

(8) Except for foster homes, have posted a written disaster plan for emergencies such as fire and earthquakes.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0155, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0160 What measures must I take for pest control? You must make reasonable attempts to keep the premises free from pests, such as rodents, flies, cockroaches, fleas, and other insects using the least toxic methods.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0160, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0165 Do I need to be concerned about the location of my home or facility? (1) Your address must be clearly visible on the home, facility, or mailbox so that firefighters or medics can easily find your location.

(2) Your home or facility must be accessible to emergency vehicles.

(3) Your home or facility must be located on a well-drained site, free from hazardous conditions. The safety of the children in care is paramount. You must discuss with the licensor any potential hazardous conditions, considering the children's ages, behaviors, and abilities.

(4) A supervision plan must be written for the children in care if it is decided that hazardous conditions are present. Some examples of hazards are natural or man-made water hazards such as lakes or streams, steep banks, ravines, and busy streets.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0165, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0170 What steps must I take to ensure children's safety around outdoor bodies of water? (1) You must ensure children in your care or placed in your home or facility are safe around bodies of water.

(2) You must daily empty and clean any portable wading pool that children use.

(3) Children under twelve must be in continuous visual or auditory range at all times when they are swimming, wading, or boating by an adult with current age appropriate first aid and CPR.

(4) You must ensure age and developmentally appropriate supervision of any child that uses hot tubs, swimming pools, spas, and around man-made and natural bodies of water.

(5) You must lock hot tub and spa areas when they are not in use.

(6) You must place a fence designed to discourage climbing and have a locking gate around a pool. The pool must be inaccessible to children when not in use.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0170, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0175 What are your requirements regarding pets and animals in my home or facility? (1) In a foster home, staffed residential home, or group care facility, you must not have any common household pets, exotic pets, animals, birds, insects, reptiles, or fish that are dangerous to the children in care.

(2) The department, at its discretion, may limit the type and number of common household pets, exotic pets, animals, birds, insects, reptiles or fish accessible to children if the department determines there are risks to the children in care.

(3) You must ensure that common household pets, exotic pets, animals, birds, insects, reptiles, and fish are free from disease and cared for in a safe and sanitary manner.

(4) Common household pets, exotic pets, animals, birds, insects, reptiles, and fish must be cared for in compliance with state regulations and local ordinances.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0175, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0180 Are alcoholic beverages allowed at my home or facility? (1) In a foster home, you may have alcoholic beverages on the premises as long as they are inaccessible to children.

(2) Any other facility must not have alcohol on the premises. The staff of these facilities may not consume alcohol on the premises or during breaks.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0180, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0185 Is smoking permitted around children? (1) You must prohibit smoking in the living space of any home or facility caring for children and in motor vehicles while transporting children.

(2) You may permit adults to smoke outdoors away from children.

(3) Nothing in this section is meant to interfere with traditional or spiritual Native American ceremonies involving the use of tobacco.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0185, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0190 May I have firearms in my home or facility? (1) Except for foster homes, you must not permit firearms, ammunition, and other weapons on the premises of homes or facilities that provide care to children.

(2) If you are licensed as a foster home, firearms, ammunition, and other weapons must be kept in locked container, gun cabinet, gun safe, or another storage area made of strong, unbreakable material when not in use.

(a) If the storage cabinet has a glass or another breakable front, the guns must be secured with a locked cable or chain placed through the trigger guards.

(b) Ammunition must be stored in a place that is separate from weapons or locked in a gun safe.

(c) Weapons and ammunition must be accessible only to authorized persons.

(3) You may allow a child to use a firearm only if:

(a) The child's social worker approves;

(b) Competent adults are supervising use; and

(c) The youth has completed an approved gun safety or hunter safety course.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0190, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0195 What are your requirements for storing dangerous chemicals or other substances? (1) You must store the following items in a place that is not accessible to preschool children or other persons with limited mental capacity or who might be endangered by access to these products:

(a) Cleaning supplies;

(b) Toxic or poisonous substances;

(c) Aerosols; and

(d) Items with warning labels.

(2) When containers are filled with toxic substances from a stock supply, you must label containers filled from a stock supply.

(3) Toxic substances must be stored separately from food items.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0195, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0200 Do I need first-aid supplies? (1) You must keep first aid supplies on hand for immediate use, including unexpired syrup of ipecac that is to be used only when following the instruction of the poison control center.

(2) The following first aid supplies must be kept on hand:

(a) Barrier gloves and one-way resuscitation mask;

(b) Bandages;

(c) Scissors and tweezers;

(d) Ace bandage;

(e) Gauze; and

(f) Thermometer.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0200, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0205 What requirements are there for the storage of medications? (1) You must keep all medications, including pet medications, vitamins and herbal remedies, in locked storage.

(2) Pet and human medications must be stored in separate places.

(3) You must store external medications separately from internal medications.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0205, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0210 What requirements do I need to follow when I transport children? When you transport children under your care, you must follow these requirements.

(1) The vehicle must be kept in a safe operating condition.

(2) The driver must have a valid driver's license.

(3) There must be at least one adult other than the driver in a vehicle when:

(a) There are more than five preschool-aged children in the vehicle;

(b) Staff-to-child ratio guidelines or your contract require a second staff person; or

(c) The child's specific needs require a second adult person.

(4) The driver or owner of the vehicle must be covered under an automobile liability and insurance policy.

(5) Your vehicles must be equipped with, seat belts, car seats and booster seats, and/or other appropriate safety devices for all passengers as required by law.

(6) The number of passengers must not exceed the vehicle's seat belts.

(7) Buses approved by the state patrol are not required to have seat belts.

(8) All persons in the vehicle must use seat belts or approved child passenger restraint systems, as appropriate for age, whenever the vehicle is in motion.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0210, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0215 May I use wheeled baby walkers? The department prohibits the use of wheeled baby walkers in foster homes and facilities.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0215, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0220 What fire safety requirements must I follow to qualify for a license? (1) If you operate a program or facility other than a foster home, staffed residential home, or child-placing agency, you must follow the regulations developed by the Washington State Fire Marshal's office. The regulations are minimum requirements for protecting life and property against fire. You can find these contained in the current Uniform Fire Code with Washington state amendments.

(2) Foster homes and staffed residential homes need inspections by fire marshal or local fire department if either:

(a) Licensors request the inspections; or

(b) Local ordinances require these inspections.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0220, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0225 What fire safety requirements are there for exits? You must comply with the fire safety requirements that follow concerning exists from homes and facilities.

(1) Exit doors and rescue windows must be easily opened to the fully open position from the inside without requiring a key or special instructions.

(2) Locks on outside exit doors must automatically unlock when the doorknob is turned from the inside.

(3) Except in foster homes, night latches, dead bolts, security chains, manually operated edge or surface-mounted flush bolts and surface bolts must not be used.

(4) Each home and facility must have at least one swinging exit door that is pivoted or hinged on the side.

(5) Other exit doors in your home or facility may be sliding doors.

(6) Each home or facility must have two exits, located at opposite ends of the building or one on each floor. The requirement for one of the two exits may be deleted if:

(a) A residential sprinkler system (complying with the state fire Marshal standards) is provided throughout the entire building; and

(b) The remaining exit is a door.

(7) Every occupied area must have access to at least one exit that does not pass through rooms or spaces that can be locked or blocked from the opposite side.

(8) Obstacles must not be placed in corridors, aisles, doorways, exit doors, stairways, ramps, or rescue windows.

(9) Barriers to exiting must be restricted to gates or other approved devices that are easily opened and do not delay exiting.

(10) Stoves or heaters must not block escape or exit routes.

(11) Flammable, combustible, or poisonous material must be stored away from exits and away from areas that are accessible to children under care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0225, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0230 Are there other fire safety requirements for inside a home or facility? You must comply with the fire safety requirements that follow.

(1) Every room used by children under care must have easy entry and exit, including one of these features:

(a) Two separate doors; or

(b) One door leading to an exit; and

(c) A window that opens to the outside and is large enough for emergency escape or rescue.

(2) No space may be lived-in by the children in care that is accessible only by a ladder, folding stairs, or a trap door.

(3) Every bathroom door lock must be designed to permit the opening of the locked door from the outside.

(4) Every closet door latch must designed to be opened from the inside.

(5) Open-flame devices and fireplaces, heating and cooking appliances, and products capable of igniting clothing must not be left unattended or used incorrectly.

(6) Fireplaces, wood stoves and other heating systems that have a surface hot enough to cause a burn must have a barrier to prevent access by children under age six years.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0230, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0235 What are your requirements for smoke detectors? (1) You must place a smoke detector in good working condition in each bedroom or in areas close to where children sleep, such as a hallway. If the smoke detector is mounted on the wall, it must be twelve inches from the ceiling and a corner.

(2) If a sleeping or napping room has a ceiling height that is at least twenty-four inches higher than its adjoining hallway, you must install a smoke detector in both the hallway and the sleeping or napping room.

(3) In foster homes, if questions arise concerning fire danger, the local fire protection authority must be consulted.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0235, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0240 What are your requirements for fire extinguishers? (1) You must have readily available at least one approved 2A10BC-rated or larger all purpose (ABC) fire extinguisher.

Note: Approved 2A10BC-rated means a fire extinguisher with an Underwriters' Laboratory label on the nameplate classifying the extinguisher as 2A10BC-rated. These extinguishers are usually multi-purpose, five-pound dry chemical units.

(2) Approved fire extinguisher(s) must be located in the area of the normal path of exiting. The maximum travel distance to an extinguisher from any place on the premises must not exceed seventy-five feet. When the travel distance exceeds seventy-five feet, additional extinguisher(s) are required.

(3) Fire extinguishers must be ready for use at all times.

(4) Fire extinguishers must be kept on a shelf or mounted in a bracket so that the top of the extinguisher is not more than five feet above the floor.

(5) Fire extinguishers must receive a maintenance certification by a licensed firm specializing in this work, based on the manufacturer's recommended schedule. Maintenance means a thorough check of the extinguisher for:

(a) Mechanical parts;

(b) Extinguishing agent; and

(c) Expelling means.

(6) Exception: New fire extinguishers do not need to receive an additional certification test during the first year.

(7) If local fire authorities require installation of a different type or size of fire extinguisher, those requirements apply instead of the departments, as long as at least the minimum size is maintained.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0240, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0245 What fire escape measures must be taken for multi-level dwellings? (1) Multi-level dwellings must have a means of escape from an upper floor.

(2) If a fire ladder is needed to escape from an upper story window, it must be stored in a location that is easily accessible.

(3) For foster homes and staffed residential homes, a local fire department official may be consulted to determine if a fire ladder is needed to ensure adequate safety.

(4) For group care programs, this determination is made by the state fire marshal representative.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0245, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0250 What fire safety instructions must I give to children? You must instruct children, under your care who are capable of understanding and following emergency evacuation procedures and conduct fire drills at regular intervals to test and practice the procedures.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0250, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0255 What are the requirements for a fire evacuation plan? (1) You must develop a written fire evacuation plan for your home or facility. The evacuation plan must include an evacuation floor plan, identifying exit doors and windows. Except in foster homes, the plan must be posted at each exit door.

(2) You must ensure that the plan includes:

(a) Action to take by the person discovering a fire;

(b) Methods for sounding an alarm on the premises;

(c) Action to take for evacuating the building that ensures responsibility for the children; and

(d) Action to take while waiting for the fire department.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0255, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0260 What are the general requirements for bedrooms? You must meet all of the following requirements for bedrooms if you provide full-time care in a home or facility.

(1) An adult must be on the same floor or within easy hearing distance and accessibility to where children under six years of age are sleeping.

(2) You must use only bedrooms that have unrestricted direct access to hallways, corridors, living rooms, day rooms, or other such common use areas.

(3) You must not use hallways, kitchens, living rooms, dining rooms, and unfinished basements as bedrooms.

(4) For facilities licensed after December 31, 1986, bedrooms must have both:

(a) Adequate ceiling height for the safety and comfort of the occupants. Normally, this would be seven and a half feet; and

(b) A window of not less than one-tenth of the required floor space that can open into the outside, allowing natural light into the bedroom and permitting emergency access or exit.

(5) For any children six years of age and over, you must furnish separate sleeping quarters for each gender.

(6) Children in care must not share the same bed.

(7) In group care facilities, single occupancy bedrooms must provide at least fifty square feet of floor space.

(8) In foster homes, single occupancy bedrooms must provide adequate floor space for the safety and comfort of the child. Normally, this would be at least fifty square feet of floor space, not including closets.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0260, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0265 What are additional requirements for bedrooms having more than one person? (1) You must not allow a child over one year of age to share a bedroom with an adult who is not the child's parent.

(2) There must be no more than four persons to a bedroom.

(3) Multiple occupancy bedrooms must provide adequate floor space for safety and comfort of the children. Normally this would be at least fifty square feet of floor space per occupant, not including closets.

(4) When a mother and her infant sleep in the same room, the room must contain at least eighty square feet of usable floor space.

(5) You must allow only one mother and her newborn infant(s) to occupy a bedroom.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0265, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0270 What are the requirements for beds? (1) Each child in care must have a bed of his or her own.

(2) For each child in care, you must provide a bed at least thirty inches wide with a clean and comfortable mattress in good condition, pillow, sheets, blankets, and pillowcases. Each child's pillow must be covered with waterproof material or be washable.

(3) Bedding must be clean.

(4) You must provide waterproof mattress covers or moisture resistant mattresses, if needed.

(5) You must provide an infant with a crib that ensures the safety of the infant and complies with chapter 70.111 RCW, Infant Crib Safety Act.

(6) Cribs must have no more than two and three-eighths inches space between vertical slats when used for infants under six months of age.

(7) Cribs, infant beds, bassinets, and playpens must:

(a) Have clean, firm, snug fitting mattresses covered with waterproof material that is easily sanitized; and

(b) Be made of wood, metal, or approved plastic with secure latching devices

(8) Crib bumpers, stuffed toys and pillows must not be used in cribs, infant beds, bassinets, or playpens.

(9) You must follow the recommendation of the American Academy of Pediatrics, 1-800-505-CRIB, placing infants on their backs each time for sleep.

(10) You may use toddler beds with a standard crib mattress that is sufficient in length and width for the comfort of children under six years of age.

(11) You must not allow children to use the loft style beds or upper bunks of double-deck beds if using them due to age, development or condition could hurt them. Examples: Preschool age children, expectant mothers and children with disabilities.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0270, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0275 Do I need a telephone at my home or facility? The department has two requirements for the telephone that you must meet at your home or facility.

(1) You must have at least one telephone on the premises for incoming and outgoing calls. The telephone must be accessible for emergency use at all times.

(2) You must post emergency phone numbers next to the phone.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0275, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0280 What are the lighting requirements for my home or facility? (1) You must locate light fixtures and provide lighting that promotes good visibility and comfort for the children under your care.

(2) In addition, group care facilities must have nonbreakable light fixture covers or shatter resistant light bulbs or tubes.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0280, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0285 Do I need a housekeeping sink? Facilities licensed to provide group care services must have and use a method of drawing clean mop water and have and use an appropriate method of wastewater disposal.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0285, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0290 What does the room temperature for my home or facility need to be? You must maintain the temperature within your home or facility at a reasonable level while occupied. You must consider the age and needs of the children under your care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0290, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0300 How must I ventilate my home or facility? You must ensure that your physical facility is ventilated for the health and comfort of the persons under your care. A mechanical exhaust to the outside must ventilate toilets and bathrooms that do not have windows opening to the outside.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0300, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0305 What are your requirements for laundry facilities? The department has specific requirements for laundry facilities at your home or facility.

(1) You must have separate and adequate facilities for storing soiled and clean linen.

(2) You must provide adequate laundry and drying equipment, or make other arrangements for getting laundry done on a regular basis.

(3) You must locate laundry equipment in an area separate from the kitchen and child care areas unless you are doing foster care in your home.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0305, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0310 What are the requirements for washing clothes? You must use an effective way to sanitize laundry contaminated with urine, feces, lice, scabies, or other potentially infectious materials. You must sanitize laundry through temperature or chemicals.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0310, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0315 What are your requirements for toilets, sinks, and bathing facilities? You must meet certain requirements for toilets, sinks, and bathing facilities.

(1) You must provide at least one indoor flush-type toilet, one nearby hand-washing sink with hot and cold running water, and
a bathing facility.

(2) You must comply with all of the following requirements for toilet and bathing facilities:

(a) Toilet and bathing facilities must allow privacy for children who are five years of age or older and opposite genders.

(b) Toilet, urinals, and hand-washing sinks must be the appropriate height for the children served, or have a safe and easily cleaned step stool or platform that is water-resistant.

(c) Hand-washing and bathing facilities must be provided with hot running water that does not exceed one hundred twenty degrees.

(d) All bathing facilities must have a conveniently located grab bar unless we approve other safety measures, such as nonskid pads.

(e) You must provide potty-chairs and toilet training equipment for toddlers. You must regularly maintain this equipment and keep it in sanitary condition. You must put potty-chairs, when in use, on washable, water-resistant surfaces.

(f) In group care facilities, whenever urinals are provided, the number of urinals must not replace more than one-third of the total number of required toilets.

(g) You must provide soap and clean towels, disposable towels or other approved hand-drying devices to the persons under your care.

(h) In programs providing care to expectant mothers:

(i) Bathing facilities must have adequate grab bars in convenient places; and

(ii) Except in foster homes, all sleeping areas must have at least one toilet and hand-washing sink on the same floor.

(3) There shall be at least one indoor flush-type toilet and one nearby handwashing sink with hot and cold or tempered running water. The following ratios of persons normally on the premises to bathrooms at the facilities shall apply:

	Toilets	Handwashing Sinks	Bathing Facilities
Group care programs and facilities	Two minimum and 1:8 ratio	Two minimum and 1:8 ratio	One minimum and 1:8 ratio
Foster family home and staffed residential home	One minimum	One minimum	One minimum

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0315, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0320 What are the requirements about drinking water? (1) You must provide the following:

(a) A public water supply or a private water supply approved by the local health authority at the time of licensing or relicensing; and

(b) Disposable paper cups, individual drinking cups or glasses, or angled jet type drinking fountains.

(2) You must not use bubbler type fountains or common drinking cups.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0320, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0325 What are the requirements for sewage and liquid wastes? You must discharge sewage and liquid wastes into a public sewer system or into a functioning septic system.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0325, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0330 Am I required to obtain a child's health history? (1) You may obtain the health history from the social worker or child-placing agency making the placement for all children that are accepted into your home or facility.

(2) The health history must include:

(a) The date of the child's last physical examination;

(b) Allergies;

(c) Any special health problems;

(d) A history of immunizations;

(e) Clinical and medical diagnoses and treatment plans; and

(f) All currently prescribed medications.

(3) When leaving the home or facility, the health history of the child must go with the child to the next placement for continuity of care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0330, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0335 When must I get medical exams for the children under my care? (1) You, together with the child's social worker, must schedule a medical exam for any child who, within the past year, has not:

(a) Been under regular medical supervision; or

(b) Had a physical exam by a physician, a physician's assistant, or an advanced registered nurse practitioner (ARNP).

(2) A physical exam (EPSDT) must be completed within thirty days of placement and annually thereafter.

Note: You may contact the child's social worker for information on this.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0335, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0340 What are your requirements for immunizations for children? (1) To receive care from you, children must have proof of current immunizations. Contact the child's social worker before beginning any immunization schedule to avoid duplication of immunizations.

(2) You may accept a child who has not received all immunizations on a conditional basis if immunizations are started as soon as medically possible.

(3) If you are providing care and have minor children of your own who are on the premises of a home or facility, your children must have proof of current immunizations.

(4) The department may give conditional approval for any of your own children who have not received all immunizations as long as their immunizations are started soon as medically possible.

(5) The department may grant exceptions to this requirement for immunizations for your children in two situations:

(a) You, as parent or guardian, have signed a statement indicating your religious, philosophical or personal objections to the requirement; or

(b) You have a physician's statement indicating that a valid medical reason exists for not obtaining immunizations for your own child.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0340, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0345 What must I do to prevent the spread of infections and communicable diseases? You must take precautions to guard against infections and communicable diseases infecting the children under care in your home or facility.

General communicable diseases and infections

(1) In each home or facility, other than a foster home, staff with a reportable communicable disease, as defined by the department of health, in an infectious stage must not be on duty until they have a physician's approval for returning to work.

(2) Each home or facility, other than a foster home, that cares for severely and multiple-handicapped children must have an infection control program supervised by a registered nurse.

(3) Foster homes with medically fragile children may use other alternatives, such as in-home nursing services, to consult on infection control procedures.

Tuberculosis

(4) Applicants for a license or adults authorized to have unsupervised access to children in a home or facility must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test upon being employed or licensed unless:

(a) The person has evidence of testing within the previous twelve months;

(b) The person has evidence that they have a negative chest x-ray since a previously positive skin test;

(c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis.

(5) The department does not require a tuberculin skin test if:

(a) A person has a tuberculosis skin test that has been documented as negative within the past twelve months; or

(b) A physician indicates that the test is medically unadvisable.

(6) Persons whose tuberculosis skin test is positive must have a chest x-ray within thirty days following the skin test.

(7) The department does not require retesting unless a person believes they have been exposed to someone with tuberculosis or if testing is recommended by their health care provider.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0345, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0350 How do I manage medications for children under my care? (1) You must meet the department's requirements for managing prescription and nonprescription medication for children under your care.

(2) If you care for children in the custody of a tribal court you must follow the direction of that court regarding giving or applying prescription and nonprescription medications or ointments.

(3) Only you or another authorized care provider may give or have access to medications for the child under your care;

(4) 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;

(5) Except for foster homes, keep a record of all medications you give a child;

(6) Foster homes must keep a record of all prescription medication given to foster children; and

(7) Properly dispose of medications that are no longer being taken or have expired.

Prescription medications

(8) You or another authorized care provider must:

(a) Give prescription medications:

(i) Only as specified on the prescription label; or

(ii) As otherwise approved by a physician or another person legally authorized to prescribe medication.

(b) Check with the physician or pharmacist about possible side effects for any prescription medications and interactions with nonprescription drugs the child is taking.

Psychotropic medications

(9) Care providers must not approve giving psychotropic medications to a child in care. Approval can only be given by one of these:

(a) The child's parent;

(b) Dependency guardians;

(c) A court order; or

(d) The child's social worker, if:

(i) The child is legally free and in the permanent custody of the department; or

(ii) It is impossible to obtain informed parental consent after normal work hours, on weekends, or on holidays.

(10) Children who are at least thirteen years old may decline to take prescription psychotropic medication. If this happens contact the child's social worker immediately.

Nonprescription medications

(11) Children taking psychotropic medications must have the prescribing physician's authorization before any nonprescription drugs are given.

(12) You or another authorized care provider must follow these requirements for nonprescription medications. You must:

(a) Give certain classifications of nonprescribed medications, only with the dose and directions on the manufacturer's label for the age and/or weight of the child needing the medication. These nonprescribed medications include but are not limited to:

(i) Nonaspirin antipyretics/analgesics, fever reducers/pain relievers;

(ii) Nonnarcotic cough suppressants;

(iii) Decongestants;

(iv) Antacids and anti-diarrhea medication;

(v) Anti-itching ointments or lotions intended specifically to relieve itching;

(vi) Shampoo for the removal of lice;

(vii) Diaper ointments and powders intended specifically for use in the diaper area of children;

(viii) Sun screen; and

(ix) Antibacterial ointments for first aid use.

(b) Give any other nonprescription medications only when approved in writing by a physician. These nonprescription medications may be given with a physician's standing order. Physician's standing orders must be patient specific.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0350, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0355 May I accept medicine from a child's parent or guardian? (1) The only medicine you may accept from the child's parent, guardian, or responsible relative is medicine in the original container labeled with:

(a) The child's first and last names;

(b) The date the prescription was filled;

(c) The medication's expiration date; and

(d) Legible instructions for administration (manufacturer's instructions or prescription label).

(2) You must notify the child's social worker when you receive a prescription from a child's parent or guardian.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0355, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0360 Whom do I notify about medication changes and reactions? (1) You must notify the child's social worker of changes in prescribed medications.

(2) You must notify the child's social worker and physician about any adverse reactions the child has to medications.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0360, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0365 When may children take their own medicine? (1) You may permit children under your care to take their own medicine as long as:

(a) They are physically and mentally capable of properly taking the medicine; and

(b) The social worker or guardian if they have custody, approves in writing.

(2) You must keep the written approval by the child's social worker in your records.

(3) When a child is taking their own medication, the medication and medical supplies must be kept locked so they are inaccessible to unauthorized persons.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0365, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0370 What food and meal guidelines must I follow? (1) Food served to children in your care must meet the needs of the children.

(2) For an educational and social environment during mealtimes, children must not be routinely separated from the adults and/or required to have separate menus unless ordered by the child's health care provider.

(3) You must provide the facilities for proper storage, preparation, and service of food to meet the needs of the program.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0370, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0375 How often must I feed children? (1) You must provide all children a minimum of three meals in each twenty-four-hour period. You may vary from this guideline only if you write to your licensor requesting a change and the request is approved by the department.

(2) The time interval between the evening meal and breakfast must not be more than fourteen hours.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0375, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0380 How do I handle a child's special diet? You must have written instructions by a physician, parent or guardian before serving nutrient concentrates, nutrient supplements, vitamins, and modified diets (therapeutic and allergy diets).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0380, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0385 Do you have special requirements for serving milk? You must follow these requirements for serving milk:

(1) Serve only pasteurized milk or a pasteurized milk product.

(2) Not serve the following types of milk to any child less than twenty-four months of age unless you have written permission by a physician:

(a) Skim milk;

(b) Reconstituted nonfat dry milk; and

(c) One and two percent butterfat milk.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0385, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0390 What home-canned foods may I use? (1) In all homes and facilities, except foster homes, you may serve only home-canned high-acid foods with a pH of less than 4.6 such as canned fruits, jams, jellies, and pickles.

(2) In foster homes, all home-canned foods must be preserved following published procedures that are approved by the extension service.

(3) You must be able to provide the printed procedure that you followed.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0390, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0395 What requirements must I meet for feeding babies? You must meet the following requirements for feeding babies:

(1) In group care settings, all formulas must be in sanitized bottles with nipples and labeled with the child's name and date prepared if more than one child is bottle-fed.

(2) You must refrigerate filled bottles if bottles are not used immediately and contents must be discarded if not used within twenty-four hours.

(3) If you reuse bottles and nipples, you must sanitize them.

(4) If breast milk is provided by anyone other than a baby's biological mother, approval must be obtained from the child's social worker.

(5) Infants who are six months of age or over may hold their own bottles as long as an adult remains in the room and within observation range. You must take bottles from the child when the child finishes feeding or when the bottle is empty.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0395, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0400 What are your requirements for diapers and diaper-changing areas? In a foster home or group care program you must follow the requirements for diapers, diaper-changing rooms and potty-chairs.

(1) You must separate diaper-changing areas from food preparation areas.

(2) You must sanitize diaper-changing areas between each use or you must use a nonabsorbent, disposable covering that is discarded after each use.

(3) For cleaning children, you must use either disposable towels or clean cloth towels that have been laundered between each use.

(4) You and any caregiver must wash hands before and after diapering each child.

(5) In group care programs, you must use disposable diapers, a commercial diaper service, or reusable diapers supplied by the child's family.

(6) In group care programs, diaper-changing procedures must be posted at the changing areas.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0400, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0405 Do I have responsibility for a child's clothing? You must provide or arrange for appropriate clothing for the children under your care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0405, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0410 May a child take personal belongings after being discharged from a home or facility? You must permit a child who is discharged from your home or facility to take with them the personal belongings they brought with them or acquired while in care. This includes clothing, personal mementos, bicycles, gifts, and any saved money or regular allowance. There are two ways this may occur:

(1) The child may take these belongings upon leaving your home or facility; or

(2) If it is impossible for the child to take their belongings at the time they leave, you are required to secure the child's belongings for up to thirty days and cooperate with the child's social worker to transfer the belongings to the child, as soon as possible.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0410, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0415 Do I have responsibility for a child's personal hygiene? You must provide or arrange for children under your care to have items needed for grooming and personal hygiene. You must assist these children in using these items, based on the child's developmental needs.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0415, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0420 What are the requirements for protecting a child under my care from abuse and neglect? As part of ensuring a child's health, welfare and safety, you must protect children under your care from all forms of child abuse and neglect (see RCW 26.44.020(12) and chapter 388-15 WAC for more details).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0420, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0425 What are the requirements about nondiscrimination? You must follow all state and federal laws regarding nondiscrimination while providing services to children in your care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0425, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0430 May I take a foster child to church services, temple, or synagogue? (1) You may have a child attend church services, temple, or synagogue, if the child chooses to participate.

(2) You must respect the religious rights of the children under your care.

(3) Children have the right to practice their own faith.

(4) Children have the right not to practice your faith without consequences.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0430, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0435 Do I have to admit or retain all children? (1) A foster home or other program has the right to refuse to admit or retain a child in a program.

The exceptions to this requirement are the individual programs that have contracts that specify a child can not be denied admission.

(2) A joint decision may be made by the provider and the placement agency to serve the child elsewhere, for the health and safety of the child or others.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0435, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0440 What must I consider in assigning work to children in my home or facility? (1) Children may do regular household tasks without payment.

(2) Children may do work assignments other than household tasks that are appropriate to their age and physical conditions and receive monetary compensation if this is part of their service plan.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0440, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0445 What activities must I provide to children? You must provide children with safe and suitable activities that contribute to developing their physical, mental, social, and emotional skills. Activities must be designed for the developmental stages of the children you serve.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0445, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0450 What types of toys must I provide to children? You must provide safe and suitable toys and equipment for all children in your care. You must have toys that relate to the different developmental stages of the children you serve.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0450, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0455 Do I need permission to travel on an overnight trip or out-of-state with my foster child? Contact the child's social worker prior to overnight trips, out-of-state, or out-of-country travel.

Note: The social worker with the agency having legal custody of the child is the contact person.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0455, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0460 What requirements do you have for supervising children? (1) You must provide or arrange for care and supervision that is appropriate for the child's age, developmental level, and condition.

(2) You must supervise children who help with food preparation in the kitchen, based on their age and skills.

(3) Preschool children and children with severe developmental disabilities must not be left unattended in a bathtub or shower.

(4) Foster parents and facility staff must provide the children in their care with appropriate adult supervision, emotional support, personal attention, and structured daily routines and living experiences.

(5) In group care children must be supervised during sleeping hours by at least one awake staff when:

(a) There are more than six children in care; and

(b) The major focus of the program is behavioral rather than the development of independent living skills such as a teen parent program or responsible living skills program; or

(c) The youth's behavior poses a risk to self or others.

(6) In foster homes and staffed residential homes, children must be supervised during sleeping hours by at least one awake staff when it is part of the written supervision plan with the child's social worker.

(7) Adequate supervision should be arranged and maintained during times of crisis when one or more family members or staff members may be unavailable to provide the necessary supervision or coverage for other children in care.

(8) When special supervision is required and agreed upon between the department and the agency or foster parent, the agency or foster parent provides the necessary supervision. This supervision may require auditory or visual supervision at all times.

(9) When a child has exhibited behavior in a previous placement or the placement agency believes the child poses a risk to other children the agency must inform the provider and jointly develop a plan to address the risk.

(10) When a child exhibits behavior that poses a safety risk to other children in care, the child must not share a bedroom with other children.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0460, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0465 What requirements must I follow when disciplining children? (1) You are responsible for disciplining children in your care. This responsibility may not be delegated to a child.

(2) Discipline must be based on an understanding of the child's needs and stage of development.

(3) Discipline must be designed to help the child under your care to develop inner control, acceptable behavior and respect for the rights of others.

(4) Discipline must be fair, reasonable, consistent, and related to the child's behavior.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0465, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0470 What types of disciplinary practices are forbidden? (1) You must not use cruel, unusual, frightening, unsafe or humiliating discipline practices, including but not limited to:

(a) Spanking children with a hand or object;

(b) Biting, jerking, kicking, hitting, or shaking the child;

(c) Pulling the child's hair;

(d) Throwing the child;

(e) Purposely inflicting pain as a punishment;

(f) Name calling, using derogatory comments;

(g) Threatening the child with physical harm;

(h) Threatening or intimidating the child; or

(i) Placing or requiring a child to stand under a cold water shower.

(2) You must not use methods that interfere with a child's basic needs. These include, but are not limited to:

(a) Depriving the child of sleep;

(b) Providing inadequate food, clothing or shelter;

(c) Restricting a child's breathing;

(d) Interfering with a child's ability to take care of their own hygiene and toilet needs; or

(e) Providing inadequate medical or dental care.

(3) You must not use methods that deprive a child of necessary services. These include, but are not limited to, contacting:

(a) The assigned social worker;

(b) The assigned legal representative;

(c) Parents or other family members who are identified in the case plan; or

(d) Individuals providing the child with therapeutic activities as part of the child's case plan.

(4) You must not use medication in an amount or frequency other than that prescribed by a physician or psychiatrist.

(5) You must not use medications for a child that has been prescribed for someone else.

(6) You must not physically lock doors or windows in a way that prohibits a child from exiting.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0470, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0475 Do you require a written statement describing my discipline methods? (1) You must provide a written statement with your application and reapplication for licensure describing the discipline methods you use.

(2) If your discipline methods change, you must immediately provide a new statement to your licensor describing your current practice.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0475, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0480 What types of physical restraint are acceptable for children in homes and group care settings? (1) You must use efforts other than physical restraint to redirect or deescalate a situation, unless the child's behavior poses an immediate risk to physical safety.

(2) In foster homes, in emergencies and only when the child's behavior poses an immediate risk to physical safety may you use physical restraint. The restraint must be reasonable and necessary to:

(a) Prevent a child on the premises from harming themself or others; or

(b) Protect property from serious damage.

(3) If your group care program is approved by DLR for the use of physical restraint, the licensee and staff must be trained in the appropriate use of restraining techniques in accordance with the department's behavior management policy before restraining a child.

(4) Medication prescribed by a physician to control behavior must be only given as prescribed.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0480, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0485 What types of physical restraint are not acceptable for children? Homes and facilities must follow these requirements. You must not:

(1) Use physical restraint as a form of punishment or discipline.

(2) Use mechanical restraints, such as handcuffs and belt restraints.

(3) Use locked time-out rooms.

(4) Use physical restraint techniques that restrict breathing, inflict pain as a strategy for behavior control, or that might injure a child. These include, but are not limited to:

(a) Restriction of body movement by placing pressure on joints, chest, heart, or vital organs;

(b) Sleeper holds, which are holds used by law enforcement officers to subdue a person;

(c) Arm twisting;

(d) Hair holds;

(e) Choking or putting arms around the throat; or

(f) Chemical restraints, including but not limited to pepper spray.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0485, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0490 What must I do following an incident that involved using physical restraint? (1) In foster homes, the foster parent must send a copy of the documented use of physical restraint to the child's social worker and licensor within forty-eight hours; or if the foster home is supervised by a child-placing agency to the case manager. The CPA case manager will furnish a copy to the child's DCFS social worker and DLR licensor.

(2) For group care programs, the director or program supervisor must review any incident with the staff who used physical restraint to ensure that the decision to use physical restraint and its application were appropriate.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0490, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0500 May I receive more than one in-home care license? (1) In exceptional situations, a family that has demonstrated exceptional abilities in relation to meeting the special needs of children to be cared for may be granted approval to be licensed for foster care and another type of family home care. Approval may be granted if it appears to be in the best interest of the child and would not jeopardize the health and safety of children in the home.

(2) The approval must be in writing and signed by the division of licensed resources director or designee.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0500, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0505 What services must a foster parent be able to provide? (1) Foster parents must be able to meet the child's basic needs and have the knowledge and skills to:

(a) Protect and nurture children in a safe, healthy environment with unconditional positive support;

(b) Support relationships among children and their parents, siblings, and kin;

(c) Meet the developmental needs of the child by:

(i) Helping the child cope with separation and loss;

(ii) Helping the child build positive attachments to appropriate adults;

(iii) Building self-esteem;

(iv) Giving positive guidance;

(v) Supporting cultural identity;

(vi) Using discipline appropriate to the child's age and stage of development;

(vii) Supporting intellectual and educational growth;

(viii) Encouraging and modeling positive social relationships and responsibilities; and

(ix) Helping the child gain age appropriate skills for independence.

(2) Foster parents must support the permanent placement plan for the child, focusing first on the birth family reuniting, and then, on options leading to a permanent placement.

(3) Foster parents are encouraged to participate as members of the child's treatment team.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0505, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0510 What educational support must I provide to children under my care? If you operate a foster home, you must:

(1) Assist the child to attend school on a regular basis if this is part of the child's service plan;

(2) Provide a suitable study area for the children under your care; and

(3) Provide opportunities to learn appropriate skills for the development of self-sufficiency.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0510, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0515 What is the minimum age to be a foster parent? You need to be at least twenty-one years old to be a foster parent.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0515, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0520 What are the training requirements for prospective foster parents? (1) To receive a foster home license, you must attend required orientation and preservice training programs that the department sponsors, or that your licensed child-placing agency offers.

(2) You need proof of completion of current first-aid/CPR training that is geared for the ages of the foster children you want in your home.

(3) You need proof of completion of HIV/AIDS training.

(4) The primary care givers must complete all required DLR-approved training after licensing.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0520, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0525 How many children may my foster home serve? (1) The department may restrict the number of children a foster home is licensed to serve. The age of the foster and birth children, and the physical and emotional condition of the children are considered in making this decision. These requirements are for all foster homes, including those that only have foster children for a short time (sometimes called a "receiving home").

(2) In a two-parent household, the total number of children in your home is restricted to six children, including your own children.

(3) In a single parent household, the total number of children in your home is restricted to four children, including your own children.

(4) A home may be licensed for the care of at least one child when the foster parents have more of their own children than specified in subsection (2) of this section, if they meet the other licensing requirements.

(5) You may have only two children under two years of age in your home at a time. This includes foster children and your own children.

(6) The capacity restrictions in this section may be exceeded in extraordinary situations, such as to place a sibling group, to place a child with a relative, or because the foster family has demonstrated exceptional abilities in relation to the special needs of a foster child, if this appears to be in the best interest of the child and would not jeopardize the

health and safety of the other children in the home. Approval to exceed the capacity restrictions must be in writing and signed by the DLR manager or designee.

(7) The department may license a foster home for up to three foster children with mental or physical disabilities that are severe enough to need semi-skilled maintenance or supportive services if:

(a) Your training and/or experience qualifies you to provide proper care;

(b) The children's treatment requires nursing service oversight; and

(c) The total number of children with mental or physical disabilities in your home is three or fewer.

(8) The department may license a foster family for up to two nonmobile children.

(9) While providing respite care, you may only exceed the number of children you are licensed to serve with prior approval by the DLR director or designee.

(10) The department may license a foster home to serve up to four children with developmental disabilities as defined in RCW 71A.10.020, at any one time.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0525, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0530 May I be employed if I am a foster parent? (1) If you are a single parent or both parents of a two-parent household are employed outside the home, you must give the child-placing agency or the department a written outline of your plan for supervising the children under your care while you are working.

(2) At least one parent must be available to respond to school crisis.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0530, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0535 Do I need to have income separate from foster care payments? You must have sufficient regular income to maintain your own family, without the foster care payments made for the children in care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0535, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0540 When may I use respite care? (1) Foster families may arrange for respite (brief relief) care only with the prior consent of the child's social worker.

(2) Respite care may be arranged in advance or on an emergency basis.

(3) Respite care may be arranged to support the care a foster parent is providing or to provide substitute care in the absence of foster parents.

(4) Respite care given outside the foster parent's home must be provided by licensed providers.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0540, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0545 May I place my foster child with another family temporarily? Foster parents must not place a child in another home temporarily or otherwise without the written consent of:

(1) The child's social worker; or

(2) The child placing agency case manager, if any.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0545, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0550 May my foster children participate in routine activities without a licensed provider supervising the activity? Contact the child's social worker for prior approval for your foster child's participation in routine activities without a licensed provider supervising the activity, such as clubs, social outings with classmates or friends.

Note: The social worker with the agency having legal custody of the child is the contact person.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0550, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0555 Do I need a social summary for children under my care? (1) Except for foster homes, all programs must develop a written diagnostic social summary for each child accepted for care.

(2) The social summary must serve as the basis of the child's admission to care.

(3) If a child needs to be accepted for emergency care, such as placement in a crisis residential center, the department does not require the social study to be completed prior to admission. In these cases, if the child remains in care beyond thirty days, a summary must be completed as soon as possible.

(4) The study must contain the following information for the child:

(a) Copies of psychological or psychiatric evaluations, if any, on the child under care.

(b) A narrative description of the child's background and family that identifies the immediate and extended family resources;

(c) The child's interrelationships and the problems and behaviors that have required care away from his or her own home;

(d) The child's primary and alternate permanency plan;

(e) Previous placement history, if any; and

(f) An evaluation of the child's need for the particular services and type of care you provide.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0555, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0560 Do I need a treatment plan for children under my care? (1) If you operate a staffed residential home or a group care program you must assist in developing and implementing a written treatment plan for each child accepted for care in any of the programs you provide.

(2) The treatment plan must:

(a) Identify the service needs of the child, parent or guardian;

(b) Describe the treatment goals and strategies for achieving those goals;

(c) Include a running account of the treatment received by the child and others involved in the treatment plan, such as any group treatment or individual counseling; and

(d) Be updated at least quarterly to show the progress toward meeting goals and list barriers to the permanent plan.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0560, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0565 Do you need to approve the program that I offer for children under my care? (1) The department must approve the program that you have developed for children under your care.

(2) You must send to DLR a detailed written program description outlining educational, recreational, and therapeutic services you will provide to children and their families. A sample of the schedule of daily activities for children under care must be included.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0565, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0570 What education and vocational instruction must I provide to the children under my care? (1) If you operate a staffed residential home or a group care program, you must meet the following requirements for providing education and vocational instruction to the children under your care. You must:

(a) Develop or arrange for an educational plan for each child in care who has not completed high school and/or the GED (high school equivalency examination);

(b) Support each child participating in their education plan; and

(c) Provide suitable study areas for children under your care.

(2) If the instruction is given on your premises, you must:

(a) Have the program certified by the office of the superintendent of public instruction and provide classrooms separate from the living area;

(b) Send the department a written description of how you will provide an educational program for children under your care; and

(c) Provide or arrange for independent living skills education for developing self-sufficiency for the children under your care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0570, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0575 What medical policies and procedures must I have? (1) If you operate a staffed residential home or a group care program, you must have written policies and procedures about the control of infections. These must include, but are not limited to, the following areas:

(a) Isolation;

(b) Aseptic procedures;

(c) Reporting communicable diseases;

(d) Hygiene, including hand washing, using the toilet, diapering, and laundering.

(2) Group care facilities must maintain current written medical policies and procedures to be followed on:

(a) Prevention of the transmission of communicable diseases including:

(i) Hand washing for staff and children;

(ii) Management and reporting of communicable diseases.

(b) Medication management;

(c) First aid;

(d) Care of minor illnesses;

(e) Actions to be taken for medical emergencies;

(f) Infant care procedures when infants are under care; and

(g) General health practices.

(3) If you are licensed as a group home or as a facility that can care for thirteen or more persons at once, you must arrange to have one of the following help you develop and periodically review your medical policies and procedures:

(a) An advisory physician,

(b) A physician's assistant, or

(c) A registered nurse.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0575, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0580 What nursing services must I provide? (1) If you operate a staffed residential home or facility caring for chronically ill children or medically fragile children, you must arrange for regular nursing visits.

(a) These must include at least monthly visits unless a different agreement is specified in the individual child's treatment plan.

(b) The nurse must be registered and currently licensed in the state of Washington.

(2) The nurse's name, address and telephone number must be readily available to the staff at your home or facility.

(3) The nurse must assist the agency in setting up a program that provides for regular medical check-ups and follow-up for special health care needs specified by the child's physician or your staff.

(4) The nurse must advise and assist nonmedical staff at your home or facility in maintaining child health records, meeting daily health needs and caring for children with minor illnesses and injuries.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0580, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0585 What social service staff do I need for my home or facility? You must provide or arrange for social services by qualified persons who have specific educational training. Except for juvenile detention facilities, social service staff must meet education and training requirements that follow:

(1) One person who provides social services must have a master's degree in social work or a closely related field from an accredited school.

(2) Social service staff without a master's degree in social work or closely related field must have a bachelor's degree in social work or a closely related field. A person with a master's degree must consult at least eight hours per month with any social service staff who have only a bachelor's degree.

(3) When social services are provided by another agency, you must have a written agreement with the agency describing the scope of service they provide. Written agreements must meet the requirements of this rule.

(4) A social service staff person must review and sign approving the child's treatment plan.

(5) A social service staff person must review and sign approving licensing application packets before they are submitted to DLR.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0585, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0590 What clerical, accounting and administrative services do I need for my home or facility? You must have sufficient clerical, accounting and administrative services to maintain proper records and carry out your program.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0590, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0595 What support and maintenance staff do I need for my home or facility? If you operate a home or facility other than a foster home, you must have sufficient support and maintenance services to maintain and repair your facility, prepare and serve meals.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0595, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0600 Do I need professional consultants for my program? (1) Except for foster homes, you must have consultants available, as needed to work with your staff, the children you serve, and the children's families. The consultants that are used by your program must meet the full professional competency requirements in their respective fields. The consultant or consultants must have:

(a) A master's degree from a recognized school of social work or similar academic training in the field they will be advising;

(b) The training, experience, knowledge and demonstrated skills in each area that he or she will be supervising; and

(c) The ability to ensure your staff develop their skills and understanding needed to effectively manage their cases.

(2) Consultants may be hired as staff or operate under a contract with your program.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0600, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0605 Is in-service training required? If you have employees in your home or facility, you must offer in-service training programs for developing and upgrading staff skills.

(1) If you have five or more employees or volunteers, your training plan must be in writing.

(2) You must discuss with the staff your policies and procedures as well as the rules contained in this chapter.

(3) You must provide or arrange for your staff to have training for the services that you provide to children under your care.

(4) Your training on behavioral management must be approved by DLR and must include nonphysical age-appropriate methods of redirecting and controlling behavior, as described in the department's behavior management policy.

(5) You must record the amount of time and type of training provided to staff.

(6) This information must be kept in each employee's file or in a separate training file.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0605, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0610 What are the required ratios of social service staff to children under care? You must meet the minimum ratios of social service staff to children under care as shown in the chart below:

Type of Program	Minimum Ratio of Full-Time Social Service Staff to Children Under Care
Day treatment program	1 to 15
Group homes	1 to 25
Child-placing agency	1 to 25
Maternity services	1 to 25
Regular and secure crisis residential centers	1 to 5

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0610, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0615 Are there specific fire safety requirements for the care of nonmobile children? (1) Floors located more than four feet above ground (one-half story up) or in the basement must not be used for care of nonmobile children for safety reasons.

(2) In your staffed residential home, if you care for more than one nonmobile child at a time, the care for both children must be on the ground floor.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0615, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0620 What safety features do I need for hazardous areas? The department requires hazardous areas in your staffed residential home or group care facility to have certain safety features.

(1) Hazardous areas must be separated from the staffed residential home or group care facility by at least a "one-hour" fire-resistant wall. Hazardous areas include rooms or spaces containing:

(a) A commercial-type cooking kitchen;

(b) A boiler;

(c) A maintenance shop;

(d) A janitor closet;

(e) A woodworking shop;

(f) Flammable or combustible materials; or

(g) Painting operations.

(2) We do not require a fire-resistant wall when:

(a) A kitchen contains only a domestic cooking range; and

(b) Food preparation does not produce smoke or grease-laden vapors.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0620, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0625 What other requirements must I follow for smoke detectors? (1) Smoke detectors must have a UL approval sticker and sound an alarm that is audible in all sleeping and napping areas.

(2) In new construction, required smoke detectors must receive their primary power from building wiring from a commercial source. Wiring must be permanent, with a disconnecting switch only for overcurrent protection.

(3) Smoke detectors must also:

(a) Be equipped with a battery backup; and

(b) Emit a signal when the batteries are low.

(4) If installed in existing buildings or buildings without commercial power, smoke detectors may be solely battery operated.

(5) Single-station smoke detectors must be tested at monthly intervals or in a manner specified by the manufacturer. Records of such testing must be maintained upon the premises.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0625, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0630 What fire prevention measures must I take? The department requires that you must take the following fire prevention measures for your staffed residential home and group care facility:

(1) You must request the local fire department to visit your home or facility to:

(a) Assist care givers in meeting all necessary fire safety requirements; and

(b) Become familiar with your home or facility.

(2) You must assure that furnace rooms are:

(a) Maintained free of lint, grease, and rubbish; and

(b) Suitably isolated, enclosed, or protected.

(3) Flammable or combustible materials must be stored away from exits and in areas that are not accessible to children. Combustible rubbish must not be allowed to collect and must be removed from the building or stored in closed, metal containers away from building exits.

(4) All trash must be removed daily from the building and thrown away in a safe manner outside the building. All containers used for the disposal of waste material must consist of noncombustible materials and have tops.

(5) All electrical motors must be kept free of dust.

(6) Open-flame devices capable of igniting clothing must not be left on, unattended or used in a manner that could result in an accidental ignition of children's clothing.

(7) Candles must not be used.

(8) All electrical circuits, devices and appliances must be properly maintained. Circuits must not be overloaded. Extension cords and multi-plug adapters must not be used in place of permanent wiring and proper outlets.

(9) House and facility numbers must be clearly visible from the street or road in front of the property. Where the home or facility is not clearly visible from the road, the address must be posted at the head of the driveway.

Note: This is to allow emergency vehicles and fire trucks to easily find addresses.

(10) Fireplaces, woodstoves, and similar devices must be installed and approved according to the rules that were in effect at the time of installation (see the local building permit). These devices must be properly maintained and must be cleaned and certified at least once a year or maintained according to the manufacturer's recommendations.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0630, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0635 What are the requirements for fire sprinkler systems? If you have sprinkler systems installed in your staffed residential home or group care facility for fire prevention, you must have them tested and certified yearly by a Washington state licensed fire sprinkler contractor.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0635, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0640 What fire safety procedures to do staffed residential home and group care program staff need to know? You and your staff at the staffed residential home or group care facility must be familiar with safety procedures related to fire prevention.

(1) You and your staff must be familiar with all aspects of the fire drill.

(2) You and your staff must be able to:

(a) Operate all fire extinguishers installed on the premises;

(b) Test smoke detectors (single station types); and

(c) Conduct frequent inspections of the home or facility to identify fire hazards and take action to correct any hazards noted during the inspection.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0640, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0645 What are the requirements for fire drills? (1) You must conduct a fire drill in your staffed residential home or group care facility at least once each month.

(2) You must maintain a written record on the premises that indicates the date and time that drill practices were completed.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0645, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0650 What requirements do you have regarding windows in staffed residential homes and group care facilities? For safety, all escape or rescue windows must not be less than twenty-four inches high by twenty inches wide and not more than forty-four inches off the floor for exits in staffed residential homes and group care facilities.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0650, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0655 Are there different construction and fire safety requirements for facilities that have mixed groups in the same building? (1) If a facility, such as a regular or a secure crisis residential center (CRC) or group home and a CRC, has mixed groups in the same building, the facil-

ity must follow the most stringent construction and fire safety requirements of the two groups.

(2) If a facility is certified by the department of health, such as a secure residential treatment center, the facility must meet construction and fire safety standards for psychiatric hospital security rooms when they have a secure CRC or a secure residential treatment center within the physical structure.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0655, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0660 Do mealtimes need to be established? You must establish and post a schedule of mealtimes.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0660, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0665 Do you have general menu requirements? The department has menu requirements for group care facilities that care for children.

(1) If you operate a facility other than a foster home or a staffed residential home you must prepare and date daily menus, including snacks, at least one week in advance.

(2) You must provide for the proper storage, preparation, and service of food to meet the needs of the program.

(3) Your program must be in compliance with the department of health standards in chapter 246-215 WAC on food service sanitation.

(4) A menu must specify a variety of foods for adequate nutrition and meal enjoyment.

(5) You must keep the menus on file for a minimum of six months so that we can review your menus.

(6) You must post each person's dietary restrictions, if any, for staff to follow.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0665, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0670 What types of group care programs are licensed to provide care to children? The following types of programs may be licensed as group care to provide care for children on a twenty-four-hour basis:

(1) Group home programs;

(2) Independent living skills programs;

(3) Maternity services;

(4) Services to children with severe developmental disabilities and medically fragile children; and

(5) Crisis residential centers and secure crisis residential centers; and

(6) Day treatment programs. Day treatment programs are considered group care programs under this chapter, though they are not twenty-four-hour residential programs.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0670, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0680 What basic elements must a group care program include? (1) Your group care program must provide a safe and healthy group living environment that meets the developmental needs of the children in your care, including;

(a) A clean, homelike environment;

(b) Basic necessities such as adequate food, appropriate clothing and recreational opportunities;

(c) Safety;

(d) An age-appropriate environment with necessary structure, routine, and rules to provide for a healthy life, growth and development.

(2) Your program must be staffed with employees who are competent to provide for the safety and needs of the children in your care.

(3) Your program must have a written statement that includes your mission, goals, and a description of the services you provide.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0680, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0685 Who may I serve as a group care program provider? (1) If you are a group care program provider, you may serve children who are at least six years of age and meet one of the following conditions:

(a) Have behavior that cannot be safely or effectively managed in foster care;

(b) Need temporary placement awaiting a more permanent placement;

(c) Need emergency placement during a temporary disruption of a current placement;

(d) Have emotional, physical, or mental disabilities; or

(e) Need a transitional living setting.

(2) If your group care program serves children with severe developmental disabilities, medically fragile children, maternity services, or meets RCW 74.15.020 (2)(m), the children may be younger than six years of age.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0685, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0690 What services must I provide if I have a group care license? You must provide specialized services that are needed by the group that you serve. These services may be provided through your own program or through using other community resources.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0690, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0695 Must I give a child an allowance? Group care facilities must give the children under their care allowances based on age, needs and ability to handle money. These facilities must keep track of allowances given to children in a ledger.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0695, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0700 What are the qualifications for an executive director for a group care program? (1) A group care program executive director or person responsible for the agency administration, agency oversight, and fiscal operation must meet, at a minimum, the requirements that follow.

(a) Be able to communicate to the department the roles, expectations and purposes of the program; and

(b) Work with representatives of other agencies.

(2) They must also meet one of these education or experience requirements:

(a) Have a bachelor's degree in social science or closely related field from an accredited school; or

(b) Have a minimum of two years of successful, full-time relevant experience, such as working in a group care facility; or

(c) Have a minimum of two years as a foster parent with a letter of recommendation from the licensing agency and supervising agency.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0700, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0705 Do I need an on-site program manager at each group care facility? Each group care facility must have an on-site program manager or person with the equivalent training and experience at each facility during business hours.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0705, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0710 What are the responsibilities of the on-site program manager for a group care program? The on-site program manager has the following responsibilities:

(1) Coordinates the day-to-day operations of the program;

(2) Supervises the child care staff;

(3) Oversees the completion of each child's plan of care and treatment.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0710, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0715 What qualifications must the on-site program manager for a group care program have? Each on-site program manager must have the following qualifications:

(1) A bachelor's degree in a social science or closely allied field from an accredited school; or

(2) Five years of successful full-time experience in a relevant field; and

(3) Supervisory abilities that promote effective staff performance; and

(4) Relevant experience, training, and demonstrated skills in each area that he or she will be supervising.

(5) The same person may have the responsibilities of the executive director and the on-site program manager if that person meets the qualifications for both positions.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0715, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0720 What qualifications must the child care staff for a group care program have? The child care staff person is responsible for the care, supervision, and behavior management of children under your care. The department requires the child care staff of each group care program:

(1) Be at least twenty-one years old;

(2) Exception: Child care staff may be eighteen to twenty years old if enrolled and participating in an internship or practicum program with an accredited college or university; and supervised by staff twenty-one years or older;

(3) Have a high school diploma or GED;

(4) Have one year of experience working with children;

(5) Have the skills and abilities to work successfully with the challenging behaviors of children in care; and

(6) Have effective communication and problem solving skills.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0720, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0725 What is the ratio of child care staff to children in group care facilities? The department has specific requirements for the ratio of child care staff to children in group care.

(1) The ratio for group homes is at least one child care staff member on site for every eight children during waking hours.

Note: Crisis residential centers, staffed residential homes, maternity programs, and programs for children with severe developmental disabilities have different requirements.

(2) At least two adults, including at least one child care staff person, must be on site whenever more than eight children are on the premises.

(3) To keep the proper ratio of staff to children, the executive director, on-site program manager, support staff and maintenance staff may serve temporarily as child care staff if they have adequate training.

(4) During sleeping hours of youth, at least one staff person must be awake in all group home programs when:

(a) There are more than six youth in care; and

(b) The major focus of the program is behavioral change rather than the development of independent living skills, such as teen parent and independent living skills programs; or

(c) The youth's behavior poses a safety risk to self or others.

(5) When only one child care staff is on site, a second staff must be on call.

(6) You must have relief staff so that all staff can have the equivalent of two days off a week.

(7) If you have more than one program in one building, such as a group care program and a crisis residential center, you must follow the most stringent staffing ratio requirements.

(8) For certified juvenile detention facilities, at least one child care staff member must be on duty for every ten children in care during the sleeping and waking hours.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0725, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0730 Do you have room requirements for group care facilities? You must meet the following room requirements to operate a group care facility.

(1) You must provide rooms that are ample in size and properly furnished for the number of children you serve.

(2) You must have a comfortably furnished living room.

(3) You must have a dining room area that is ample in size and suitably furnished for your residents.

(4) Exception: Juvenile detention facilities are not required to meet these first three standards.

(5) With more than twelve children, you must provide at least one separate indoor recreation area. Its size and location must be sufficient for the age and number of the children to engage in recreational and informal education activities.

(6) You must provide a room or area that is used as an administrative office. In addition, suitable offices must be provided for social service staff. In facilities caring for fewer than thirteen children, these offices may be combined with the administrative office.

(7) You must provide a space that can be used as a visiting area.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0730, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0735 When do I need a special care room? (1) If you operate a group facility, you must provide a special care room reserved for the care of a person who needs to be separated from the group due to injury, illness or the need for additional rest.

(2) A special care room must:

(a) Be located in a place that easily allows the person to be supervised;

(b) Have toilet and lavatory facilities that are easily accessible to any person staying in the special care room.

(3) After each use have the area and equipment sanitized if used by any person who is suspected of having a communicable disease.

(4) You may use the special care room for other purposes when it is not needed for the separation and care of an ill or injured person.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0735, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0740 What are the kitchen requirements? (1) You must provide facilities to properly store, prepare, and serve food to meet the needs of the children under your care.

(2) All food service facilities and food handling practices in day treatment programs and group care facilities must comply with rules and regulations of the state board of health governing food service sanitation (see chapter 246-215 WAC).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0740, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0745 Who may provide maternity services? The following programs, homes, facilities, and agencies that may provide or arrange for maternity services include:

(1) Foster homes;

(2) Staffed residential homes;

(3) Group homes for new mothers with infants;

(4) Independent living programs; and

(5) Child placing agencies.

Note: The rules in WAC 388-148-0745 through 388-148-0795 apply exclusively to licensing requirements for agencies providing or arranging maternity service.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0745, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0750 What maternity services must I provide? If you operate a licensed program for expectant mothers and new mothers with infants, you must provide or arrange for the following services:

(1) Information and referral services to every expectant and new mother who applies for care.

(2) Individual or group counseling sessions, if necessary, about the following topics:

(a) Pregnancy counseling;

(b) Independent living education;

(c) Infant and child care training;

(d) Living arrangements;

(e) Medical care planning;

(f) Legal issues;

(g) Vocational or educational guidance;

(h) Plans for the child;

(i) Financial, emotional or psychological problems;

(j) Relations with parents and birth father; and

(k) Home management and consumer education.

(3) An expectant mother's delivery in a licensed hospital or licensed birthing facility.

(4) Postpartum medical examinations, as prescribed by a physician, to a new mother.

(5) Childcare, as needed.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0750, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0755 How are maternity services delivered? (1) Maternity services must not be contingent upon a parent's decision to keep or relinquish her child.

(2) If you do not directly provide maternity services to an expectant or new mother in your facility, you must either:

(a) Arrange for these services through formal agreements with other community agencies; or

(b) Assist the clients in your program to get these services.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0755, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0760 Do you need to approve daily activities that I offer to expectant or new mothers? The department must approve the program of daily activities that you've developed for expectant or new mothers, whether your program is residential or nonresidential.

(1) The department requires that you provide us with a written program description about the daily activities you offer. The program description must outline educational, recreational, and therapeutic services that you intend to provide to expectant mothers and new mothers with infants.

(2) You must also provide us with a schedule of typical daily activities for the mothers under your care.

Exception: Foster homes are not required meet the standard in this section.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0760, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0765 What types of health education must I offer expectant and new mothers? You need to offer or arrange health education for expectant and new mothers that includes the following areas:

(1) Pregnancy hygiene;

(2) Suitable preparation for childbirth;

(3) The physiological changes during pregnancy;

(4) Examinations and childbirth procedures;

(5) Postnatal and pediatrics care;

(6) Contraception and family planning;

(7) Nutritional requirements for mother and child;

(8) Child health and development; and

(9) Psychological and emotional changes during and after pregnancy.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0765, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0770 Is a group care program required to provide child care? (1) If your program serves parents with children, you must provide or assist the parent in arranging for licensed child care when appropriate. An example is when parents are working or are in school and need childcare.

(2) The childcare home or facility must be licensed.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0770, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0775 Do expectant and new mothers need to be under a physician's care? Expectant and new mothers must be under a physician's care for prenatal care to receive maternity services from programs or facilities licensed by the department.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0775, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0780 What are my responsibilities if a specialist is required? You must provide or arrange for consultation regarding prenatal care by specialists meeting their full professional qualifications when the physician requests prenatal consultants.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0780, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0785 What is the proper ratio of staff to children in home or group care facilities offering maternity services? Residential programs provide twenty-four-hour care to expectant mothers and to new mothers with infants.

(1) These programs must employ sufficient numbers of residential staff to meet the physical, safety, health and emotional needs of the residents. Residential staff are in charge of supervising the day-to-day living situation for youth.

Note: Child care staff may carry out any maintenance tasks that do not detract from their primary function.

(2) When youth are on the premises, the ratio of staff to residents must be as follows:

(a) At least one residential staff member must be on duty for every eight mothers.

(b) When more than eight persons (including mothers and children) are on the premises, at least two adults, including at least one child care staff must be on duty.

(3) You must have relief staff so that all staff can have the equivalent of two days off a week.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0785, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0790 Do you have room requirements for facilities offering maternity services? (1) If you have a residential program for expectant mothers or new mothers with infants, you must meet the room requirements for group facilities (WAC 388-148-0730).

(2) If your facility offers medical clinics, you must have a separate, adequately equipped examination room with adequate nursing equipment.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0790, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0795 How is capacity determined for a maternity services facility? We count the number of mothers and children in determining capacity. The space required for a mother and infant bedroom needs to be considered when determining the capacity of a facility or home (see WAC 388-148-0670).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0795, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0800 What is the purpose of day treatment programs? (1) A day treatment program must provide educational and therapeutic group experiences for emotionally disturbed children who are not in need of residential care. These services are provided during part of the twenty-four-hour day, usually during a five-day week.

(2) Day treatment is for children who are:

(a) Unable to adjust to school programs due to disruptive behavior, family stress, learning disabilities or other serious emotional disabilities; and/or

(b) Are unable to profit from outpatient child guidance clinic services and related programs.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0800, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0805 What staff must my day treatment program have? (1) Your day treatment program must have an executive director to manage the financial and administrative operations of the program and an on-site program manager to supervise the child care staff and the treatment program at the facility.

Note: The executive director and on-site program manager may be the same person if that person is qualified for both positions.

(2) Either the executive director or on-site program manager must be on the premises while the children are in care. Another competent person may be left in charge during the director's and/or program supervisor's temporary absence.

(3) The qualifications for executive director and on-site program manager are outline in WAC 388-148-0700 and 388-148-0715, respectively.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0805, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0810 What consultants must my day treatment program have? If you operate a day treatment program, you must use psychiatrists, psychologists, teachers, and group counselors for children under care as follows. Your day treatment program must:

(1) Receive regular consultation from a child psychiatrist;

(2) Provide or arrange for a psychologist for psychological testing and related services if the child's school does not provide these services;

(3) Provide or arrange for teaching by certified teachers qualified by training or experience in remedial education; and

(4) Use group counselors who are qualified by training or by experience in the care of disturbed children.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0810, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0815 What is the ratio of counselor and teaching staff to children in a day treatment program? There must be one counselor or teacher for every six children who are in a day treatment program.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0815, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0820 What type of care is offered for medically fragile children and children with severe developmental disabilities? Specialized group care programs are designed to provide residential care to children who need intensive personal care due to medical fragility and/or severe developmental disabilities. The children may require skilled health care, physical therapy, or other forms of therapy.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0820, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0825 Who provides services for medically fragile children and children with severe developmental disabilities? Individuals and agencies are licensed to provide services to medically fragile children and children with severe developmental disabilities, including staffed residential homes, group homes and child-placing agencies.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0825, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0830 What services must you provide for medically fragile children and children with severe developmental disabilities? (1) If you care for medically fragile children and children with severe developmental disabilities you must ensure the following services are provided, if prescribed by a physician:

(a) An individualized treatment plan suited to the unique needs of each child in care; and

(b) Care by physicians, including surgeons, general and family practitioners, and specialists in the child's particular diagnosis on either a referral, consultative, or ongoing treatment basis.

(2) You must also provide the following nursing services, if prescribed by a physician, if you care for medically fragile children, or children with severe developmental disabilities unless these children are in a foster home:

(a) Sufficient licensed nursing staff to meet the nursing care needs of the children; or

(b) Regular nursing consultation that includes at least one weekly on-site visit by a registered nurse.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0830, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0835 Do I need to have a multidisciplinary care plan for medically fragile children and children with severe developmental disabilities? If you operate a program licensed for the care of medically fragile children and children with severe developmental disabilities, you must maintain a multidisciplinary plan of care for each child in care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0835, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0840 What must the multidisciplinary care plan for a medically fragile child or a child with severe developmental disabilities include? The multidisciplinary care plan must address the social service, medical, nutritional, rehabilitative, and educational needs of each medically fragile child or child with severe developmental disabilities.

(1) The plan must describe:

(a) The care given for each child;

(b) The goals to be accomplished; and

(c) The professional services responsible for each element of care.

(2) The care plan must be reviewed, evaluated, and updated annually by professional staff involved in the care of the child to reevaluate each child's condition, progress, prognosis and need for ongoing care and services.

(3) You must record progress reports in the child's record on a quarterly basis.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0840, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0845 What are the requirements for nurses in programs who care for medically fragile children or children with severe developmental disabilities? If nursing services are prescribed by a physician, the department has several requirements for programs that care for medically fragile children or children with severe developmental disabilities.

(1) The registered nurse's name, address, and telephone number must be readily available.

(2) The agency or program must have the nurse assist in implementing a regular health care program that both:

(a) Oversees the health of all children; and

(b) Provides follow-up care of special health needs identified by the child's physician or facility or program staff.

(3) The agency or program must have the nurse advise and assist nonmedical personnel in maintaining medical records, meeting daily health needs, and caring for children with minor illnesses and injuries.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0845, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0850 When do I use a nurse? You must use a nurse to consult with you at your home or facility if you have infants, medically fragile children or children with severe developmental disabilities under your care and meet these specific conditions:

(1) If you have four or more infants, you must arrange for monthly on-site visits with a registered nurse that is trained or experienced in the care of young children.

(2) You must have a written agreement with the registered nurse about your infant care program.

(3) If you have children with severe developmental disabilities requiring nursing services, you must have a registered nurse on staff or under contract.

(4) The nurse must advise you and your staff on your infant care program and your child health program.

(5) You must document the nurse's on-site visits.

(6) The nurse's name and telephone number must be posted or otherwise available in your home or facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0850, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0855 Do I need to provide a therapy room for children with severe developmental disabilities? (1) If you care for children with severe developmental disabilities, you must provide them with a room for physical and occupational therapy, if these services are prescribed by a physician. The room must be adequate for storing equipment used during therapy sessions.

(2) If you do not have a room for physical and occupational therapy, you must arrange for these therapies outside of your facilities.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0855, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0860 Are there additional room requirements if I serve children with severe developmental disabilities? If you operate a group care program that serves children with severe developmental disabilities, you must follow these additional room requirements.

(1) If you are licensed to care for thirteen or more children, you must provide separate, safe play areas for children under one year of age or children not walking. The department must approve the rooms or areas.

(2) Children under one year of age must be cared for in rooms or areas separate from older children.

(3) No more than eight children under one year of age may be in the room at a time.

(4) Hand-washing facilities must be available in these rooms.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0860, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0865 What food requirements exist for medically fragile children and children with severe developmental disabilities? There may be specific food requirements if you operate a home or facility that cares for medically fragile children and children with severe developmental disabilities:

(1) All modified diets must be planned, reviewed, and approved by a dietitian. You must use the services of a dietitian who meets current registration requirements of the American dietetic association.

(2) You must follow the dietary plan for each child as prescribed by the child's physician. You must document in the child's file that staff are following the physician's order.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0865, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0870 What additional record-keeping requirements exist for medically fragile children and children with severe developmental disabilities? (1) In addition to meeting standard requirements for keeping records (see WAC 388-148-0120 through 388-148-0140), you must also keep the following information for any medically fragile child and child with severe developmental disabilities:

(a) Information you received upon admission including family background, current diagnosis and medical status, an inventory of personal belongings, medical history, and a report of a physical examination and diagnosis by a physician;

(b) Information about the child's daily care including treatment plans, medications, observations, medical examinations, physicians' orders, allergic responses, consent authorizations, releases, diagnostic reports, and revisions of assessments;

(c) Upon discharge, a summary including diagnoses, treatments, and prognosis by the person responsible for providing care, and any instructions and referrals for continuity of care; and

(d) Evidence of meeting criteria for eligibility for services from the division of developmental disabilities.

(2) If the child has died, you must also have the following information:

(a) The time and date of death;

(b) Apparent cause of death;

(c) Notification of the physician and relevant others (including the coroner if necessary); and

(d) Regarding the disposal of the child's body and how the child's personal effects will be dealt with.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0870, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0875 What types of crisis residential centers may be licensed? (1) A facility may be licensed as a regular crisis residential center (CRC) or a secure crisis residential center.

(2) A foster home may be licensed as a family CRC. The foster home licensed, as a CRC, must meet the licensing standards for foster homes outlined in this chapter.

(3) Family CRCs and regular CRCs are not locked facilities, but are operated in a way that reasonably assures that youth placed there will not run away.

Note: Regular CRCs are also known as semi-secure CRCs, as referred to in RCW 13.32A.030 (13) and (14).

(4) A secure facility is designed and operated to prevent a youth from leaving without permission of the staff. This facility has locking doors, locking windows, or secured perimeters.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0875, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0880 What levels of secure CRCs exist? The department licenses two types of secure crisis residential centers (CRCs): Level one and level two. Level one is the most secure facility and level two is the least secure facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0880, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0885 What are the requirements for a level-one secure CRC? A level-one crisis residential center (CRC) must meet each of these requirements:

(1) Be a free-standing facility, separate unit, or separate building within a campus with windows and exterior doors that prevent exit.

(2) Meet or exceed the current state building code when locking doors and windows prevent exit.

(3) Ensure that no youth is kept in a locked room that isolates the youth from the general population and/or staff.

(4) Maintain a recreation area, within the secured facility or secured on the property of the facility, that can support youth's vigorous physical activity. (Any fences used to secure the recreation area must meet or exceed the specifications of the level-two CRC referenced in WAC 388-148-0890(3)).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0885, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0890 What are the requirements for a level-two secure CRC? A level-two secure crisis residential center (CRC) must meet each of these requirements:

(1) Prevent unauthorized entering and exiting with a nonscalable fence around the perimeter of the facility property;

(2) Not prevent exit by locking facility doors or windows;

(3) Design the nonscalable fence that does not cause injury, such as avoiding use of electrification, razor wire or concertina wire;

(4) Ensure that no youth is kept in a locked room that isolates him or her from the general population and/or staff; and

(5) Maintain a recreation area surrounded by a nonscalable fence that can support youth's vigorous physical activity.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0890, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0895 May a juvenile detention center operate as a secure CRC? (1) A juvenile detention center may operate as a secure crisis residential center (CRC). The physical facility must be operated so that no direct communication or physical contact can be made between a resident of the secure crisis residential center and a person held in the detention facility.

(2) Staff assigned to the secure crisis residential center youth must not be simultaneously assigned to the juvenile detention center residents on the same shift.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0895, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0900 What youth may a CRC serve?

All CRCs

A crisis residential center (CRC) provides emergency, temporary residence to youth ages twelve through seventeen who meet one of the following criteria:

(1) Are beyond the control of their parents or guardians and behave in a way that endangers any person's welfare;

(2) Need assistance getting food, shelter, health care, clothing, educational services, and/or resolving family conflicts;

(3) Need temporary protective custody; or

(4) Have parents who are not able or willing to continue efforts to keep the family together.

Secure CRCs

Youth ordered by the court to serve time for contempt on CHINS, APY, or truancy orders may be ordered into a secure CRC that is co-located with a detention facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0900, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0905 Can law enforcement officers place youth in secure CRCs? Law enforcement officers must place youth in secure crisis residential centers (CRCs), when available, when youth:

(1) Are runaways;

(2) Are in dangerous situations; or

(3) Are in violation of curfew.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0905, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0910 What hours do CRCs have to be open? Crisis residential centers (CRC) must be open twenty-four hours a day, seven days a week.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0910, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0915 What steps must be taken after a youth is admitted into a CRC?

All CRCs

(1) The director or designee of a crisis residential center (CRC) must immediately notify the parents of the youth who has been admitted.

(2) If the director or designee of any CRC is unable to contact the youth's parents within, forty-eight hours, he or she must:

(a) Contact the department and request that the case be reviewed for dependency filing under chapter 13.34 RCW or "child in need of services" filing under chapter 13.32A RCW; and

(b) Document the contact with the department in the youth's case record.

Secure CRCs

(3) Within the first twenty-four hours after admitting a youth to a secure crisis residential center, and each twenty-four hours after, the director or designee must assess the youth's risk of running.

(4) The CRC director or designee must determine what type of CRC, regular or secure, would be best for the youth.

(5) The CRC director or designee must use the following criteria in making the decision, considering the safety, health and welfare of the youth and others:

(a) The youth's age and maturity;

(b) The youth's physical, mental, and emotional condition upon arrival at the center;

(c) The circumstances that led to the youth's placement at the facility;

(d) The youth's behavior;

(e) The youth's history of running away;

(f) The youth's willingness to cooperate in conducting the assessment;

(g) The youth's need for continued assessment, protection, and intervention services in a CRC; and

(h) The likelihood the youth will remain at a CRC.

(6) The CRC director or designee must put the decision about the youth's status in writing in the youth's file.

(7) After a youth is admitted, the CRC director or designee must ensure that a youth is assessed for any health needs requiring immediate attention.

(8) By the first school day after admission, the crisis residential center staff must:

(a) Notify the youth's school district about the youth's placement; and

(b) Assess the youth for any educational needs as a part of the assessment process for inclusion in the discharge summary.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0915, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0920 What if a youth seems unlikely to remain in a regular CRC? If a crisis residential center (CRC) director or designee decides that a youth is unlikely to stay in a regular facility, he or she must make reasonable efforts to transfer the youth to a secure facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0920, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0925 What happens when no space exists at a secure CRC? If space is not available in a secure crisis residential center (CRC), the director or designee of the secure CRC may transfer a different youth from that facility to a regular CRC as long as the youth:

(1) Has been in the secure facility for at least twenty-four hours; and

(2) Is considered likely to remain at a regular CRC facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0925, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0930 How is a youth transferred from one type of CRC to another? After deciding that a youth needs to be transferred from one type of crisis residential center (CRC) to another, the director or designee initiating the change must take these steps:

(1) Obtain the department's agreement with the transfer decision.

(2) Communicate with the CRC where the youth is being relocated:

(a) Assure mutual agreement with the transfer decision; and

(b) Make sure that space for the youth is available to support the transfer.

(3) Document all communication related to the transfer into the youth's file.

(4) The CRC director or designee initiating the transfer must establish and maintain the following written documents:

(a) Transfer procedures for the transfer of youth to another crisis residential center; and

(b) Protocols/agreements with the other crisis residential center's director for youth transfers.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0930, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0935 How long may a youth stay at a CRC? All CRCs

(1) Youth may stay in any crisis residential center (CRC) for up to five days.

(2) If a youth has been transferred between CRCs, the total number of days spent in both CRCs may not exceed five days.

Secure CRCs

(3) Any youth admitted to a secure CRC must remain there for at least twenty-four hours, unless their parent or guardian removes them.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0935, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0940 What does a youth's orientation to a CRC need to include? (1) As part of admission to a crisis residential center (CRC), the CRC staff must give an orientation to youth that includes, but is not limited to:

(a) A description of the CRC's program and services;

(b) The physical facility;

(c) The department-approved policy that states that youth may not have guns and other weapons, alcohol, tobacco, and drugs within the facility; and

(d) The department-approved policy on client visitation that includes access to the youth's attorney.

(2) Written documentation of this orientation must be in each youth's file.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0940, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0945 What intervention services must be provided or arranged for by the CRC? (1) Crisis residential centers (CRCs) must provide or arrange, at a minimum, the following services:

(a) Assessment of the family in order to develop a treatment plan for the youth;

(b) Family counseling focused on communication skills development and problem solving;

(c) Individual and/or group counseling; and

(d) Referrals to transition the family to community-based services.

(2) Intervention services must be documented, in writing, in the youth's case record.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0945, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0950 What behavior management practices are required for a CRC? (1) Crisis residential centers (CRC) must follow the department's behavioral management policy as specified in the general licensing requirement section of this chapter (see WAC 388-148-0465 through 388-148-0490).

(2) A CRC must develop policies and procedures when the behavior management practices include use of physical restraint, including:

(a) Who may authorize the use of physical restraint; and

(b) Under what circumstances physical restraint may be used, including time limitations, re-evaluation procedures, and supervisory monitoring.

(3) Written policies and procedures about using physical restraint must be submitted to the department for approval before the policies and procedures are implemented.

(4) All staff must be trained in behavior management techniques prior to using physical restraint.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0950, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0955 What is the purpose of a multidisciplinary team in a CRC? (1) Crisis residential centers (CRC) must have multidisciplinary teams available as a service to youth and their families, if they request the service.

(2) The purpose of the multidisciplinary team is to evaluate the youth and the youth's family and when agreed to by the family, assist the with any of the following services:

(a) Developing a plan for accessing available social and health-related services;

(b) Obtaining referrals to a chemical dependency specialist and/or county-designated mental health professional;

(c) Recommending no further intervention because the youth and family have worked out the problems that were causing family conflicts; and

(d) Reconciling the youth and family.

(3) Members of multidisciplinary teams may include:

(a) Educators;

(b) Law enforcement personnel;

(c) Court personnel;

(d) Family therapists or mental health providers;

(e) Chemical dependency treatment providers;

(f) Licensed health care practitioners;

(g) Social service providers;

(h) Youth residential placement providers;

(i) Other family members;

(j) Church representatives; and

(k) Members of the family's community.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0955, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0960 When may a multidisciplinary team be requested? (1) After a youth is admitted into a crisis residential center (CRC), the CRC director or designee must advise the parent or guardian and the youth of their rights to request a multidisciplinary team.

(2) The director or designee also may set up a multidisciplinary team when he or she:

(a) Believes that the:

(i) Youth is a "child in need of services" under RCW 13.32A.030; and

(ii) Parent is unavailable or unwilling to continue efforts to maintain the family structure.

(b) Needs help contacting the youth's parents. If the director or designee is unable to contact the parent or guardian within forty-eight hours, the director or designee must:

(i) Contact the department and request the case be reviewed for a dependency filing under chapter 13.34 RCW or a "child in need of services" filing under chapter 13.32A WAC; and

(ii) Document this information in the child's case file.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0960, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0965 How is a multidisciplinary team convened? (1) The crisis residential center (CRC) director or designee must notify the members of the multidisciplinary team of the need to convene.

(2) The director or designee must:

(a) Tell the youth's parents or guardians about the multidisciplinary team if the parents did not make the initial request to form a team;

(b) Advise the parents of their right to select additional members; and

(c) Assist in getting prompt involvement of additional persons that the parent or youth have requested to be added to the multidisciplinary team.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0965, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0970 May a parent disband the multidisciplinary team? (1) The crisis residential center (CRC) director or designee must advise the parents of their right to disband the multidisciplinary team within twenty-four hours after they receive notice of the team forming, excluding weekends and holidays.

(2) Parents may disband the multidisciplinary team:

(a) Unless a dependency petition has been filed (under RCW 13.32A.140); or

(b) After a dispositional hearing has taken place ordering out-of-home placement for the youth.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0970, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0975 What qualifications must a crisis residential center executive director have? A crisis residential center executive director must meet the same qualifications that are specified for group care executive directors (see WAC 388-148-0700).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0975, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0980 Do I need a program manager on-site at each facility? Each crisis residential center facility must have an on-site program manager or person meeting those qualifications to coordinate the day-to-day operations of the facility on the premises during business hours, when youth are present.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0980, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0985 What qualifications must the on-site program manager for a crisis residential program have? Each on-site program manager must meet the qualifications outlined under WAC 388-148-0710.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0985, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0990 What additional qualifications must the crisis residential center youth care staff have? (1) At a crisis residential center (CRC), the primary duties of the youth care staff are the care, supervision, and behavioral management of youth. All youth care staff in a CRC must meet the qualifications for youth care staff in a group care program (see WAC 388-148-0715).

Additional CRC youth care staff qualifications

(2) Additional requirements for youth care staff that work in a CRC are as follows:

(a) At least fifty percent of the youth care staff must have completed:

(i) A bachelor's degree; or

(ii) At least two years of college and one year of work in a residential care program for adolescents.

Note: Youth care staff may substitute experience for education on a year-for-year basis. A Bachelor of Arts degree in behavioral or social science may substitute for experience.

(3) The remaining youth care staff must have at least a high school diploma or GED and one of the following:

(a) One year of successful experience working with youth in a group setting;

(b) One year of successful experience as a foster parent for three or more children;

(c) Have skills and abilities to work successfully with the challenging behaviors of children in care; and

(d) Have effective communication and problem solving skills.

Note: Two years of college may be substituted for the required experience.

(4) Each youth care staff person must be at least twenty-one years of age, unless they are between eighteen and twenty-one, enrolled and participating in an internship program with an accredited college or university.

Note: Staff under twenty-one years of age must be supervised by a staff twenty-one years old or older.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0990, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0995 What are the ratio requirements of youth care staff to youth in crisis residential centers? (1) You must ensure the safety of the youth that are residing in crisis residential centers (CRCs) by maintaining staffing ratios. This may require a staffing ratio higher than the minimum listed if necessary for the health and safety of youth and/or staff.

Regular CRCs

(2) At all times, regular crisis residential centers must have at least one youth care staff on duty for every four youth in care.

(3) Regular crisis residential centers must have at least two awake youth care staff on duty during waking hours of the youth.

(4) Regular crisis residential centers must have at least one awake youth care staff on duty during sleeping hours of the youth. One or more additional (back-up) staff must be on the premises during sleeping hours to maintain staffing ratios.

Under extraordinary circumstances, the DLR director may approve an alternative back-up plan.

Secure CRCs

(5) At all times, secure crisis residential centers must have at least two staff on duty at all times when youth are present.

(6) At all times, secure crisis residential centers must have at least one youth care staff on duty for every three youth in care.

(7) At all times, secure crisis residential centers that are located in the same facility as detention facilities must have the at least one awake youth care staff on duty for every four youth in care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0995, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1000 What training must staff at a crisis residential center have? (1) All staff working at a crisis residential center (CRC) must complete a minimum of sixteen hours of preservice job orientation prior to beginning unsupervised child care responsibilities. Training must include:

(a) Presentation of the CRC agency's policies and procedures manual;

(b) Behavior management techniques;

(c) Crisis intervention techniques;

(d) Family intervention techniques;

(e) Child abuse and neglect reporting requirements;

(f) Youth supervision requirements; and

(g) HIV/AIDS/Blood-borne pathogen training.

(2) Staff working at a CRC must complete a minimum of twenty-four hours of on-going education and in-service training annually. This training must include:

(a) Crisis intervention techniques, including verbal de-escalation, positive behavior support, and physical response/restraint training as approved by the department;

(b) Behavior management techniques;
(c) Substance abuse;
(d) Suicide assessment and intervention;
(e) Family intervention techniques;
(f) Cultural diversity;
(g) Mental health issues and interventions;
(h) Mediation skills;
(i) Conflict management/problem-solving skills;
(j) Physical and sexual abuse; and
(k) Emergency procedures.

(3) All staff working at a CRC must have current first aid and CPR training.

(4) The director or designee of the CRC must document completion of all training in each staff person's personnel file.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1000, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1005 What recordkeeping is required for crisis residential centers? (1) Crisis residential centers (CRC) must follow the general licensing requirements for recordkeeping (see WAC 388-148-0125).

(2) In addition, a CRC must record:

(a) The time and date a placement is made;

(b) The names of the person and organization making the placement; and

(c) Reasons for the placement.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1005, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1010 What additional record-keeping requirements exist for secure crisis residential centers? (1) If you operate secure crisis residential centers (CRC), you must maintain, at a minimum, hourly logs of where the youth are physically located.

(2) You must have a policy on the use and retention of these logs, including but not limited to staff briefings between shifts to verify:

(a) Where youth are physically located at each shift change; and

(b) That weekly inspections take place of any security devices.

(3) You must retain these logs for seven years.

(4) You must also maintain a log and written report that identifies all incidents requiring physical restraints for a youth. (see WAC 388-148-0490)

(5) Within seven days of a youth's discharge, you must send the child's social worker a written summary that includes, but is not limited to:

(a) Community-based referrals;
(b) Assessment information on the family and child;
(c) Family reconciliation attempts;
(d) Contacts with families and professionals involved;
(e) Recommendations for all family members;
(f) Medical and health related issues; and
(g) Any other concerns, such as legal issues and school problems.

(6) You must retain a copy of any discharge summaries in the youth's case record at the secure crisis residential center.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1010, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1015 What is the purpose of a staffed residential home? A staffed residential home may employ staff to provide twenty-four-hour care to children who:

(1) Are unable to successfully live in a foster home;

(2) Have emotional disturbances or physical or mental disabilities;

(3) Are medically fragile; or

(4) Are in transition from residential care to a foster home.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1015, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1020 Must a staffed residential home operate in conjunction with another program? A staffed residential home for children may be operated only in conjunction with a licensed child-placing agency or group care program. It may also be operated under a contract or written agreement with children's administration or the division of developmental disabilities.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1020, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1025 What must be included in a written agreement to provide services as a staffed residential home? A written agreement with the department to provide services to children at a staffed residential home must include but is not limited to:

(1) The number of children served at one time;

(2) The expectations of services to be provided;

(3) The steps to be taken to include the child's family;

(4) The plan on how coordination will occur with community partners;

(5) The plan on how permanency planning for the children will take place;

(6) A safety and supervision plan for each child; and

(7) A behavior management plan for each child, as appropriate.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1025, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1030 What services must a staffed residential home provide? (1) A staffed residential home must be able to provide the specialized services required by the group that is served in the staffed residential home. These services may be provided through your own program or through using other community resources.

(2) You must provide care and supervision for children you serve in a staffed residential home, considering their ages and physical conditions.

(3) You must submit a written program description for department approval that includes:

(a) A list of services that you will provide to children and their families;

(b) Who and how these services will be carried out; and

(c) A schedule of typical daily activities for the children under your care.

(4) Services for children must include:

(a) Transportation;

(b) Teaching social and living skills;

(c) Opportunities for play and recreation; and

(d) Opportunities to participate in community and cultural activities.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1030, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1035 Who must be on the premises when children are under care at a staffed residential home? The on-site program manager or a person meeting the same qualifications must be on the premises of the staffed residential home during business hours when children are under care if:

(1) The major focus of the program is behavioral rather than the development of independent living skills such as a teen parent program or responsible living skills program; and

(2) The youth's behavior poses a risk to self or others.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1035, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1040 What are the qualifications for staff at a staffed residential home? The executive director, on-site program manager, and child care staff at a staffed residential home must meet the qualifications outlined for group care program section (WAC 388-148-0700, 388-148-0715, and 388-148-0720).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1040, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1045 What is the ratio of child care staff to children in staffed residential homes? (1) You must meet the minimum ratios of child care staff to children under care at a staffed residential home.

(2) To keep the proper ratio of staff to children, the director, support staff and maintenance staff may serve as child care staff if they have adequate training.

(3) The ratio for staffed residential homes is, at least, one child care staff for every six children during waking hours of children.

(4) During sleeping hours of youth, at least, one staff person must be awake when:

(a) There is a written supervision agreement or a contract with the department of social and health services specifying an awake staff for either the program or a specific child; or

(b) The youth's behavior poses a safety risk to self and/or others.

(5) The need for overnight supervision must be documented in each child's treatment plan, if awake supervision is necessary.

(6) You may only be licensed for maximum of three pregnant or parenting youth

(7) When only one child care staff person is on duty, a second person must be on call and available to respond within one half-hour.

(8) You must have relief staff so that all staff can have the equivalent of two days off a week. This is not required for family members if the staffed residential home a family residence.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1045, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1050 How many children may I serve in my staffed residential home? The department restricts the number of children that a licensed staffed residential home may serve.

(1) The department may license a staffed residential home for six or fewer children. The total number of children in your home or facility must not exceed six at any time.

(2) The department may restrict the number of children in a staffed residential home according to the age and needs of the children.

(3) If only one staff person is on duty at a staffed residential home providing maternity services, that home must not care for more than four persons under the age of eighteen. An additional staff person is required to care for more than four children.

(4) You may have only two children under two years of age in your home at a time.

(5) The department may license a staffed residential home for up to three children with mental or physical disabilities that are severe enough to require nursing care if you meet the following conditions:

(a) You provide staff that are qualified by training and experience to provide proper care, including necessary medical procedures; and

(b) The children's treatment is under the supervision of physicians.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1050, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1055 Are there room requirements for staffed residential homes? The department has certain requirements for rooms that you must meet in order to operate a staffed residential home.

(1) You must provide rooms that are ample in size and properly furnished for the number of children you serve.

(2) You must provide each of the following rooms or areas:

(a) Bedrooms that meet general licensing requirements (WAC 388-148-0260 through 388-148-0270) and have additional space for any special medical equipment needed by children;

(b) At least one comfortably furnished living room;

(c) A dining room area that is ample in size and suitably furnished for your residents;

(d) At least one separate indoor recreation area with a size and location that is suitable for recreational and informal education activities;

(e) A room or area that may be used as an administrative office; and

(f) A visiting area where visitors can have privacy.

(3) The licensor and staffed residential home director may decide what rooms may have multiple uses (for example, dining room and recreation area or visiting area and living room).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1055, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1060 What services may a child-placing agency provide? The department licenses child-placing agencies to provide:

(1) Certification of eligible foster homes meeting full licensing requirements;

(2) Maternity services to expectant mothers;

(3) Specialized (treatment) foster care;

(4) Residential care programs, such as group homes, crisis residential centers, and independent living skills programs; and

(5) Adoption services.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1060, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1065 Do child-placing agency foster homes and group care facilities need to be licensed before placements? The department must license all foster homes and group care facilities that are used by child-placing agencies before any children are placed in them (see WAC 388-148-0015).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1065, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1070 What health histories need to be provided to foster or adoptive parents? (1) To meet department requirements, your child-placing agency must provide adoptive (see WAC 388-25-0330), or foster parents with the following information when available, at the time of placement:

(a) The mental and physical health histories of the birth parents;

(b) A written health history for each child prior to placement, including a history of immunizations, allergies, previous illnesses, and conditions that may adversely affect the child's health; and

(c) The developmental and psychological history for the adoptive children.

Note: You must arrange for the child's medical examinations, immunizations, and health care as required by WAC 388-148-0335 and 388-148-0340.

(2) The adoptive parent(s) must sign one copy of the report, showing that they have received the information. You must retain this signed copy in the child's permanent file.

(3) When the child is being placed for adoption, your report must not contain information that might identify the birth parents.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1070, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1075 When may child-placing agencies from outside the state place children in this state? Child-placing agencies with offices in other states or another country may arrange to place children in Washington state under each of the following conditions:

(1) The out-of-state agency must be fully licensed, certified, or recognized for child-placing functions in its own home state or country.

(2) All public and private agencies must comply with the requirements of the "interstate compact on the placement of children (ICPC)" (see RCW 26.34.011).

Note: Contact the ICPC program manager with children's administration for more information.

(3) The in-state facility receiving children is responsible for:

(a) Conducting a study of the home where the child will be placed;

(b) Related case management; and

(c) Supervising the placement until the child is legally adopted, reaches eighteen years of age, or returns to the originating state.

(4) An out-of-state agency must give us copies of the following written documents:

(a) Written agreements with Washington state agencies;

(b) Evidence of the agency's legal authority to place the child; and

(c) Certification that the agency will assume financial responsibility for any child placed in Washington state until the child is adopted, financially independent, or reaches the age of eighteen.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1075, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1080 Are child-placing agencies required to have office space? You must be housed in offices that are adequately equipped to carry out your child-placing agency's programs and that can offer privacy for interviews with parents and children and storage space.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1080, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1085 How may my child-placing agency certify a foster home for licensing by the department? (1) To certify a foster home for licensing by the department, you must use applications, home study forms, and procedures that are approved by the department (see WAC 388-148-0050 through 388-148-0080).

(2) A foster home must be certified by your child-placing agency as meet the licensing requirements your child-placing in order to be licensed by the department.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1085, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1090 What children may child-placing agency foster homes accept? As part of our requirements, foster homes that child-placing agencies certify as meeting our licensing requirements may accept children only from:

(1) The licensed child-placing agency that certified the foster home; or

(2) The department, as long as these conditions are met:

(a) The child is in the legal custody of, or is under the department's supervision; and

(b) The child placements are approved in advance in writing by the child-placing agency responsible for supervising the foster home or facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1090, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1095 May different child-placing agencies share eligible foster parents for placement? (1) Different child-placing agencies may share eligible foster parents for placement as long as safety and health requirements are met.

(2) The participating agencies must have written agreements between them specifying the criteria and conditions for sharing foster parents prior to the placement of the children. This includes child-placing agencies placing children in DCFS foster homes.

(3) The written agreements must specify roles and responsibilities of each agency.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1095, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1100 What do I need to consider in making foster care placements? (1) In planning a foster care placement for a child, you must consider:

(a) The child's basic right to their own home and family;

(b) The importance of providing skillful professional service to the child's birth parents to help them meet each child's needs in the home;

(c) Each child's individual needs, cultural, and religious background and family situation;

(d) The wishes and participation of each child's parent(s); and

(e) The selection of a foster home that will enhance each child's capacities and meet each child's individual needs.

(2) You must use a written social summary for each child as the basis for acceptance for foster care and related social services.

(3) Every foster care placement that you facilitate must be based on well-planned, individual preparation of the child and the child's family. However, in an emergency situation, you may place a child in a foster home prior to preparing the child and the child's family.

(4) A child may be placed in foster care only with the written consent of the child's parents, a protective custody order, or under a court order. This consent or order must include approval for emergency medical care or surgery.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1100, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1105 May I share information about the child with the foster parents? (1) You must give foster parents any information that may be shared about the child and the child's family. Sharing information about behavioral and emotional problems is especially important. This helps foster parents make an informed decision about whether or not to accept a child in their home.

(2) You must inform the foster parents that this information is confidential and can not be shared with persons who are not involved with the care of the child.

(3) You must document in the child's file that you have shared this information at the time of placement.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1105, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1110 How often should the case manager contact the foster child and family? The case manager must contact a foster child and the foster child's foster family, according to a case plan that reflects the child's needs. Case managers must make in-home health and safety visits as required by children's administration policy. Each foster child and one or both foster parents must be seen at each visit.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1110, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1115 Do you have requirements for adoptive services? (1) As a child-placing agency providing adoption services, you must meet the department's requirements under chapter 388-25 WAC.

(2) You must recruit potential adoptive families that reflect the diversity of children in your community.

(3) You must provide adoptive applicants with the following services, at a minimum:

(a) Information about the adoption process;

(b) Your agency's policies, practices and legal procedures;

(c) Types of children available for adoption and implications for parenting different types of children; and

(d) Information on adoption support programs.

(4) You must document that you provided this information to the adoptive applicant in the applicant's file.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1115, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1120 What is the process for adoptions? You must go through the following steps to place a child for adoption.

(1) The applicants must submit an application (including a completed background inquiry form) to the child-placing agency.

(2) Once you have received an application, but before you have sign a contract for services, you must give the applicants a written statement about:

(a) The adoption agency's fixed fees and fixed charges to be paid by the applicant;

(b) An estimate of additional itemized expenses to be paid by applicant; and

(c) Specific services covered by fees that you offer for child placement or adoption.

(3) Your staff must complete an adoptive home study as required in RCW 26.33.190 with the participation of the applicant(s). For the study, your staff and the applicants need to decide about:

(a) The suitability of the applicant(s) to be adoptive parent(s); and

(b) The type of child(ren) for which the applicant or applicants are best suited.

(4) Your staff must accept or deny the application and give an explanation for your decision.

(5) You must file preplacement (home study) reports with the court (as required by RCW 26.33.180 through 26.33.190).

(6) Your staff must prepare the potential adoptive parent(s) for placement of a specific child by:

(a) Locating and providing information about the child and the birth family to the prospective adoptive family as described in chapter 388-25 WAC;

(b) Discussing the likely implications of the child's background for adjusting in the adoptive family.

(7) Your staff must reevaluate the applicant(s) suitability for adopting a child each time an adoptive placement is considered.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1120, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1125 What requirements exist for specialized adoptive services? Specialized adoptive services are inter-country adoption, interstate adoption and adoptions for children with special needs (such as developmental disability or emotional disability).

(1) If your child-placing agency is providing specialized adoptive services, you must have:

(a) Supervisory staff who have specialized training in the particular area of adoption that you want to provide; and

(b) A written in-service training program for staff in these specialized adoptive services.

(2) If you are facilitating the adoptive placement of children who have special needs, you must:

(a) Have adoptive families who are able to meet the children's special needs, such as behavioral disturbance, medical problems or developmental disabilities; or

(b) Have a plan for active recruitment of suitable adoptive families.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1125, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1130 Must my child-placing agency retain the records of adopted children? Your child-placing agency must retain a record of each child you place in permanent custody. This record must contain all available identifying legal, medical, and social information and must be kept confidential, as required by chapter 26.33 RCW.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1130, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1135 What happens to the adopted children's records if my agency closes? If your agency closes, you must make arrangements for the permanent retention of the adopted children's records. You must inform DSHS, children's administration state adoption program manager about the closure of the agency and where the files will be kept (for example, by another adoption agency or Washington state archival files).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1135, filed 8/28/01, effective 9/28/01.]

Chapter 388-155 WAC
MINIMUM LICENSING REQUIREMENTS FOR FAMILY CHILD DAY CARE HOMES

WAC

WAC 388-155-040 Local ordinances and codes. The department must issue or deny a license on the basis of the applicant's compliance with minimum licensing and procedural requirements. Local officials must be responsible for enforcing city ordinances and county codes, such as zoning and building regulations.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-040, filed 8/16/01, effective 9/16/01; 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 must maintain on the premises a copy of the written waiver approval.

(5) The department's denial of a waiver request must not be subject to appeal under chapter 34.05 RCW.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-050, filed 8/16/01, effective 9/16/01; 91-04-048 (Order 3136), § 388-155-050, filed 2/1/91, effective 3/4/91.]

WAC 388-155-060 Dual licensure. The department must not issue a family child care home license to the appli-

cant 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 74.15.030. 01-17-084, § 388-155-060, filed 8/16/01, effective 9/16/01. 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 388-155-080 Issuance of license. (1) The department issues 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) Must 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. 01-17-084, § 388-155-080, filed 8/16/01, effective 9/16/01; 91-04-048 (Order 3136), § 388-155-080, filed 2/1/91, effective 3/4/91.]

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 must 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 must 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. 01-17-084, § 388-155-085, filed 8/16/01, effective 9/16/01; 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 must 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) Must 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 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 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 must 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 must be governed under RCW 43.20A.205.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-090, filed 8/16/01, effective 9/16/01; 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 must provide written notification by personal service, including by the licensor, or certified mail which must 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 must 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 statute 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 must 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. 01-17-084, § 388-155-092, filed 8/16/01, effective 9/16/01; 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 must 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. 01-17-084, § 388-155-093, filed 8/16/01, effective 9/16/01; 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 must post the final notice of a civil penalty in a conspicuous place in the facility.

(2) The notice must remain posted until payment is received by the department.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-094, filed 8/16/01, effective 9/16/01; 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 must send written notification by certified mail or other means showing proof of service. This notification must 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. 01-17-084, § 388-155-095, filed 8/16/01, effective 9/16/01; 96-20-095, § 388-155-095, filed 10/1/96, effective 11/1/96.]

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 must notify the parent in advance about the trip.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-160, filed 8/16/01, effective 9/16/01; 91-04-048 (Order 3136), § 388-155-160, filed 2/1/91, effective 3/4/91.]

WAC 388-155-190 Capacity. (1) The department must 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 must 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 must 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. 01-17-084, § 388-155-190, filed 8/16/01, effective 9/16/01; 91-04-048 (Order 3136), § 388-155-190, 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 (1-800-505-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. 01-17-084, § 388-155-270, filed 8/16/01, effective 9/16/01; 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 388-155-330 Indoor play area. (1) The home's indoor premises must 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 must 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. 01-17-084, § 388-155-330, filed 8/16/01, effective 9/16/01; 91-04-048 (Order 3136), § 388-155-330, filed 2/1/91, effective 3/4/91.]

WAC 388-155-370 Storage. (1) The licensee must provide accessible individual space for the child to store clothes and personal possessions.

(2) The licensee must provide sufficient space to store equipment, supplies, records, files, cots, mats, and bedding.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-370, filed 8/16/01, effective 9/16/01; 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 must 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 must 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 must locate light fixtures and provide lighting intensities promoting good visibility and comfort for the child in care.

(4) The licensee must 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 must ventilate the home for the health and comfort of the child in care.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-380, filed 8/16/01, effective 9/16/01; 91-04-048 (Order 3136), § 388-155-380, filed 2/1/91, effective 3/4/91.]

WAC 388-155-420 Child abuse, neglect, and exploitation. The licensee and assistant must protect the child in care from child abuse, neglect, or exploitation as required under chapter 26.44 RCW.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-420, filed 8/16/01, effective 9/16/01; 91-04-048 (Order 3136), § 388-155-420, filed 2/1/91, effective 3/4/91.]

WAC 388-155-480 Reporting of death, injury, illness, epidemic, or child abuse. The licensee 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 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. 01-17-084, § 388-155-480, filed 8/16/01, effective 9/16/01; 91-04-048 (Order 3136), § 388-155-480, filed 2/1/91, effective 3/4/91.]

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 must be separated from the family child day care home or any exits by a fire wall.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-605, filed 8/16/01, effective 9/16/01. 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 must 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 must 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 must be installed in the upper level, except that when the lower level contains a sleeping or napping area, a smoke detector must be located on each level.

(4) When sleeping or napping rooms are on an upper level, the smoke detector must 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 must be installed in both the hallway and the sleeping/napping room.

(6) Smoke detectors must sound an alarm audible in all areas of the building.

(7) In new construction, required smoke detectors must receive their primary power from the building wiring when such wiring is served from a commercial source. Wiring must 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 must be maintained upon the premises.

(10) Single station smoke detectors must be tested at monthly intervals or in a manner specified by the manufac-

turer. Records of such testing shall be maintained upon the premises.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-610, filed 8/16/01, effective 9/16/01. 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 must 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 74.15.030. 01-17-084, § 388-155-620, filed 8/16/01, effective 9/16/01. 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 must be provided on each floor level occupied for day care use. Such extinguisher must 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 must be operationally ready for use at all times.

(3) Fire extinguisher must 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 must 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 74.15.030. 01-17-084, § 388-155-630, filed 8/16/01, effective 9/16/01. 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 must 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 must document this contact.

(2) Furnace rooms must be maintained free of lint, grease and rubbish accumulations and other combustibles and suitably isolated, enclosed or protected.

(3) Flammable or combustible materials must be stored away from exits and in areas which are not accessible to children. Combustible rubbish shall not be allowed to accumulate and must be removed from the building or stored in closed, metal containers.

(4) The licensee must 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 must be of noncombustible materials with tops. Electrical motors shall be kept dust-free.

(5) Open-flame devices capable of igniting clothing must not be left on, unattended or used in a manner which could result in an accidental ignition of children's clothing. Candles must not be used.

(6) A flashlight must be available for use as an emergency power source.

(7) All electrical circuits, devices and appliances must be properly maintained. Circuits must not be overloaded. Extension cords and multi-plug adapters must 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 must 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 must be in such a position as to be plainly visible and legible from the street or road fronting the property. Said numbers must contrast with their background.

(10) Fireplaces, woodstoves, similar devices and their connections must 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 must 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 must be erected to prevent children from coming in contact with the open flames and/or hot surfaces.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-640, filed 8/16/01, effective 9/16/01. 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, must be tested on an annual basis by a person or agency qualified by licensing. The results of the system test must be documented on forms provided by the licensor and maintained at the home for inspection by the licensor.

[Statutory Authority: RCW 74.15.030. 01-17-084, § 388-155-650, filed 8/16/01, effective 9/16/01. 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 must develop written fire evacuation plans. The evacuation plan must include an evacuation floor plan, identifying exit doors and windows, that must be posted at a point clearly visible to the assistant and parents. Plans must 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 74.15.030. 01-17-084, § 388-155-660, filed 8/16/01, effective 9/16/01. 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 must be conducted at least once each month. A written record, the fire safety record and evacuation plan, must 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 74.15.030. 01-17-084, § 388-155-670, filed 8/16/01, effective 9/16/01. 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 must 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 74.15.030. 01-17-084, § 388-155-680, filed 8/16/01, effective 9/16/01. 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.]

Chapter 388-160 WAC

MINIMUM LICENSING REQUIREMENTS FOR OVERNIGHT YOUTH SHELTERS

WAC

388-160-130 Repealed.
388-160-140 Repealed.
388-160-150 Repealed.
388-160-160 Repealed.
388-160-170 Repealed.
388-160-180 Repealed.
388-160-190 Repealed.
388-160-200 Repealed.
388-160-210 Repealed.
388-160-220 Repealed.
388-160-230 Repealed.
388-160-240 Repealed.
388-160-250 Repealed.
388-160-260 Repealed.
388-160-270 Repealed.
388-160-280 Repealed.
388-160-290 Repealed.
388-160-300 Repealed.
388-160-310 Repealed.
388-160-320 Repealed.
388-160-340 Repealed.
388-160-350 Repealed.
388-160-360 Repealed.
388-160-370 Repealed.
388-160-380 Repealed.
388-160-390 Repealed.
388-160-400 Repealed.
388-160-410 Repealed.
388-160-420 Repealed.
388-160-430 Repealed.
388-160-440 Repealed.
388-160-460 Repealed.
388-160-470 Repealed.
388-160-480 Repealed.
388-160-490 Repealed.
388-160-500 Repealed.
388-160-510 Repealed.
388-160-520 Repealed.
388-160-530 Repealed.
388-160-540 Repealed.
388-160-550 Repealed.
388-160-560 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-160-010 Authority. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-010, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-020 Definitions. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-020, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-030 Exceptions to rules. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-030, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-040 Effect of local ordinances. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-040, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-050 Fire standards. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-060 Certification of exempt agency. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-060, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-070 Application or reapplication for license or certification—Investigation. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-070, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-080 Limitations on licenses and dual licensure. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-090 General qualifications of licensee, applicant, and persons on the premises. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-100 Age of licensee. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-100, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-110 Posting of license. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-110, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-120 Licensure—Denial, suspension, or revocation. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-130 Licensed capacity. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-130, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-140 Discrimination prohibited. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-140, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-150 Religious activities. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-150, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-160 Discipline. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-160, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-170 Corporal punishment. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-170, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-180 Abuse, neglect, or exploitation. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-180, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-190 Site and telephone. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-190, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-200 Equipment, safety, and maintenance. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-200, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-210 Firearms and other weapons. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-210, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-220 Prohibited substances. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-220, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-230 Storage. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-230, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-240 Bedrooms and sleeping areas. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-240, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-250 Kitchen facilities. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-250, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-260 Housekeeping sink. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-260, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-270 Laundry. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-270, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-280 Toilets, handwashing sinks, and bathing facilities. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-280, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-290 Lighting. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-290, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-300 Pest control. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-300, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-310 Sewage and liquid wastes. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-310, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-320 Water supply. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-320, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-340 Health and emergency policies and procedures. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-340, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-350 First aid. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-350, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-360 Medication management. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-360, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-370 Staff health. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-370, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-380 HIV/AIDS education and training. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-380, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-390 Nutrition. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-390, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-400 Bedding. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-400, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-410 Overnight youth shelters—Purpose and limitations. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-410, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-420 Governing body/citizens board for overnight youth shelters. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-420, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-430 Intake. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-440 Groupings. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-440, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-460 Staffing. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-470 Supervision of youth. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-470, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-480 Child care workers—Qualifications. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-490 Program supervision. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-500 Training. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-510 Services. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-510, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-520 Client records and information—Overnight youth shelters. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-520, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-530 Personnel policies and records—Overnight youth shelters. [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.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-540 Reporting of death, injury, illness, epidemic, or child abuse. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-540, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-550 Reporting runaway youth. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-550, filed 10/4/96, effective 11/4/96.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

388-160-560 Reporting circumstantial changes. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-560, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

WAC 388-160-0005 Authority. The following rules including minimum licensing requirements for overnight youth shelters are adopted under chapter 74.15 RCW.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0005, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0015 What is the purpose of overnight youth shelters? (1) The purpose of overnight youth shelters is to provide youth with an emergency sleeping arrangements.

(2) The overnight youth shelter may be licensed to provide care for one of the following categories of youth:

(a) Youth from thirteen through seventeen years of age; or

(b) Youth sixteen through twenty years of age.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0015, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0025 What definitions apply to this chapter? The following definitions apply to this chapter.

"Capacity" means the maximum number of children a facility is licensed to care for at a given time.

"Children's administration" means a management section of the department of social and health services responsible for many services to children including but not limited to: child protective services, child welfare services, policy development, budget and fiscal operations.

"Compliance agreement" means a written plan of short duration with a specific ending date for completion of the plan. The agreement addresses the improvement or correction of specific issues to maintain or increase the safety and well-being of children in care.

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

"DLR" means the division of licensed resources. A division of children's administration of the department of social and health services.

"Full licensure" means the facility licensed or approved by the department of social and health services meets all applicable licensing standards.

"I" or **"you"** refers to anyone who operates an overnight youth shelter.

"Overnight youth shelter" or **"OYS"** means a licensed facility operated by a nonprofit agency that provides overnight shelter to homeless or runaway youth. Overnight youth shelters do not provide residential care during daytime hours.

"We" refers to the department, including DLR licensors.

"Youth" means an individual who is under twenty-one years old. The term "child" or "children" may also be used in some sections.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0025, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0035 What services must be offered at a shelter? (1) At a minimum, all overnight youth shelters must offer the following services to all clients:

(a) A client identification and intake assessment including:

(i) Emergency contacts (phone numbers);

(ii) Areas of possible problems, such as school status, medical problems, family situation and suicide evaluation;

(iii) History of assaultive or predatory behavior; and

(iv) Drug and/or 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 must provide (as needed by the youth) information about:

(a) Educational or vocational services;

(b) Housing;

(c) Medical care or services;

(d) Substance abuse services;

(e) Mental health services;

(f) Other treatment agencies;

(g) Food programs;

(h) Disability services; and

(i) Other DSHS services.

(3) If the overnight youth shelter cannot directly provide these services, staff must have information for referrals to programs or organizations that would provide these services to clients.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0035, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0045 What must I include in the assessment when a youth first enters a shelter? (1) When a youth first enters an overnight youth shelter, you must:

(a) Determine whether the parents are aware of the whereabouts of the youth;

(b) Determine whether an adult contact exists; and

(c) Notify the police or children's administration intake (either the local CPS number or toll-free 1-886-ENDHARM) of any youth twelve years of age or younger who is unaccompanied by an adult and is requesting service.

(2) As part of the initial assessment, you must also assess the youth's:

(a) Recent history;

(b) Outstanding warrants;

(c) Physical and medical needs, including medication;

(d) School status;

(e) Immediate needs for counseling; and

(f) Options for the near future.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0045, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0055 How does the department decide how many youth I may serve in my overnight youth shelter? (1) The number of youth that an overnight youth shelter may serve is based on an evaluation of the following factors:

(a) Physical accommodations in your overnight youth shelter;

(b) The number of staff and volunteers available for providing care;

(c) The skills of your staff and volunteers; and

(d) The ages and characteristics of the people you are serving.

(2) Based on our evaluation, we may license you for the care of fewer persons than you would normally serve in your category.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0055, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0065 How old do I have to be to apply for a shelter license? You must be at least twenty-one years old to apply for a license for an overnight youth shelter.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0065, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0075 What qualifications do I need to care for youth at an overnight youth shelter? If you are requesting a license or a position as an employee, intern, or a volunteer at an overnight youth shelter, you must not:

(1) Have a history of founded child abuse or neglect.

(2) Be disqualified by our background check (see chapter 388-06 WAC).

(3) The department may require additional information from you, your staff, interns, or volunteers. We may request this information at any time and it may include, but is not limited to any of the following evaluations and/or documentation of completed treatment:

(a) Substance and alcohol abuse evaluations;

(b) Psychiatric evaluations;

(c) Psycho-sexual evaluations; and

(d) Medical evaluations or reports.

(4) Any evaluation or information requested by the department must be supplied at the expense of the applicant or licensee.

(5) The department must approve the evaluator providing the above services and you must give the licensor permission to speak with the evaluator before and after the evaluation.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0075, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0085 Who must be on the premises when youth are present at an overnight youth shelter? (1) In an open or dormitory type setting, a same gender staff person must be within visual and auditory range of same gender youth at all times. The staff must be awake while on-duty.

(2) At least one fully trained lead counselor must be on the premises at all times when youth are present.

(3) A qualified program supervisor must be on call at all times when the shelter is open or youth are present (see WAC 388-160-0095 for qualifications). The program supervisor may be on-staff, on contract or available by written agreement.

(4) Staff must represent both genders to reflect the population of youth in care.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0085, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0095 What qualifications must a program supervisor have in order to work in a shelter? Every overnight youth shelter must have a program supervisor. The program supervisor must have either a:

(1) Master's degree in social work or a related field and one year of experience working with adolescents; or

(2) Bachelor's degree and three years of experience working with adolescents.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0095, filed 7/5/01, effective 8/5/01.]

WAC 388-160-010 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-0105 What qualifications must a lead counselor have in order to work in a shelter? To work in an overnight youth shelter, lead counselors must meet the following qualifications:

(1) Be at least twenty-one years of age;

(2) Have at least one year of experience working with adolescents;

(3) Have completed HIV/AIDS/Blood-borne pathogen training;

(4) Have completed first aid and CPR; and

(5) Have completed a tuberculin test (as required under WAC 388-160-0565).

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0105, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0115 What minimum qualifications must child care staff, lead counselors, interns, and volunteers have in order to work in a shelter? (1) All child care staff, lead counselors, interns, and volunteers who work at an overnight youth shelter must be at least twenty-one years old. Note: Eighteen through twenty-year-old persons may work or volunteer at an overnight youth shelter if they are enrolled and participating in an internship program through an accredited college or university. They must be on-duty and supervised by a fully-trained staff person twenty-one years old or older.

(2) Child care staff, interns, and volunteers also must have successfully completed:

(a) A background check (see chapter 388-06 WAC);

(b) A tuberculin test (as required under WAC 388-160-0565);

(c) Current first aid and cardio-pulmonary resuscitation (CPR) training; and

(d) HIV/AIDS/Blood-borne pathogen training consistent with the department of health approved curriculum prior to beginning work with youth. If the training is not readily available, it must be completed within sixty days of beginning work.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0115, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0125 What training is required for overnight youth shelter staff, lead counselors, interns and volunteers? (1) All overnight youth shelter staff, lead counselors, interns, and volunteers must receive training before providing care for youth. The overnight youth shelter must ensure that this training includes, at a minimum, the following subjects:

(a) Job responsibilities, including the mandatory reporting requirements for licensee and their staff;

(b) Facility administration;

(c) Supervision of youth;

(d) Behavior management training in accordance with department behavior management guidelines;

(e) Fire safety procedures;

(f) Handling of emergency situations; and

(g) Current first aid and cardiopulmonary resuscitation (CPR) training.

(2) HIV/AIDS/Blood-borne pathogen training consistent with the department of health approved curriculum must be completed prior to beginning work with youth. If the training is not readily available, it must be completed within sixty days of beginning work.

(3) An overnight youth shelter must provide on-going training to all staff, interns, and volunteers.

(a) The training must cover qualifications for each position, including supervisory skills, adolescent development and problems, and the needs of youth.

(b) The shelter's training must also include, at a minimum, classes addressing:

(i) Sexual abuse;

(ii) Predatory behavior;

(iii) Substance abuse;

(iv) Depression;

(v) Mental health;

(vi) Teen suicide;

(vii) Injurious behavior towards one's self or others; and

(viii) Cultural sensitivity.

(3) New overnight youth shelter staff, interns, and volunteers must work shifts with fully trained staff until the new person has completed all required training.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0125, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0135 What is the required ratio of staff to youth in a shelter? (1) A shelter licensed for youth who are thirteen through seventeen years old must have one staff person to every eight youth.

(2) A shelter licensed for youth who are sixteen through twenty years old must have one staff person to every six youth.

(3) A shelter must maintain the staffing ratio while youth are asleep.

(4) At least one staff person must remain awake while youth are asleep. Other staff persons may be asleep, but must be available in the shelter in case of emergency.

(5) Whenever only one staff person is required to be on duty, a second staff person must be on call.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0135, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0145 How do I apply or reapply for a license? (1) To apply or reapply for a license, the person or legal entity responsible for your overnight youth shelter must send the following information to the department licensor:

(a) The application form;

Note: If you are applying for a license renewal, you must send the application form to the department licensor ninety days prior to the expiration of your current license.

(b) A completed and signed criminal history and background inquiry form from each applicant, staff person, intern, board member and volunteer who:

(i) Is at least sixteen years old;

(ii) Is not a foster child or shelter youth; and

(iii) Has unsupervised access to youth.

(c) Written verification of:

(i) A tuberculosis test unless you have religious beliefs which prohibit the test;

(ii) First-Aid and cardiopulmonary resuscitation (CPR) training; and

(iii) HIV-AIDS/Blood-borne pathogens training.

(2) If a person required to have a background check has lived in Washington state less than three years immediately prior to their application, a completed FBI fingerprint form must be provided to us for that person.

(3) We may require additional information from you including, but not limited to:

(a) Substance and alcohol abuse evaluations;

(b) Psychiatric evaluations;

(c) Psycho-sexual evaluations; and

(d) Medical evaluations.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0145, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0155 May I receive more than one type of group care license at the same physical location? (1) If you are licensed to operate an overnight youth shelter, you may not hold a license for any other type of residential care at the same physical location.

(2) If you make it clear to us that care for one kind of client does not interfere with the care for another kind of client an exception to WAC 388-160-0155(1) may be granted. (See WAC 388-160-0175 for exceptions.)

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0155, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0165 Does the department put limitations or conditions on a person who is licensed? Even if we approve you for an overnight youth shelter license, we may put limitations or conditions on the license to ensure youth's safety and health.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0165, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0175 Does the department allow exceptions to the licensing requirements? (1) At its discretion, the department may make a written exception, and

license or continue to license an overnight youth shelter that does not meet the minimum licensing requirements.

(2) Exceptions are approved for nonsafety requirements only.

(3) The safety and well-being of the youth receiving care must not be compromised.

(4) You must request an exception to the licensing requirements in writing.

(5) You must keep a copy of the approved exception to the licensing requirements for your files.

(6) Along with an exception to the licensing requirements, the department may require you to enter into a compliance agreement to ensure the safety and well-being of the youth in your care.

(7) You do not have appeal rights if the department denies your request for an exception to our requirements.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0175, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0185 Does the department issue probationary licenses? (1) The department may issue a probationary license as part of a corrective action plan with a licensed provider.

(2) The department must base its decision as to whether a probationary license will be issued on the following:

(a) Intentional or negligent noncompliance with the licensing rules;

(b) A history of noncompliance with the rules;

(c) Current noncompliance with the rules;

(d) Evidence of a good faith effort to comply; and

(e) Any other factors relevant to the specific situation.

(3) A probationary license may be issued for up to six months. At its discretion, the department may extend the probationary license for an additional six months.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0185, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0195 When must the department deny, suspend or revoke a license? (1) A license must be denied, suspended or revoked if the department decides that you cannot provide care for youth in a way that ensures their safety, health and well-being.

(2) The department must disqualify you for any of the reasons that follow.

(a) You have failed your background check (see chapter 388-06 WAC).

(b) You have been found to have committed child abuse or neglect or you treat, permit or assist in treating children in your care with cruelty, indifference, abuse, neglect, or exploitation.

(c) You or anyone on the premises had a license denied or revoked from an agency that provided care to children or vulnerable adults.

(d) You attempt to get a license by deceitful means, such as making false statements or leaving out important information on the application.

(e) You commit, permit or assist in an illegal act on the premises of a home or facility providing care to children.

(f) You are using illegal drugs, or excessively using alcohol and/or prescription drugs.

(g) You knowingly allowed employees or volunteers who made false statements on their applications to work at your agency.

(h) You repeatedly lack qualified or an adequate number of staff to care for the number and types of children under your care.

(i) You have refused to allow our authorized staff and inspectors to have requested information or access to your facility, child and program files, and/or your staff and clients.

(j) You are unable to manage the property, fiscal responsibilities, or staff in your agency.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0195, filed 7/5/01, effective 8/5/01.]

WAC 388-160-020 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-0205 Are there other reasons the department must suspend my overnight youth shelter license? (1) The department must suspend your license to provide care to children, if we receive a notice from the division of child support that you are not in compliance with a support order.

Note: The governing authority is RCW 43.20A.205 and 74.20A.320.

(2) The suspension of your license for noncompliance of a support order would be effective the date you receive a notice that we received the certificate of noncompliance from the division of child support.

(3) Your license would remain suspended until you provide proof that you are in compliance with the child support order.

(4) You would not have a right to an administrative hearing based on a suspension of your license due to noncompliance of a child support order.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0205, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0215 When may the department suspend or revoke my overnight youth shelter license? A license may be suspended or revoked if you exceed the conditions of your facility license by:

(1) Having more youth than the license allows;

(2) Having youth with ages different than the license allows;

(3) Failing to provide a safe and healthy environment for youth in your care; or

(4) Failing to comply with any other licensing requirements.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0215, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0225 How does the department notify me if my license is modified, denied, suspended or revoked? The department sends you a certified letter informing you of our decision to modify, deny, suspend or revoke your license. The letter will include any applicable laws or regulations and provide you with information on what to do if you disagree with the department's decision.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0225, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0235 What may I do if I disagree with the department's decision to modify, deny, suspend or revoke my license? You have the right to appeal any decision the department makes to modify, deny, suspend or revoke your license, except for circumstances identified in WAC 388-160-0205.

(1) You may request an administrative hearing if you disagree with our decision to modify, suspend, revoke or deny your license.

(2) You must request an administrative hearing within twenty-eight days of receiving a certified letter with our decision (chapter 34.05 RCW).

(3) You must send a letter to the Office of Administrative Hearings, PO Box 42489, Olympia, WA 98504-2489, 1-800-583-8271 requesting an administrative hearing. The letter must have the following attachments:

(a) A specific statement of your reasons for disagreeing with the decision and any laws that relate to your reasons; and

(b) A copy of the certified letter from the department containing the decision that you are disputing.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0235, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0245 What incidents involving youth must I report? (1) You or your staff must report any of the following incidents within forty-eight hours to your local children's administration child protective services intake staff:

(a) Any alleged incidents of child abuse or neglect;

(b) Any violations of the licensing requirements;

(c) Death of a child;

(d) Any youth's suicide attempt that results in injury requiring medical attention or hospitalization;

(e) Any emergent medical care to any youth in care;

(f) Any use of physical restraint that is alleged improper or excessive;

(g) Sexual contact between two or more youth;

(h) Physical assaults between two or more youth that result in injury requiring off-site medical attention or hospitalization;

(i) Unexpected health problems that require off-site medical attention;

(j) Any medication given incorrectly that required off-site medical attention;

(k) Serious property damage that is a safety hazard and is not immediately corrected.

(2) In addition to WAC 388-160-0245 (1)(a) through (k), you or your staff must report any of the following incidents to the youth's DSHS social worker, if the youth is a client of DSHS;

(a) Suicidal/homicidal ideas, gestures or attempts that do not require professional medical attention;

(b) Unexpected health problems that do not require professional medical attention;

(c) Any incident of medication incorrectly administered;

(d) Physical assaults between two or more children resulting in injury that does not require professional medical attention;

(e) Runaways; and

(f) Use of physical restraints for routine discipline.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0245, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0255 Are there other reporting requirements? Any occurrence of food poisoning or communicable disease must be reported to the local public health department, as required by the department of health.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0255, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0265 Do I need to report runaway youth who stay at the shelter? (1) Within eight hours of learning that a youth staying at a shelter does not have parental permission to be there, shelter staff must 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 must:

(a) Make the report by telephone or other reasonable means; and

(b) Document the report in writing in the youth's file.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0265, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0275 What changes to my overnight youth shelter must I report to my licensor? (1) You must report to your licensor any changes in the information contained in your original licensing application that might cause the department to reclassify your overnight youth shelter. Changes include any of the following:

(a) Changes in your location;

(b) Change in the designated space, or phone number;

(c) Changes in the maximum number, age ranges, and gender of persons you wish to serve;

(d) Changes in the structure of your facility or premises due to events causing damage such as a fire, or caused by remodeling; or

(e) Additions of any new staff person, intern, employee or volunteer, who might have contact with the youth in care.

(2) A license is valid only for the person or organization named on the license.

(3) You must also report the following changes to your licensor:

(a) A change of your facility's chief executive;

(b) The death, retirement, or incapacity of the person who holds the license;

(c) A change in name of a licensed corporation, or name by which your facility is commonly known; or

(d) Changes in the agency's articles of incorporation and bylaws.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0275, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0285 What are the department's requirements for keeping client records? (1) Your records must be kept at your overnight youth shelter and contain, at a minimum, the following information:

(a) The child's name and birthdate;

(b) Daily attendance logs and referrals;

(c) Names, address and home and business telephone numbers of parents or persons to be contacted in case of emergency;

(d) Dates and kinds of illnesses, accidents, medications and treatments given at the shelter;

(e) An incident log documenting the use of physical restraint; and

(f) Other information determined relevant by the department.

(2) Identifying and personal information about the youth must be kept confidential.

(3) You must keep information about the youth and their families in a secure place.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0285, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0295 Do I need a citizens' board for my overnight youth shelter? (1) Every overnight youth shelter must have a citizens' board that complies with laws and rules for nonprofit boards of directors. If the overnight youth shelter is part of a larger agency that has a citizens' board, that board will suffice.

(2) The shelter director must keep the following on file:

(a) A list of all members of the current citizens' board; and

(b) A copy of the articles of incorporation filed with the secretary of state verifying nonprofit status.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0295, filed 7/5/01, effective 8/5/01.]

WAC 388-160-030 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-0305 What personnel policies must I have? The following requirements apply to licensed overnight youth shelters.

(1) Employees, interns, or volunteers with unsupervised access to youth are not allowed to have unsupervised access to youth until the department approves their background checks.

(2) If you have five or more staff, you must have written policies describing duties and qualifications of staff, and staff benefits.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0305, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0315 What personnel records must I keep? You must keep personnel records on file for each staff person and volunteer for your overnight youth shelter. These must include:

(1) An employment application, including work and education history;

(2) Documentation of completed criminal history and background check form;

(3) A record of a negative Mantoux, tuberculin skin tests results, X-ray, or an exemption to the skin test or X-ray;

(4) A record of participation in HIV/AIDS education and training, including blood borne pathogens training;

(5) A record of participation in staff development training;

(6) A record of participation in the program's orientation;

(7) Documentation of a valid food handler permit, when applicable; and

(8) A record of participation in the current first-aid/CPR/Blood-borne pathogens training.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0315, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0325 Where must I post my license? You must post your license where it can be easily viewed by the public.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0325, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0335 What other information must I keep readily available? If you operate an overnight youth shelter, you must have the telephone number of "on-call" master's or bachelor's degree-level persons with other emergency numbers readily available for staff.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0335, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0345 Are local ordinances part of our licensing requirements? (1) Local ordinances (laws), such as zoning regulations and local building codes, fall outside the scope of our licensing requirements.

(2) The department may require you to provide proof that you have met local ordinances.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0345, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0355 What fire safety requirements must I follow to qualify for a license? If you operate an overnight youth shelter, you must follow the regulations developed by the Washington state fire marshall's office. The regulations are minimum requirements for protecting life and property against fire. You can find these contained in the Uniform Fire Code as adopted with Washington state amendments.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0355, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0365 Where may my shelter be located? (1) Your overnight youth shelter must be located on a well-drained site free from hazardous conditions. The safety of the youth in care is paramount.

(2) You must discuss with the licensor any potential hazardous conditions, considering the youth's ages and behaviors. Some examples of hazards are natural or man-made water hazards such as lakes or streams, steep banks, ravines, and busy streets.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0365, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0375 May I have firearms in my overnight youth shelter? (1) You may not have firearms or other weapons on the premises.

(2) Firearms and weapons that are confiscated from youth must be locked up and given to law enforcement officers as soon as possible.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0375, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0385 What substances are prohibited at overnight youth shelters? (1) During operating hours when youth are in care, no staff, intern, or volunteer on the premises or caring for youth off-site may be under the influence of, consume, or possess alcoholic beverages or illegal drugs.

(2) You must prohibit smoking in:

(a) Your facility while caring for youth; and

(b) Any motor vehicles transporting youth.

(3) You may permit adults to smoke outdoors away from youth.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0385, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0395 What are your requirements for storing dangerous items? (1) You must lock the following items:

(a) Cleaning supplies,

(b) Toxic substances,

(c) Poisons,

(d) Aerosols,

(e) Items with warning labels.

(2) You must label containers filled from a stock supply. The labels must identify all contents.

(3) Toxic substances must be stored separately from food items.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0395, filed 7/5/01, effective 8/5/01.]

WAC 388-160-040 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-0405 Do I need to have first aid supplies? (1) You must keep first aid supplies on hand for immediate use, including unexpired syrup of ipecac that is to be used only when following the instructions of the poison control center.

(2) The following first aid supplies must be kept on hand:

(a) Barrier gloves and one-way resuscitation mask;

(b) Ace bandage and band-aids;

(c) Scissors and tweezers;

(d) Gauze; and

(e) Thermometer.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0405, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0415 What structural safety requirements must my facility meet? You must keep your equipment and the physical structures in your facility safe and clean for the youth you serve. At a minimum you must:

(1) Maintain your buildings, premises, and equipment in a clean and sanitary condition, free of hazards and in good repair;

(2) Provide handrails for steps if the department decides handrails are necessary for safety;

(3) Have emergency lighting devices available and in operating condition;

(4) Refinish all flaking or deteriorating lead-based paint with lead-free paint or other nontoxic material for exterior and interior wall surfaces and equipment;

(5) Have washable, water-resistant floors in the facility's toilet rooms, kitchen, and other rooms exposed to moisture;

Exception: We may approve washable, short-pile carpeting that is kept clean and sanitary for your facility's kitchen.

(6) Have easy access to rooms occupied by youth in case an emergency arises.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0415, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0425 What measures must I take for pest control? You must keep the premises free from pests, such as rodents, flies, cockroaches, fleas, and other insects using the least toxic methods.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0425, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0435 What are your requirements for kitchens? If your overnight youth shelter provides food service, you must ensure:

(1) The proper storage, preparation, and service of food to meet the needs of the youth; and

(2) Provide the facilities and implement practices as required by the rules and regulations of the department of health that govern food service sanitation (see chapter 246-215 WAC).

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0435, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0445 What are the requirements for bedrooms in shelters? You must comply with the following requirements for bedrooms:

(1) Provide sleeping areas at least fifty square feet per occupant of unobstructed floor area with a ceiling height of at least seven feet, six inches;

(2) Not use hallways and kitchens as sleeping rooms;

(3) Maintain a space that is at least thirty inches between sleeping youths;

(4) Provide sleeping areas separated by a visual barrier five feet high or more for gender; and

(5) Separate youth under eighteen years old from youth who are eighteen through twenty years old by having a staff or volunteer supervise open space or have a physical barrier to prevent contact.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0445, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0455 What are your requirements for bedding? (1) An overnight youth shelter providing youth with sleeping equipment and bedding must keep the equipment and bedding in good repair, clean, and sanitary.

(2) The shelter must accept the use of sleeping and bedding equipment that is personally provided by the youth if it is not a health or safety risk.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0455, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0465 What telephone requirements must I follow? The department has two requirements for the telephone that you must meet at your overnight youth shelter.

(1) You must have at least one telephone on the premises for incoming and outgoing calls. The telephone must be accessible for emergency use at all times.

(2) You must post emergency phone numbers next to the phone.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0465, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0475 What are the lighting requirements for my overnight youth shelter? You must locate light fixtures and provide lighting that promotes good visibility and comfort for the youth.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0475, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0485 What are the requirements about drinking water? You must provide:

(1) A public water supply or a private water supply approved by the local health authority prior to the time of licensing or relicensing; and

(2) Disposable paper cups, individual drinking cups or glasses, or inclined-jet type drinking fountains.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0485, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0495 What are your requirements for laundry facilities? The department has specific requirements for laundry facilities at your overnight youth shelter. You must:

(1) Have separate and adequate facilities for storing soiled and clean linen;

(2) Provide adequate laundry and drying equipment or make other arrangements for getting laundry done on a regular basis; and

(3) Locate laundry equipment in an area separate from the kitchen.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0495, filed 7/5/01, effective 8/5/01.]

WAC 388-160-050 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-0505 What are the requirements for washing clothes? You must sanitize laundry contaminated with urine, feces, lice, scabies, or other potentially infectious materials through temperature or chemical measures.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0505, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0515 What are the requirements for toilets, sinks, and bathing facilities in shelters? You must provide:

(1) Two or more indoor flush-type toilets close to handwashing sinks with hot and cold running water;

(2) One toilet and sink for the first eight youth, with a second toilet and sink when four more youth are on the premises;

(3) Privacy for persons of the opposite sex at toilets and any bathing facilities;

(4) Hot and cold running water not exceeding one hundred twenty degrees Fahrenheit at handwashing sinks, and bathing facilities;

(5) A conveniently located grab bar or nonslip floor surfaces in any bathing facilities;

(6) Urinals instead of toilets as long as only urinals do not replace more than one-third of the total required number of toilets; and

(7) Dispenser soap and individual towels, disposable towels, or other approved single-use hand drying devices, at handwashing sinks, and any bathing facilities.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0515, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0525 Do overnight youth shelters require a housekeeping sink? An overnight youth shelter must have and use a method of drawing clean mop water and disposing of wastewater.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0525, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0535 What are the requirements for sewage and liquid wastes? An overnight youth shelter must discharge sewage and liquid wastes into a public sewer system or into a functioning septic system.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0535, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0545 What health and emergency policies and procedures must I have? (1) An overnight youth shelter must have current written health policies and procedures including, but not limited to:

(a) First aid;

(b) Infection control;

(c) Care of minor illnesses; and

(d) General health practices and actions to be taken in event of medical and other emergencies.

(2) Health policies and procedures must be readily available for staff orientation and implementation.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0545, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0555 How must I manage medications for youth at my shelter? An overnight youth shelter must requirements for manage nonprescription and prescription medications by:

(1) Place any medication brought into the shelter by a youth in locked storage so it is unavailable to other youth in care;

(2) Supervise youth who take their own medication according to the prescription or manufacturer's instructions; and

(3) Properly dispose of medications that are no longer being taken.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0555, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0565 What must I do to prevent the spread of infections and communicable diseases? (1) You must take precautions to guard against infections and communicable diseases infecting the youth in care in your overnight youth shelter.

(2) Staff with a reportable communicable disease, as defined by the department of health, in an infectious stage must not be on duty until the staff has a physician's approval for returning to work.

(3) Those persons who have been approved for unsupervised access to children in an overnight youth shelter facility must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test prior to being employed, volunteering, or being licensed unless:

(a) The person has evidence of testing within the previous twelve months;

(b) The person has evidence that they have a negative chest x-ray since a previously positive skin test;

(c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis; or

(d) A physician indicates that the test is medically unadvisable.

(4) Persons whose tuberculosis skin test is positive must have a chest x-ray within thirty days following the skin test.

(5) The department does not require retesting unless a person believes they have been exposed to someone with tuberculosis or if testing is recommended by their health care provider.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0565, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0575 What nutritional guidelines must I follow? An overnight youth shelter providing meals must consider the age, cultural background, and nutritional requirements of youth served when preparing meals.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0575, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0585 What are your requirements for protecting a youth under my care from child abuse and neglect? As part of ensuring health, welfare and safety, you must protect youth in your care from all forms of child abuse and neglect (see RCW 26.44.020(12)).

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0585, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0595 What are the requirements about nondiscrimination? Overnight youth shelters must follow all state and federal laws regarding nondiscrimination while providing services to youth in care.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0595, filed 7/5/01, effective 8/5/01.]

WAC 388-160-060 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-0605 What religious activities are allowed in overnight youth shelters? (1) You must respect the religious rights of the youth in care.

(2) Youth have the right to practice their own faith.

(3) Youth have the right not to practice another person's or any faith.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0605, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0615 How much supervision is required for child care staff and volunteers? The program supervisor must provide two hours of supervision for each forty hours that child care staff and volunteers work at overnight youth shelters.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0615, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0625 What requirements must I follow when disciplining youth? (1) You are responsible for disciplining youth in your care. This responsibility must not be delegated to any nonstaff, including youth in care.

(2) You must write down your disciplinary practices and include these with your application for a license.

(3) Discipline must be:

(a) Based on an understanding of the individual's needs and stage of development;

(b) Designed to help the youth under your care to develop inner control, acceptable behavior and respect for the rights of others; and

(c) Fair, reasonable, consistent, and related to the individual's behavior.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0625, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0635 What types of disciplinary practices are forbidden? (1) You must not use cruel, unusual, frightening, unsafe or humiliating discipline practices, including but not limited to:

(a) Spanking the youth with a hand or object;

(b) Biting, jerking, kicking, or shaking the youth;

(c) Pulling the youth's hair;

(d) Throwing the youth;

(e) Purposely inflicting pain as a punishment;

(f) Name calling, using derogatory comments, or abusing the youth verbally; and

(g) Threatening the youth with physical harm.

(2) You must not use methods that interfere with a youth's basic needs, including but not limited to:

(a) Depriving the youth of sleep;

(b) Depriving the youth of adequate food, clothing or shelter; or

(c) Interfering with a youth's ability to take care of their own hygiene and toilet needs.

(3) You must not use methods that deprive a youth of necessary services, including:

(a) Access to the youth's legal representative;

(b) DSHS social worker, if one is assigned; or

(c) Emergency medical or dental care.

(4) You must not use medication in an amount or frequency other than that prescribed by a physician or psychiatrist.

(5) You must not use medications for a youth that have been prescribed for someone else.

(6) You must not physically lock doors or windows in a way that prohibits a youth from exiting.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0635, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0645 What types of physical restraint are acceptable for youth in overnight youth shelters? (1) If your overnight youth shelter is approved for the use of physical restraint, the licensee and staff must be trained in the appropriate use of restraining techniques in accordance with the department's behavior management policy before restraining a youth. Restraint training must be nationally recognized and DLR approved.

(2) You must use other efforts to redirect or de-escalate the situation before using a physical restraint.

(3) If a youth's behavior poses an immediate risk to physical safety you may use physical restraint that is reasonable and necessary to:

(a) Protect youth on the premises from harming themselves or others; or

(b) Protect property from serious damage.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0645, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0655 What types of physical restraint are not acceptable in overnight youth shelters? (1) You must not use physical restraint as a form of punishment.

(2) You must not use mechanical restraints, such as handcuffs and belt restraints.

(3) You must not use locked time-out rooms.

(4) You must not use physical restraint techniques that restrict breathing, inflict pain as a strategy for behavior control or might injure a youth. These include, but are not limited to:

(a) An adult sitting on or straddling a youth;

(b) Sleeper holds, which are holds used by law enforcement officers to subdue a person;

(c) Arm twisting;

(d) Hair holds;

(e) Youth being thrown against walls, furniture, or other large immobile objects;

(f) Choking or putting arms around a throat;

(g) Restriction of body movement by placing pressure on joints, chest, heart, or vital organs; or

(h) Chemical restraints, except prescribed medication, including but not limited to pepper spray.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0655, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0665 Do I need to document instances when physical restraint is used? (1) You must document all instances of the use of physical restraints and follow the behavior management policy of children's administration regarding the information to be reported. You must keep a copy of this document at your overnight youth shelter. At a minimum, you must record:

(a) The youth's name and age;

(b) The date of the use of the restraint;

(c) The time in and out of the restraint;

(d) The events preceding the behavior that lead to using the restraint;

(e) The de-escalation methods that were used;

(f) Names of those involved in the restraint and any observers;

(g) A description of the type of restraint used;

(h) A description of injuries to the youth, or others, including caregivers;

(i) An analysis of how the restraint might have been avoided; and

(j) The signature of the person making the report.

(2) Additional information on behavior management and the use of physical restraints can be obtained from the department.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0665, filed 7/5/01, effective 8/5/01.]

WAC 388-160-070 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-080 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-090 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-100 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-110 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-120 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-130 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-140 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-150 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-160 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-170 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-180 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-190 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-200 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-210 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-220 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-230 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-240 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-250 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-260 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-270 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-280 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-290 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-300 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-310 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-320 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-340 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-350 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-360 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-370 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-380 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-390 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-400 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-410 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-420 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-430 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-440 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-460 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-470 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-480 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-490 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-500 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-510 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-520 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-530 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-540 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-550 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-160-560 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-200 WAC
FINANCIAL AND MEDICAL ASSISTANCE—GENERAL PROVISIONS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-200-1050 Department and client responsibilities. [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.] Repealed by 01-10-104, filed 5/1/01, effective 6/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.

388-200-1300 Necessary supplemental accommodation services (NSA). [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.] Repealed by 01-10-104, filed 5/1/01, effective 6/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.

388-200-1350 Dispute resolution for clients needing supplemental accommodations. [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.] Repealed by 01-10-104, filed 5/1/01, effective 6/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.

WAC 388-200-1050 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-200-1300 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-200-1350 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-222 WAC
DIVERSION ASSISTANCE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-222-001 Definitions. [Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-001, filed 10/1/97, effective 11/1/97.] Repealed by 01-03-066, filed 1/12/01, effective 3/1/01. Statutory Authority: RCW 74.08.090, 74.04.050.

388-222-010 Diversion cash assistance (DCA). [Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-010, filed 10/1/97, effective 11/1/97.] Repealed by 01-03-066, filed 1/12/01, effective 3/1/01. Statutory Authority: RCW 74.08.090, 74.04.050.

388-222-020 Diversion cash assistance payments. [Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-020, filed 10/1/97, effective 11/1/97.] Repealed by 01-03-066, filed 1/12/01, effective 3/1/01. Statutory Authority: RCW 74.08.090, 74.04.050.

WAC 388-222-001 through 388-222-020 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-273 WAC
WASHINGTON TELEPHONE ASSISTANCE PROGRAM

(Formerly chapter 388-31 WAC)

WAC

WAC 388-273-0010 Purpose of the Washington telephone assistance program. The Washington telephone assistance program (WTAP) is designed to help low-income households afford access to local telephone service. For the purposes of this chapter, **"we"** and **"us"** mean the department of social and health services (DSHS). **"You"** means the person who is applying and eligible for WTAP.

[Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0010, filed 4/9/01, effective 6/1/01.]

WAC 388-273-0020 Who may receive WTAP. To receive WTAP benefits, you must:

(1) Be receiving from us:

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

(b) State family assistance (SFA);

(c) General assistance;

(d) Refugee assistance;

(e) Food assistance;

(f) Supplemental Security Income (SSI);

(g) Medical assistance, including Medicare cost sharing programs;

(h) Community options program entry system (COPES); or

(i) Chore services.

(2) Be age eighteen or older or, if under eighteen, be the responsible head of household;

(3) Apply to the local exchange company that provides your local flat rate telephone service. In exchange areas where wireline service is not available without service extension, you may apply to an eligible wireless carrier;

(a) **"Local exchange company"** means an eligible telecommunication carrier providing local service, i.e., the telephone company.

(b) **"Flat rate service"** is telephone service with a single monthly payment that allows unlimited local calling for a specified length of time. The local exchange flat rate includes any federal end user access charges and other charges necessary to obtain the service.

(4) Have the lowest available flat rate service; and

(5) Have the local telephone service billed in your name.

[Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0020, filed 4/9/01, effective 6/1/01.]

WAC 388-273-0025 Benefits you receive as a WTAP participant. (1) WTAP participants receive a:

(a) Discount on local telephone flat rate services, when the flat rate is more than the WTAP assistance rate;

(b) Waiver of deposit requirements on local telephone service; and

(c) Fifty percent discount on service connection fees. Any connection fee discounts available from other programs are added to the WTAP discount, to pay part or all of the remaining fifty percent.

(2) WTAP benefits are limited to one residential line per household.

(3) The deposit waiver and the discount on connection fees are available once per service year. **"Service year"** means the period beginning July 1 and ending June 30 of the following calendar year.

(4) Your benefits begin the date you are approved for WTAP assistance and continue through the next June 30.

(5) WTAP benefits do not include charges for line extension, optional extended area service, optional mileage, customer premises equipment, applicable taxes or delinquent balances owed to the telephone company.

[Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0025, filed 4/9/01, effective 6/1/01.]

WAC 388-273-0030 How you can apply for WTAP. (1) You can apply for WTAP by contacting the local telephone company.

(2) The telephone company contacts us to verify that you are eligible for benefits under WAC 388-273-0020 before they add WTAP to your telephone account.

(3) You will know you are receiving WTAP benefits when you have a WTAP credit on your telephone bill.

[Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0030, filed 4/9/01, effective 6/1/01.]

WAC 388-273-0035 What we reimburse the local telephone company. (1) Within available funding limits, we reimburse local telephone companies for fully documented administrative and program expenses associated with WTAP. The reimbursable expenses are limited to:

(a) Program services provided after eligibility for WTAP is verified;

(b) Correct, verifiable billing items;

(c) Invoices submitted within ninety days following the month the expense occurred;

(d) Items charged in error that have been corrected within sixty days from the date we return the report of invoicing error to the local phone company;

(e) Salaries and benefits for time required to implement and maintain WTAP, with the exception that time required for the correction of case number and client identification errors is not an allowable expense;

(f) Travel expenses for attending hearings, meetings, or training pertaining to WTAP;

(g) Expenses for supplies and materials for implementing and maintaining WTAP;

(h) Postage and handling for delivery of WTAP material;

(i) Administrative charge for change of service orders specified by tariffs; and

(j) Documented indirect costs associated with implementing and maintaining WTAP.

[Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0035, filed 4/9/01, effective 6/1/01.]

Chapter 388-290 WAC
WORKING CONNECTIONS CHILD CARE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-290-010 What is the purpose of the working connections child care program? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-015 What basic steps does the department take to decide if I'm eligible for WCCC? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-075 Who is a consumer in 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, § 388-290-075, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-125 What activities can the department pay WCCC for if I get a temporary aid for needy families (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, § 388-290-125, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-150 What activities can the department pay WCCC for if I don't get a 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, § 388-290-150, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-200 Can the department pay WCCC if I'm self-employed? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-270 Can the department authorize WCCC if I'm not working or in an approved activity right now? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-280 Can the department pay WCCC for activity fees or bonuses? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-300 Which children and consumers can and cannot get 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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-350 If I'm in an approved activity, what are the steps the department takes to figure my WCCC copayment? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-375 How is the income that my family receives used in 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, § 388-290-375, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-400 What makes up a family in the WCCC program? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-450 What income does the department count in WCCC? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-475 What income does the department exempt in WCCC? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-500 What are the different kinds of income in WCCC the department uses to get my 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, § 388-290-500, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-525 How does the department figure my 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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-600 How does the department figure my countable income, and what is countable income used for? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-650 How does the department figure my copayment, once my countable income is known? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-700 Does the department set the minimum copayment if I'm a minor parent? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-750 Are there other times when the department sets the minimum 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, § 388-290-750, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-800 When does the department calculate copayments? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-850 What child care providers can the department pay under the WCCC program? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-854 When will the department not pay toward the cost of in-home/relative child care? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-858 Why do we review your in-home/relative provider's criminal background information? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-862 When is a criminal background check required? [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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-866 Where does the department get the criminal background information on 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.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-870 What does the department do with the criminal background information on the in-home/relative provider? [Statutory Authority: RCW 43.43.830, 43.43.832, and

WAC 388-290-0001 What is the purpose of the working connections child care program? The purpose of working connections child care (WCCC) is to help families with children pay for child care to find jobs, keep their jobs, and get better jobs.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0001, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0005 Who is considered a consumer for the WCCC program? (1) If you apply for or receive WCCC, you are considered the consumer.

(2) In WCCC, an eligible consumer is one of the following individuals who has parental control of one or more children, and is the child's:

(a) Parent;

(b) Stepparent;

(c) Legal guardian;

(d) Adult sibling or step-sibling;

(e) Nephew or niece;

(f) Aunt;

(g) Uncle;

(h) Grandparent; or

(i) Any of the above relatives with the prefix great, such as great-aunt.

(3) You are not an eligible consumer when you:

(a) Are the only parent in the household; and

(b) Will be away from the home for more than thirty consecutive days.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0005, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0010 What makes me eligible for WCCC benefits? You may be eligible for WCCC benefits if:

(1) Your family is described under WAC 388-290-0015;

(2) You're participating in an approved activity under WAC 388-290-0040, 388-290-0045, or 388-290-0050;

(3) You and your children are eligible under WAC 388-290-0020;

(4) Your countable income, is at or below two hundred twenty-five percent of the Federal Poverty Level (FPL) (under WAC 388-290-0065); and

(5) Your share of the child care cost, called a copayment (under WAC 388-290-0075) is lower than the total DSHS maximum monthly payment for all children in the family who are eligible for subsidized care.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0010, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0015 How does the WCCC program determine my family size? The WCCC program determines your family size by reviewing those individuals who live together in the same household as follows:

(1) **If you are:**	**We count the following individuals as part of the family for WCCC eligibility:**
(a) A single parent, including a minor parent living independently;	You and your child(ren).
(b) Unmarried parents that have at least one mutual child;	Both parents and all their children living in the household.
(c) Unmarried parents with no mutual children;	Unmarried parents and their respective children are counted as separate WCCC families.
(d) Married parents;	Both parents and all their children living in the household.
(e) Undocumented parents (all other family rules in this section apply);	Both parents and all children, documented and undocumented, as long as the child needing care is a U.S. citizen or legally residing in the United States.
(f) A consumer as defined in WAC 388-290-0005 and you are not financially responsible for the child(ren);	Only the child(ren) are counted as the WCCC family. The child(ren) and his/her income is counted for WCCC eligibility.
(g) A minor parent with children and live with a parent/guardian;	Only the minor parent and the children.
(h) Family members who are temporarily out of the household because of employment requirements, such as the military (all other family rules in this section apply).	This individual as part of the household.
(2) **If your household includes:**	**We count the following individuals as part of the family for WCCC eligibility:**
(a) Eighteen year old siblings of the children requiring care who are enrolled in approved secondary education or general equivalency diploma (GED) program.	The eighteen year olds unless they are a parent themselves, until they turn nineteen, or complete HS/GED, whichever comes first.
(b) Siblings of the children requiring care who are up to twenty-one years of age and who are participating in an approved program through the school district's special education department under RCW 28A.155.0202.	The individual participating in an approved program through RCW 28A.155.0202 up to twenty-one years of age, unless they are a parent themselves.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0015, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0020 When can I get WCCC benefits? (1) Depending on your circumstances, or those of your child(ren), you might be eligible for WCCC if you are:

(a) An employee of the same child care facility where your child(ren) is receiving care and you do not provide direct care to your own child(ren) during the time WCCC is requested;

(b) In sanction status for temporary assistance for needy families (TANF), while you are in an activity needed to remove the sanction or employment;

(c) A parent in a two-parent family and one parent is not able or available to provide care for your child(ren) while one is working, looking for work, or preparing for work;

(i) "Able" means physically, mentally, and emotionally capable of caring for a child in a responsible manner.

(ii) "Available" means able to provide care when they are not participating in an approved work activity under WAC 388-290-0040, 388-290-0045, and 388-290-0050 during the time you need child care.

(d) A married consumer described under WAC 388-290-0005 (1)(d) through (i). Only you or your spouse must be participating in activities under WAC 388-290-0040, 388-290-0045, or 388-290-0050.

(2) You might be eligible for WCCC if your child(ren) is legally residing in the country and is:

(a) Less than thirteen years of age; or

(b) Thirteen years of age and less than age nineteen, and:

(i) Has a verified special need, according to WAC 388-290-0220; or

(ii) Is under court supervision.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0020, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0025 What rights do I have when I apply for or receive WCCC benefits? When you apply for or receive WCCC benefits you have the right to:

(1) Be treated politely and fairly without regard to race, color, creed, religion, sex, presence of any sensory, mental or physical disability, sexual orientation, political affiliation, national origin, religion, age, gender, disability, or birthplace;

(2) Have an application accepted and acted upon within thirty days;

(3) Be informed, in writing, of your legal rights and responsibilities related to WCCC benefits;

(4) Only have your information shared with other agencies when required by federal or state regulations;

(5) Get a written notice, at least ten days before the department makes changes to lower or stop benefits except in WAC 388-290-0120;

(6) Ask for a fair hearing if you do not agree with the department about a decision.

(7) Ask a supervisor or administrator to review a decision or action affecting your benefits without affecting the right to a fair hearing;

(8) Have interpreter or translator service within a reasonable amount of time and at no cost to you;

(9) Be allowed to choose your provider as long as the provider meets the requirements in WAC 388-290-0125; and

(10) Refuse to speak to a fraud early detection (FRED) investigator from the division of fraud investigations. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. This request will not affect your eligibility for benefits.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0025, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0030 What responsibilities do I have when I apply for or receive WCCC benefits? When you apply for or receive WCCC benefits you have a responsibility to:

(1) Supply the department with information so we can determine your eligibility and authorize child care payments correctly;

(2) Choose a provider who meets requirements of WAC 388-290-0125 and make your own child care arrangements;

(3) Pay, or make arrangements to have someone pay, your WCCC copayment directly to your child care provider;

(4) Keep and provide when requested, accurate attendance records when you choose in-home/relative child care;

(5) Pay your in-home/relative provider the entire amount the department sends you for in-home/relative care;

(6) Require the in-home/relative provider to sign a receipt when you pay the provider. You must keep the receipts for one year for DSHS to review on request;

(7) Notify WCCC staff, within five days, of any change in providers;

(8) Notify your provider within ten days when we change your child care authorization;

(9) Provide notice to WCCC staff within ten days of any change in:

(a) The number of child care hours needed (more or less hours);

(b) Your household income to include TANF grant stops or starts;

(c) Your household size such as any family member moves in or out of your home;

(d) Employment, school or approved TANF activity (starting, stopping or changing);

(e) The address or phone number of your in-home/relative provider;

(f) Your home address or telephone number; or

(g) Your legal obligation to pay child support.

(10) 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 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0030, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0035 What responsibilities does the WCCC program staff have? The WCCC program staff are responsible to:

(1) Allow you to choose your provider as long as they meet the requirements in WAC 388-290-0125;

(2) Review your chosen in-home/relative provider's background information because the department:

(a) Wants you to have this information to help you:

(i) Make informed, safe, and responsible decisions about your child(ren)'s care provider; and

(ii) Reduce the risk of harm to children by caregivers that have been convicted of certain crimes.

(b) Does not pay for any of the cost of child care provided by individuals convicted of crimes listed in WAC 388-290-0160 or 388-290-0165.

(3) Authorize payments only to child care providers who allow you to see your children whenever they are in care;

(4) Only authorize payment when no adult in your WCCC family is "able or available" to care for your children (under WAC 388-290-0020).

(5) Inform you of:

(a) Your rights and responsibilities under the WCCC program at the time of application and eligibility review;

(b) The types of child care providers we can pay;

(c) The community resources that can help you select child care, when needed; and

(d) Any change in your copayment during the authorization period except under WAC 388-290-0120(4).

(6) Respond to you within ten days if you report a change of circumstance which affects your WCCC eligibility/copayment; and

(7) Provide prompt child care payments to your licensed or certified provider.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0035, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0040 If I receive a temporary assistance for needy families (TANF) grant, when might I be eligible for WCCC benefits? If you receive a temporary assistance for needy families (TANF) grant, you may be eligible for WCCC benefits for up to sixteen hours maximum per day for your hours of participation in the following:

(1) A WorkFirst activity under chapter 388-310 WAC;

(2) Employment or self-employment;

(3) Transportation time between the location of child care and your place of employment or approved activity;

(4) Up to ten hours per week of study time before or after regularly scheduled classes or up to three hours of study time per day when needed to cover time between classes for your approved activity; and

(5) Up to eight hours per day of sleep time when it is needed, such as if you work nights and sleep days.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0040, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0045 If I don't get a temporary assistance for needy families (TANF) grant, when might I be eligible for WCCC benefits? If you do not receive TANF, you may be eligible for WCCC benefits for up to sixteen hours maximum per day for the hours of your participation or enrollment in the following:

(1) Employment or self-employment under WAC 388-290-0050;

(2) Secondary education or general equivalency diploma (GED) program if you are age twenty-one or younger.

(3) Same-day job search if you are a TANF applicant;

(4) The food stamp employment and training program under chapter 388-444 WAC;

(5) Adult basic education (ABE), English as a second language (ESL), high school/GED, vocational education, or job skills training or other program under WAC 388-310-1000, 388-31-1050, 388-310-1200, or 388-310-1800, and you are:

(a) Working:

(i) Twenty or more hours per week; or

(ii) Sixteen or more hours per week in a work study job.

(b) Participating in the educational program for no longer than thirty-six months.

(6) WCCC may be approved for activities listed in WAC 388-290-0040 (3) through (5), when needed.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0045, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0050 Can I get WCCC benefits if I'm self-employed? You may be eligible for WCCC benefits for up to sixteen hours maximum per day when you're self-employed.

(1) If you get TANF:

(a) You must have an approved self-employment plan under chapter 388-310 WAC; and

(b) The amount of WCCC you get for self-employment is equal to the number of hours in your approved plan.

(2) If you don't get TANF:

(a) During the first six months of your WCCC eligibility, the number of hours of WCCC you can get will be calculated based on your self-employment earnings. The number of hours of WCCC you get is based on whichever is more:

(i) Your work hours reported in your business records; or

(ii) The average number of monthly hours equal to dividing your monthly self-employment income by the federal or state minimum wage (whichever minimum wage is lower).

(b) After the first six months, the number of hours of WCCC you can get each month is based on the lesser of subsections (2)(a)(i) or (ii) of this section.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0050, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0055 Can the WCCC program authorize benefits if I'm not working or in an approved activity right now? (1) The WCCC program can authorize WCCC payments for up to two weeks when you're waiting to enter an approved activity under WAC 388-290-0040 or 388-290-0045.

(2) We can authorize WCCC payments for up to four weeks if you experience a gap for reasons out of your control such as a layoff in employment, or approved activity, and:

(a) Your employment, or the approved activity, will resume within that period; or

(b) You're looking for another job and you received WCCC immediately before the gap in employment, or approved activity.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0055, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0060 What income is counted when determining WCCC eligibility and copayments? The WCCC program counts income as money you get from:

(1) A TANF grant, except when exempt under WAC 388-290-0070(9);

(2) Child support payments;

(3) Supplemental Security Income (SSI);

(4) Other Social Security payments, such as SSA and SSDI;

(5) Refugee assistance payments;

(6) Payments from the Veterans' Administration, disability payments, or payments from labor and industries (L&I);

(7) Unemployment compensation;

(8) Other types of income not listed in WAC 388-290-0070;

(9) Wages from employment or self-employment. "Self-employment income" means your gross income from self-employment minus allowable business expenses in WAC 388-450-0085; and

(10) Lump sums as money you get from a one-time payment such as back child support, an inheritance, or gambling winnings.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0060, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0065 How does the WCCC program define and use my income?

We consider ...	... To equal ...
(1) The sum of all income listed in WAC 388-290-0060. We:	Your expected average monthly income.
(a) Determine the number of months it took your family to earn the income and divide the amount by those months to get an average monthly amount;	
(b) Use the best available estimate of your family's current income when you don't have income history to make an accurate estimate of your future income; or	
(c) Ask for evidence of your future income such as a letter from your employer.	
(2) Lump sum payments received in the month of application or during your WCCC eligibility. We:	
(a) Verify that any lump sum payment income presented to us is accurate;	
(b) Divide the lump sum payment by twelve to come up with a monthly amount (we apply that amount to the month it was received and the remaining months of the current authorization period);	
(c) Add any monthly lump sum amount to your expected average monthly income.	Total monthly income.
(3) Your total monthly income minus any child support paid out (through a court order, division of child support administrative order, or tribal government order).	Countable income. Your countable income is used to figure your initial and on-going eligibility and your copayment for WCCC.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0065, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0070 What income types and deductions are not counted when figuring my income eligibility and for WCCC benefits? (1) The WCCC program does not count the following income types when figuring your income eligibility and copayment:

(a) Income types as defined in WAC 388-450-0035, 388-450-0040, and 388-450-0055;

(b) Compensatory awards, such as an insurance settlement or court-ordered payment for personal injury, damage, or loss of property;

(c) Adoption support assistance and foster care payments;

(d) Reimbursements, such as an income tax refund;

(e) Diversion cash assistance and the early exit bonus;

(f) Income in-kind, such as working for rent;

(g) Military housing and food allowance;

(h) 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;

(i) Payments to you by your employer for benefits such as medical plans;

(j) Earned income of a WCCC family member defined under WAC 388-290-0015(2).

(2) WCCC deducts the amount you pay for child support under court order, division of child support administrative order, or tribal government order, from your other income types when figuring your eligibility and co-pay for the WCCC program.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0070, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0075 What are the steps the WCCC program takes to figure my family's WCCC eligibility and copayment amount? The WCCC program takes the following steps to figure your WCCC income eligibility and copayment:

(1) Determine your family size (under WAC 388-290-0015); and

(2) Determine your countable income (under WAC 388-290-0065).

(3) If your family's countable monthly income falls within the range below, then your copayment is:

YOUR INCOME	YOUR COPAYMENT is:
At or below 82% of the FPL	$10
Above 82% of the FPL up to 137.5% of the FPL	$20
Above 137.50 of the FPL - 225% of the FPL	The dollar amount equal to subtracting 137.5% of FPL from countable income, multiplying by 44%, then adding $20
Income above 225% of the FPL, you are not eligible for WCCC benefits.	

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0075, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0080 When does the WCCC program determine and review my eligibility and copayments? (1) At the time you apply for WCCC; and

(2) At least every six months.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0080, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0085 When might my WCCC copayment change? (1) Once we have determined that you are eligible for WCCC benefits, your copayment could change when:

(a) Your activity changes under WAC 388-290-0040, 388-290-0045, or 388-290-0050;

(b) Your monthly income decreases;

(c) Your family size increases;

(d) You are no longer eligible for the three-month TANF grant exemption under WAC 388-290-0070(h) or the minimum copayment under WAC 388-290-0090.

(2) If your copayment changes during your eligibility period, the change is effective the first of the month following the change.

(3) We do not increase your copayment during your current eligibility period when your countable income remains at or below two hundred twenty-five percent of the FPL, and:

(a) Your monthly countable income increases; or

(b) Your family size decreases.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0085, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0090 When do I pay the minimum copayment? You will pay the minimum copayment when:

(1) Your countable monthly income is at or below eighty-two percent of the FPL;

(2) You are a minor parent, and:

(a) Receiving TANF; or

(b) Part of your parent's or relative's TANF grant.

(3) In the first full month following the month you get a job, if you get TANF at the time of application for WCCC; or

(4) The first month you receive WCCC, if you don't get TANF at the time of application for WCCC.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0090, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0095 I receive temporary assistance for needy families (TANF) and I am determined eligible for WCCC, when do my benefits begin? When you receive TANF, and are eligible for WCCC, your benefits begin when your eligible provider (under WAC 388-290-0125) is caring for your child and you have begun your approved activity under WAC 388-290-0040.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0095, filed 12/19/01, effective 1/19/02.]

WAC 388-290-010 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-0100 If I do not receive temporary assistance for needy families (TANF) and I am determined eligible for WCCC, when do my benefits begin? (1) When you do not receive TANF and are eligible for WCCC your benefits begin as described in WAC 388-290-0055(1) or the date you apply for WCCC and the following requirements are met:

(a) You have turned all your information in within thirty days of your application date;

(b) You meet all eligibility requirements; and

(c) Your eligible provider (under WAC 388-290-0125) is caring for your child(ren).

(2) Your application date is whichever is earlier:

(a) The date your application is date stamped as received; or

(b) The date your application is entered into our automated system as received.

(3) If you fail to turn in all your information within thirty days from your application date you must restart your application process. Your benefits begin date will start as described in subsection (2) of this section.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0100, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0105 What is the process for my WCCC review for reauthorization of my WCCC benefits? (1) You are required to complete a review of your WCCC benefits before the end date of your current WCCC eligibility period. The WCCC program determines if you are still eligible by:

(a) Requesting on-going eligibility review information prior to the end date of your current WCCC eligibility period; and

(b) Reviewing the requested information.

(2) Your WCCC benefits may continue if:

(a) Your review eligibility information is received no later than ten days after your previous eligibility period ends;

(b) Your provider is eligible for payment under WAC 388-290-0125; and

(c) You are eligible for WCCC.

(3) If you are determined eligible for WCCC benefits based on your review information, the program will notify you of continued benefits.

(4) If you provide the requested review information to us more than ten days beyond your last eligibility period, you are determined eligible for WCCC and you:

(a) Receive TANF, your benefit begin us when:

(i) You begin your approved activity, and

(ii) Your eligible provider (under WAC 388-290-0125) is caring for your child.

(b) Do not receive TANF, your benefit begin date is the date your:

(i) Application is date stamped as received;

(ii) Application is entered into our automated system as received; or

(iii) Eligible provider (under WAC 388-290-0125) is caring for your child; whichever is later.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0105, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0110 What circumstances might affect my on-going eligibility for the WCCC benefits and when might I be eligible again? (1) Your eligibility for WCCC stops when you:

(a) Do not pay copayment fees assessed by the department and mutually acceptable arrangements to pay the copayment are not made with your child care provider;

(b) Do not complete the requested review information before the deadline noted in WAC 388-290-0105 (2)(a); or

(c) Do not meet other WCCC eligibility requirements related to family size, income and approved activities.

(2) You might be eligible for WCCC again when you meet all WCCC eligibility requirements, and:

(a) Back copayment fees are paid; or

(b) Mutually acceptable payment arrangements are made with your child care provider(s).

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0110, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0115 When does the WCCC program provide me with advance and adequate notice of payment changes? (1) The WCCC program provides 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 388-290-0120.

(2) "Advance and adequate notice," means a written notice of a WCCC reduction, suspension, or termination that is mailed at least ten days before the date of the intended action which includes the Washington Administrative Code (WAC) supporting the action, and your right to request a fair hearing.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0115, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0120 When doesn't advance and adequate notice of payment changes apply to me? The WCCC program does not give you advance and adequate notice 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 new authorization period results in a change in child care benefits;

(5) The location where child care occurs does not meet requirements under WAC 388-290-0130 (2) or (3); or

(6) The department determines your in-home/relative provider:

(a) Is not of suitable character and competence;

(b) May cause a risk of harm to your child(ren) based on the provider's physical, emotional or mental health; or

(c) Has been convicted of, or has charges pending for crimes listed in WAC 388-290-0160 or 388-290-0165.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0120, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0125 What child care providers can I choose under the WCCC program? To receive payment under the WCCC program, your child care provider must be:

(1) Licensed as required by chapter 74.15 RCW;

(2) Meeting their states licensing regulations, for providers who care for children in states bordering Washington. DSHS pays the lesser of the following to licensed or certified child care facilities in bordering states:

(a) The provider's usual daily rate for that child; or

(b) The DSHS maximum child care subsidy daily rate for the DSHS region where the child resides.

(3) Exempt from licensing but certified by the department, such as:

(a) Tribal child care facility that meet the requirements of tribal law;

(b) Child care facilities on a military installation; or

(c) Child care facilities operated on public school property by a school district.

(4) An in-home/relative provider meeting the requirements in WAC 388-290-0130.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0125, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0130 What in-home/relative providers can I choose under the WCCC program? (1) To be authorized as an in-home/relative provider under the WCCC program, your in-home/relative provider must be a U.S. citizen or legally residing in the country, meet the requirements in WAC 388-290-0135 and must:

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

(b) Not be disqualified based on information in WAC 388-290-0140 (3) or (4).

(2) A relative provider must be one of the following adult relatives providing care in the home of either the child or the relative;

(a) An adult sibling living outside the child's home;

(b) An extended tribal family member under chapter 74.15 RCW; or

(c) A grandparent, aunt, uncle, or great-grandparent, great-aunt or great-uncle.

(3) A nonrelative provider may be an adult friend or neighbor and must provide care in the child's own home.

(4) The in-home/relative provider may not be the child's biological, adoptive, or step-parent.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0130, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0135 When I choose an in-home/relative provider, what information must I submit to receive WCCC benefits? When you choose in-home/relative child care, you must submit the following and complete certain forms:

(1) The in-home/relative child care provider's name and address; and

(2) A copy of the provider's valid Social Security Number and photo identification to the department;

(3) A completed background inquiry application; and

(4) A completed form which makes the following assurances:

(a) The provider is:

(i) Of suitable character and competence;

(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.

(e) As the WCCC consumer, you will instruct the in-home/relative child care provider that he/she will have the following responsibilities:

(i) Provide constant care and supervision of the child throughout the arranged time of care in accordance with the needs of the child; and

(ii) Provide developmentally appropriate activities for the child.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0135, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0140 When does the WCCC program not pay for the cost of in-home/relative child care? The WCCC program will not pay for the cost of in-home/relative care if:

(1) Your in-home/relative provider does not meet the requirements in WAC 388-290-0130 or 388-290-0135;

(2) You fail to submit a completed criminal background inquiry form or the provider's Social Security card and photo identification to the department;

(3) We determine your in-home/relative provider is not of suitable character and competence or 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 388-290-0160 or 388-290-0165.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0140, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0145 When is my provider's criminal background check required and will I be notified of the results? (1) The department requires the criminal background check for each in-home/relative provider under chapter 74.15 RCW:

(a) When you request WCCC payments for a new in-home/relative provider:

(b) Every two years for existing in-home/relative providers; or

(c) When the department has a valid reason to do a criminal background check more frequently.

(2) You will receive notice telling you whether or not the department is able to authorize WCCC payment.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0145, filed 12/19/01, effective 1/19/02.]

WAC 388-290-015 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-0150 Where does the WCCC program get the criminal background information on the in-home/relative provider? The WCCC program 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;

(3) Reports from credible community sources that indicate a need to investigate another state's records; and

(4) Disclosure by the in-home/relative provider.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0150, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0155 What happens after the WCCC program reviews my in-home/relative provider's criminal background information? After the WCCC program receives the in-home/relative provider's criminal background information we compare the criminal background information including pending charges with convictions listed in WAC 388-290-0160 or 388-290-0165 and:

(1) Determine if the in-home/relative provider's criminal background contains information that will not allow the authorization of payment for part of the cost of WCCC using the following rules:

(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 called theft; and

(c) Convictions whose titles are preceded with the word "attempted" are given the same weight as those titles without the word "attempted."

(2) Notify whether or not the department is able to authorize payment for part of the cost of care;

(3) Deny or stops payment for part of the cost of care by this in-home/relative provider, when the criminal background information disqualifies the in-home/relative provider; and

(4) Assist you in finding other child care arrangements.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0155, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0160 What convictions permanently disqualify my in-home/relative provider from being

authorized by the WCCC program? If your provider has been convicted of any crime listed in WAC 388-006-0170, the provider is permanently disqualified as an in-home/relative child care provider for WCCC.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0160, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0165 Are there other convictions that will disqualify my in-home/relative provider? (1) If your provider has been convicted within the last five years of any crime listed in WAC 388-006-0180, your provider is disqualified as an in-home/relative child care provider for WCCC.

(2) If your provider has a conviction listed in WAC 388-06-0180 and it has been more than five years, the department will review the provider's background to determine character, suitability, and competence by reviewing:

(a) The amount of time that has passed since the conviction;

(b) The seriousness of the crime that led to the conviction;

(c) The provider's age at the time of conviction;

(d) The number and types of convictions in the provider's background; and

(e) Documentation indicating you have successfully completed all court-ordered programs and restitution.

(3) If your provider has a conviction other than those listed in WAC 388-06-0170 or 388-006-0180 the department will review the provider as described in (2)(a) through (d) above.

(4) The crime will not be considered a conviction for the purposes of WCCC when it has been pardoned or a court of law acts to expunge or vacate the conviction record.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0165, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0180 When are the WCCC program subsidy rates in this chapter effective? DSHS child care subsidy rates in this chapter are effective on or after January 1, 2002 when a family:

(1) Has a household change that requires their authorization to be updated;

(2) Is newly authorized to receive child care subsidies; or

(3) Is reauthorized to continue receiving child care subsidies.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0180, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0185 How does the WCCC program set rates when my child is five years old? The rate paid for a five year old child is:

(1) The preschool rate for a child who has not entered kindergarten; or

(2) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0185, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0190 What does the WCCC program pay for and when can the program pay more? (1) The WCCC program pays for:

(a) Basic child care hours, either full day, half day or hourly:

(i) A full day of child care is authorized to licensed/certified facilities when care is needed for five or more hours per day;

(ii) A half day of child care is authorized to licensed/certified facilities when care is needed for less than five hours per day; and

(iii) Hourly child care is authorized when the provider is an in-home/relative.

(b) A registration fee (under WAC 388-290-0245);

(c) An activity fee (under WAC 388-290-0245);

(d) Care for nonstandard hours (under WAC 388-290-0210 and 388-290-0215);

(e) An infant bonus (under WAC 388-290-0250); and

(f) Special needs when the child has a documented need for higher level of care (under WAC 388-290-0220, 388-290-0225, 388-290-0230, and 388-290-0235).

(2) We pay more than the basic child care subsidy daily rate if:

(a) Care is not available at the DSHS daily rate within a reasonable distance then the provider's usual daily rate is authorized; or

(b) Care is over ten hours per day then an additional amount of care is authorized.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0190, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0200 What daily rates does DSHS pay for child care in a licensed or certified child care center? DSHS pays the lesser of the following to a licensed or certified child care center:

(1) The provider's usual daily rate for that child; or

(2) The DSHS maximum child care subsidy daily rate for that child as listed in the following table.

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 12 yrs)
Region 1	Full-Day	$24.32	$20.45	$19.32	$18.18
	Half-Day	$12.16	$10.23	$9.66	$9.09
Region 2	Full-Day	$24.55	$20.50	$19.00	$16.82
	Half-Day	$12.27	$10.25	$9.50	$8.41
Region 3	Full-Day	$32.50	$27.09	$23.41	$22.73
	Half-Day	$16.25	$13.55	$11.70	$11.36
Region 4	Full-Day	$37.82	$31.59	$26.50	$23.86
	Half-Day	$18.91	$15.80	$13.25	$11.93
Region 5	Full-Day	$27.73	$23.86	$21.00	$18.64
	Half-Day	$13.86	$11.93	$10.50	$9.32
Region 6	Full-Day	$27.27	$23.41	$20.45	$20.00
	Half-Day	$13.64	$11.70	$10.23	$10.00

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0200, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0205 What daily rates does DSHS pay for child care in a licensed or certified family child care home? DSHS pays the lesser of the following to a licensed or certified child care center:

(1) The provider's usual daily rate for that child; or

(2) The DSHS maximum child care subsidy daily rate for that child as listed in the following table.

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 12 yrs)
Region 1	Full-Day	$20.00	$18.00	$18.00	$16.00
	Half-Day	$10.00	$9.00	$9.00	$8.00
Region 2	Full-Day	$20.00	$19.00	$17.00	$17.00
	Half-Day	$10.00	$9.50	$8.50	$8.50
Region 3	Full-Day	$29.00	$25.00	$22.00	$20.00
	Half-Day	$14.50	$12.50	$11.00	$10.00
Region 4	Full-Day	$30.00	$29.67	$25.00	$24.00
	Half-Day	$15.00	$14.83	$12.50	$12.00
Region 5	Full-Day	$22.00	$20.00	$19.00	$17.00
	Half-Day	$11.00	$10.00	$9.50	$8.50
Region 6	Full-Day	$22.00	$20.00	$20.00	$19.00
	Half-Day	$11.00	$10.00	$10.00	$9.50

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0205, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0210 When can the WCCC program authorize the nonstandard hour child care bonus? (1) DSHS authorizes nonstandard hour child care bonus when fifteen or more hours of care are needed per month, that are:

(a) Before 6:00 a.m. or after 6:00 p.m. Monday through Friday; and/or

(b) Any time on Saturday or Sunday.

(2) DSHS authorizes the nonstandard hour bonus (NSB) to licensed or certified child care providers as follows:

(a) The DSHS maximum child care subsidy daily rate or the provider's usual daily rate for that child, whichever is less; and

(b) The monthly nonstandard hour bonus listed below.

DSHS Monthly Nonstandard Hour Bonus	
Region 1	$80.00
Region 2	$78.00
Region 3	$97.00
Region 4	$109.00
Region 5	$87.00
Region 6	$84.00

(3) The provider may claim the NSB when less than fifteen hours of care is provided only when:

(a) The provider held a space for the child during NSB hours; and

(b) The child was scheduled to attend.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0210, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0220 How does DSHS determine that my child qualifies for a special needs daily rate? To qualify for the DSHS child care programs special needs subsidy daily rate my 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 an individual who is:

(a) Not employed by the child care facility; and

(b) A health, mental health, education or social service professional with at least a master's degree; or

(c) A registered nurse.

(4) Be thirteen to nineteen years old and be a dependent of the courts.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0220, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0225 What is the DSHS child care subsidy daily rate for children with special needs in a licensed or certified child care center? DSHS authorizes special needs daily rates to licensed or certified child care centers under WAC 388-290-0200 and whichever of the following is greater:

(1) The provider's reasonable documented additional cost associated with the care of the child; or

(2) The daily rate listed in the table below.

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 12 yrs)
Region 1	Full-Day	$7.30	$6.14	$5.80	$5.45
	Half-Day	$3.65	$3.07	$2.90	$2.73
Region 2	Full-Day	$7.36	$6.15	$5.70	$5.05
	Half-Day	$3.68	$3.08	$2.85	$2.52
Region 3	Full-Day	$9.75	$8.13	$7.02	$6.82
	Half-Day	$4.88	$4.06	$3.51	$3.41
Region 4	Full-Day	$11.35	$9.48	$7.95	$7.16
	Half-Day	$5.67	$4.74	$3.98	$3.58
Region 5	Full-Day	$8.32	$7.16	$6.30	$5.59
	Half-Day	$4.16	$3.58	$3.15	$2.80
Region 6	Full-Day	$8.18	$7.02	$6.14	$6.00
	Half-Day	$4.09	$3.51	$3.07	$3.00

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0225, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0230 What is the DSHS child care subsidy daily rate for children with special needs in a licensed or certified family child care home? DSHS authorizes special needs daily rates to licensed or certified child care centers under WAC 388-290-0205 and whichever of the following is greater:

(1) The provider's reasonable documented additional cost associated with the care of the child; or

(2) The daily rate listed in the table below.

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 12 yrs)
Region 1	Full-Day	$6.00	$5.40	$5.40	$4.80
	Half-Day	$3.00	$2.70	$2.70	$2.40
Region 2	Full-Day	$6.00	$5.70	$5.10	$5.10
	Half-Day	$3.00	$2.85	$2.55	$2.55
Region 3	Full-Day	$8.70	$7.50	$6.60	$6.00
	Half-Day	$4.35	$3.75	$3.30	$3.00
Region 4	Full-Day	$9.00	$8.90	$7.50	$7.20
	Half-Day	$4.50	$4.45	$3.75	$3.60
Region 5	Full-Day	$6.60	$6.00	$5.70	$5.10
	Half-Day	$3.30	$3.00	$2.85	$2.55
Region 6	Full-Day	$6.60	$6.00	$6.00	$5.70
	Half-Day	$3.30	$3.00	$3.00	$2.85

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0230, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0235 What is the DSHS in-home/relative child care daily rate for children with special needs? (1) DSHS authorizes two dollars and six cents an hour for in-home/relative child care for care of a child with special needs and the lesser of:

(2) The provider's reasonable documented additional cost associated with the care for that child with special needs; or

(3) Sixty-two cents per hour.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0235, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0240 What is the DSHS child care subsidy rate for in-home/relative child care and how is it paid? (1) The maximum the WCCC program pays for child care provided by an in-home/relative provider is the lesser of the following:

(a) Two dollars and six cents per hour for the child who needs the greatest number of hours 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 daily rate for that care.

(2) The WCCC program may pay above the maximum daily rate for children who have special needs under WAC 388-290-0235.

(3) When care is provided by an in-home/relative provider, the WCCC programs pays benefits directly to the consumer, who is defined in WAC 388-290-0005. We consider the consumer the employer of the child care provider.

(4) 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.

(5) 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.

(6) 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 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0240, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0245 When can the WCCC program authorize payment of fees for registration and/or special activities? (1) The WCCC program pays licensed or certified child care providers a registration fee once per calendar year of fifty dollars per child or the provider's usual fee, whichever is less only if the fees are:

(a) Required of all parents whose child(ren) are in care with that provider; and

(b) Needed to maintain the child care arrangement.

(c) The registration fee may be authorized more than once per calendar year when:

(i) There is a break in child care services with the same provider of more than sixty days and the provider's usual policy is to charge an additional registration fee when there is a break in care; or

(ii) The child(ren) change child care providers.

(2) The WCCC program pays licensed or certified child care providers a monthly activity fee of twenty dollars per child or the provider's actual cost for the activity, whichever is less only if the fees meet the conditions in subsections (1)(a) and (b) of this section.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0245, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0250 When can WCCC pay a bonus for enrolling an infant? The WCCC program pays licensed or certified child care providers a one-time bonus of two hundred fifty dollars for each infant they newly enroll in care if all the following conditions are met:

(1) The child being cared for is less than twelve months of age;

(2) The child care facility has not already received a bonus for that infant;

(3) We expect care to be provided for five days or more; and

(4) The provider must care for the infant a minimum of five days in order to claim the bonus.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0250, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0255 When can the WCCC program establish a protective payee to pay my in-home/relative provider? The WCCC program establishes a protective payee to pay your in/home-relative provider when:

(1) You do not pay your in-home/relative child care provider your copayment and/or the entire amount the department sends you for in-home/relative child care;

(2) We issued a child care warrant to the correct address and twelve or more working days have passed since the issuance date, and you have not reported the WCCC warrant lost, stolen, or destroyed;

(3) You have a history of failing to pay your in-home/relative provider(s); or

(4) You have a protective payee for your TANF grant.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0255, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0260 Do I have the right to ask for a hearing about my WCCC benefits and how do I ask for one? (1) WCCC consumers have a right to request a hearing under chapter 388-02 WAC on any action affecting WCCC benefits except for mass changes resulting from a change in policy or law.

(2) Licensed or certified child care providers can request hearings under chapter 388-02 WAC only for WCCC overpayments.

(3) To request a hearing you or the licensed or certified provider:

(a) Contacts the office which sent them the notice; or

(b) Writes to the Office of Administrative Hearings, 919 Lakeridge Way SW, PO Box 42488, Olympia WA 98504-2488; and

(c) Makes the request for a hearing within ninety days of the date a decision is received.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0260, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0265 When can I get WCCC benefits 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 you are a WCCC consumer, you may not receive WCCC benefits pending the outcome of a hearing if you request payment to a provider who is not eligible under WAC 388-290-0125.

(4) If you are eligible for WCCC, you may receive child care benefits for another eligible provider, pending the outcome of the hearing.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0265, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0270 What is a WCCC overpayment and when might I have one? (1) A WCCC overpayment:

(a) Occurs when a consumer or a provider has received benefits or payment which they are not eligible to receive;

(b) Is written by WCCC staff and expected to be paid back by either the consumer or the provider.

(2) The WCCC program establishes WCCC overpayments, regardless of whether you are a current or past WCCC consumer, when we made payment for WCCC benefits and:

(a) You are no longer eligible or you are eligible for a smaller amount of care. The overpayment will start from the day your circumstances change and you become ineligible;

(b) You knowingly fail to report information to the department that affects the amount of WCCC you are eligible for; or

(c) You do not have attendance records and/or payment receipts to support the amount you billed the department.

(3) When setting up an overpayment, we reduce the WCCC overpayment by the amount of the WCCC underpayment when applicable.

(4) In areas not covered by this section, WCCC consumers are subject to chapter 388-410 WAC (Benefit errors).

(5) We set up overpayments starting the date that we paid for WCCC when you were not eligible or eligible for a lesser amount of care.

(6) The WCCC program recovers WCCC overpayments from licensed/certified child care providers, when:

(a) The provider receives payment for WCCC services not provided;

(b) The provider does not have attendance records that support the billing;

(c) We pay the provider more than they are eligible to bill; or

(d) The provider receives payment from DSHS and the provider is not eligible based on WAC 388-290-0125.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0270, filed 12/19/01, effective 1/19/02.]

WAC 388-290-075 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-125 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-150 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-200 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-270 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-280 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-300 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-350 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-375 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-400 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-450 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-475 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-500 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-525 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-600 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-650 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-700 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-750 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-800 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-850 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-854 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-858 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-862 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-866 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-870 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-874 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-878 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-882 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-886 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-888 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-900 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-905 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-910 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-915 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-920 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-925 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-930 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-935 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-940 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-945 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-950 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-310 WAC
WORKFIRST

WAC

WAC 388-310-0800 WorkFirst—Support services.

(1) **Who can get support services?**

People who can get support services include:

(a) WorkFirst participants who receive a TANF cash grant;

(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) Are actively working with a social worker and need support services to remove the barriers that are preventing them from living in a department approved living arrangements and/or meeting the school requirements.

(d) Former WorkFirst recipients who are working at least twenty hours or more per week for up to one year after leaving TANF if they need support services to meet a temporary emergency. This can include up to four weeks of support services if they lose a job and are looking for another one (see also WAC 388-310-1800); or

(e) American Indians who receive a TANF cash grant and have identified specific needs due to location or employment.

(2) **Why do I receive support services?**

WAC 388-290-600 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-650 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-700 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-750 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-800 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-850 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-854 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-858 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-862 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-866 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-870 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-874 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-878 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-882 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-886 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-888 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-900 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-905 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-910 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-915 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-920 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-925 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-930 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-935 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-940 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-945 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-950 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-310 WAC
WORKFIRST

WAC

WAC 388-310-0800 WorkFirst—Support services.

(1) **Who can get support services?**

People who can get support services include:

(a) WorkFirst participants who receive a TANF cash grant;

(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) Are actively working with a social worker and need support services to remove the barriers that are preventing them from living in a department approved living arrangements and/or meeting the school requirements.

(d) Former WorkFirst recipients who are working at least twenty hours or more per week for up to one year after leaving TANF if they need support services to meet a temporary emergency. This can include up to four weeks of support services if they lose a job and are looking for another one (see also WAC 388-310-1800); or

(e) American Indians who receive a TANF cash grant and have identified specific needs due to location or employment.

(2) **Why do I receive support services?**

Although not an entitlement, you may receive support services for the following reasons:

(a) To help you participate in work and WorkFirst activities that lead to independence.

(b) To help you to participate in job search, accept a job, keep working, advance in your job and/or increase your wages.

(c) 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.)

(3) **What type of support services may I receive and what limits apply?**

There is a limit of three thousand dollars per person per program year (July 1st to June 30th) for WorkFirst support services you may receive. Most types of support services have dollar limits.

The chart below shows the types of support services that are available for the different activities (as indicated by an "x") and the limits that apply.

Definitions:

• Work-related activities include looking for work or participating in workplace activities, such as community jobs or a work experience position.

•• Safety-related activities include meeting significant or emergency family safety needs, such as dealing with family violence. When approved, safety-related support services can exceed the dollar or category limits listed below.

••• Some support services are available if you need them for other required activities in your IRP.

Type of support service	Limit	• Work	•• Safety	••• Other
Reasonable accommodation for employment	$1,000 for each request	x		
Clothing/uniforms	$200 per adult per program year	x		
Diapers	$50 per child per month	x		
Employer reimbursement	Reimburse 50 percent of employer costs during on-the-job training	x		
Haircut	$40 per each request	x		
Lunch	Same rate as established by OFM for state employees	x		
Personal hygiene	$50 per adult per program year	x		
Professional, trade, association, union and bonds	$300 for each fee	x		
Relocation related to employment (can include rent, housing, and deposits)	$1,000 per program year	x		
Short-term lodging and meals in connection with job interviews/tests	Same rate as established by OFM for state employees	x		
Tools/equipment	$500 for each request	x		
Car repair needed to restore car to operable condition	$500 per program year	x	x	
License/fees/liability insurance	$600 per each license, fee or liability insurance request per program year	x	x	
Mileage, transportation, and/or public transportation	Same rate as established by OFM for state employees	x	x	
Counseling	No limit	x	x	x
Educational expenses	$300 for each request if it is an approved activity in your IRP and you do not qualify for sufficient student financial aid to meet the cost	x		x
Medical exams (not covered by Medicaid)	$150 per exam	x	x	x
Public transportation	$150 per month	x	x	x
Testing-diagnostic	$200 each	x	x	x

(4) **What are the other requirements to receive support services?**

Other restrictions on receiving support services are determined by the department or its agents. They will decide what support services you receive, as follows:

(a) It is within available funds; and

(b) It does not assist, promote, or deter religious activity; and

(c) There is no other way to meet the cost.

(5) **What is a transitional work expense?**

(a) A transitional work expense is a special type of support services that is only paid once in a lifetime. It is authorized in two payments of five hundred dollars to cover your work expenses and help you exit TANF sooner and stay off of assistance longer. The first payment is made in the month after your TANF grant closes if you can show you have a plan for staying employed and off of TANF. The second payment is paid if you are still employed and off of TANF three months later.

(b) To qualify for the first transitional work expense payment of five hundred dollars, you must also meet the following conditions:

(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 TANF grant; and

(iii) You are in the assistance unit and getting a TANF/SFA grant of one hundred dollars or less a month; and

(iv) Neither you or anyone else in your assistance unit is in sanction status; and

(v) You voluntarily stop getting your TANF/SFA grant.

(6) **What happens to my support services if I do not participate as required?**

The department will give you ten days notice, following the rules in WAC 388-310-1600, then discontinue your support services until you participate as required.

[Statutory Authority: RCW 74.08.090, 74.04.050, 78.08A.340, 74.04.050, and [WSR] 99-14-043. 01-17-053, § 388-310-0800, filed 8/13/01, effective 9/1/01. 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?**

You may participate in basic education as part of WorkFirst under any of the following circumstances:

(a) You may choose to participate, if you are twenty years of age or older and are working in paid or unpaid employment or in job search for a minimum of twenty hours a week (in addition to the basic education).

(b) You may be required to participate if you are a mandatory participant, a parent eighteen or nineteen years of age, you do not have a high school diploma or GED certificate and you need this education in order to find employment.

(c) You will be required to be in high school or a GED certification program if you are a mandatory participant, sixteen or seventeen years old and you do not have a high school diploma or GED certificate.

(d) Employment security department (ESD) has determined that you are a seasonal worker (that is, your normal way of life is based on recurring cycle of seasonal employment). Under WorkFirst, seasonal workers qualify for full-time education and training during the off season.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-15-009, § 388-310-0900, filed 7/6/01, effective 8/6/01; 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) Employment security department (ESD) has determined that you are a seasonal worker (that is, your normal way of life is based on a recurring cycle of seasonal employment). Under WorkFirst, seasonal workers qualify for full-time education and training during the off season; or

(c) You are in an internship or practicum for up to twelve months that is paid or unpaid and required to complete a course of vocational training or to obtain a license or certificate in a high demand field, as determined by the employment security department; or

(d) You lack job skills that are in demand for entry level jobs in your area; and 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, preemployment 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, 74.04.050. 01-15-009, § 388-310-1000, filed 7/6/01, effective 8/6/01; 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) Employment security department (ESD) has determined that you are a seasonal worker (that is, your normal way of life is based on a recurring cycle of seasonal employment). Under WorkFirst, seasonal workers qualify for full-time education and training during the off season; or

(c) You are in an internship or practicum for up to twelve months that is paid or unpaid and required to complete a course of vocational training or to obtain a license or certificate in a high demand field, as determined by the employment security department; or

(d) You lack job skills that are in demand for entry level jobs in your area; and

(e) 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, preemployment 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, 74.04.050. 01-15-009, § 388-310-1050, filed 7/6/01, effective 8/6/01; 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 388-310-2000 Individual development accounts (IDA). (1) What are individual development accounts?

Individual development accounts (IDAs) are special savings accounts for people eligible for or receiving TANF or SFA. The IDA's will help families save money for qualified purchases that will help them become financially self-sufficient. Your IDA account may only be used for the following qualified purchase: Acquisition cost for a first home, post-secondary education expenses, or business expenses for self-employment. You may only deposit income that you have earned through work into an IDA, the state matches those funds, helping you reach your goal more quickly.

(2) **Who helps you set up an IDA?**

The state office of trade and economic development (OTED) administers the IDA program. OTED contracts with local nonprofit agencies to enroll participants in the IDA program, monitor account activity and provide training and other support services while you are enrolled.

(3) **Who can enroll in the IDA program?**

To enroll in the IDA program, you must receive (or be eligible to receive) TANF or SFA assistance, or post TANF families with income below one hundred seventy-five percent of the federal poverty level. You may remain enrolled in the program for three years from the date of opening your IDA account.

(4) **What happens once you enroll in the IDA program?**

Once you've enrolled, your IDA contractor will help you develop an individual savings plan that identifies the steps you must take to earn the match. To earn the match you must:

(a) Attend financial skills classes to learn how to manage your personal finances.

(b) Open your savings account at a financial institution that is participating in the IDA program through an agreement with the IDA contractor.

(c) Deposit savings from earned income into your account on at least a quarterly basis.

(5) **How are your IDA matching funds handled?**

Your matching funds are held in a separate account until you are ready to make a qualified purchase. The IDA contractor provides you with monthly statements showing the amount of matching funds you have earned.

(6) **How much money can you save with an IDA?**

The state will give you up to two dollars for every dollar you save, up to a maximum match of four thousand dollars. So, if you save two thousand dollars (the maximum amount allowed), you could earn four thousand dollars in match, for a total of six thousand dollars.

(7) **When can you withdraw money from your account?**

When you have an IDA, you really have two types of accounts: your own savings account and a trust account holding your match funds.

(a) You can withdraw your own savings at any time - it's your money; but you will forfeit any match that was earned on those funds and could jeopardize your ability to stay in the program. You also need to report any withdrawals to your DSHS case manager if you are receiving any type of public assistance benefits.

(b) You cannot withdraw your match until you are ready to purchase your asset and have met all of the requirements in your individual savings plan. At that time, the IDA contractor will withdraw the matching funds and pay them directly to the person or organization that you are purchasing your asset from (such as the mortgage company, college, or bank).

(8) **Will having an IDA affect your eligibility for other public assistance programs?**

The funds held in your IDA cannot be taken into consideration when determining if you qualify for TANF, Social Security, Food Stamps, or Medicaid. However, if you withdraw savings from your IDA other than to purchase your asset, or if you leave the IDA program early, your eligibility could be affected. See WAC 388-470-0065 for more details about how IDAs affect your eligibility for other types of public assistance benefits.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.220. 01-03-042, § 388-310-2000, filed 1/9/01, effective 2/9/01.]

Chapter 388-330 WAC
BACKGROUND INQUIRIES

WAC

388-330-010 through 388-330-060 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-330-010 Purpose and authority. [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.] Repealed by 01-18-025, filed 8/27/01, effective 10/1/01. Statutory Authority: RCW 74.15.030.

388-330-020 Scope. [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.] Repealed by 01-18-025, filed 8/27/01, effective 10/1/01. Statutory Authority: RCW 74.15.030.

388-330-030 Application of inquiry findings. [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.] Repealed by 01-18-025, filed 8/27/01, effective 10/1/01. Statutory Authority: RCW 74.15.030.

388-330-035 Appeal of disqualification. [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.] Repealed by 01-18-025, filed 8/27/01, effective 10/1/01. Statutory Authority: RCW 74.15.030.

388-330-040 Inquiry form to be submitted—Time requirements. [Statutory Authority: RCW 74.15.030. 89-07-096 (Order 2777), § 388-330-040, filed 3/22/89.] Repealed by 01-18-025, filed 8/27/01, effective 10/1/01. Statutory Authority: RCW 74.15.030.

388-330-050 Release of information. [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.] Repealed by 01-18-025, filed 8/27/01, effective 10/1/01. Statutory Authority: RCW 74.15.030.

388-330-060 Sanctions for noncompliance. [Statutory Authority: RCW 74.15.030. 89-07-096 (Order 2777), § 388-330-060, filed 3/22/89.] Repealed by 01-18-025, filed 8/27/01, effective 10/1/01. Statutory Authority: RCW 74.15.030.

WAC 388-330-010 through 388-330-060 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-400 WAC
PROGRAM SUMMARY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-400-0015 General assistance for children—Summary of eligibility requirements. [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.] Repealed by 01-03-121, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1.

388-400-0020 General assistance for pregnant women—General eligibility requirements. [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.] Repealed by 01-07-001, filed 3/7/01, effective 5/1/01. Statutory Authority: RCW 74.04.050, 74.04.057.

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 in a TANF/SFA assistance unit as allowed under WAC 388-408-0015 through 388-408-0030;

(b) Meet the citizenship/alien status requirements of WAC 388-424-0005;

(c) Live in the state of Washington. A child must live with a caretaker relative, guardian, or custodian who meets the state residency requirements of WAC 388-468-0005;

(d) Do not live in a public institution unless specifically allowed under RCW 74.08.025;

(e) Meet TANF/SFA:

(i) Income requirements under chapter 388-450 WAC;

(ii) Resource requirements under chapter 388-470 WAC; and

(iii) Transfer of property requirements under chapter 388-488 WAC.

(f) Assign your rights to child support as required under WAC 388-422-0005;

(g) Cooperate with the division of child support (DCS) as required under WAC 388-422-0010 by helping them:

(i) Prove who is the father of children applying for or getting TANF or SFA; and

(ii) Collect child support.

(h) Tell us your Social Security number as required under WAC 388-476-0005;

(i) Cooperate in a review of your eligibility as required under WAC 388-434-0005;

(j) Cooperate in a quality assurance review as required under WAC 388-464-0001;

(k) Participate in the WorkFirst program as required under chapter 388-310 WAC; and

(l) Report changes of circumstances as required under WAC 388-418-0005.

(2) If you are an adult and do not have a child living with you, you must be pregnant and meet the requirements of WAC 388-462-0010.

(3) If you are an unmarried pregnant teen or teen parent:

(a) Your living arrangements must meet the requirements of WAC 388-486-0005; and

(b) You must attend school as required under WAC 388-486-0010.

(4) 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, court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis* as required under WAC 388-454-0005; or

(c) If the child lives with a parent or other adult relative that provides care for the child, that adult cannot have used up their sixty-month lifetime limit of TANF or SFA cash benefits as defined in WAC 388-484-0005.

(5) You cannot get TANF if you have been:

(a) Convicted of certain felonies and other crimes under WAC 388-442-0010; or

(b) Convicted of unlawful practices to get public assistance under WAC 388-446-0005 or 388-446-0010.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-400-0005, filed 1/22/01, effective 3/1/01. 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 388-400-0015 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-400-0020 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-400-0030 How do I qualify for refugee cash assistance? (1) To be eligible for refugee cash assistance (RCA), you must:

(a) Provide the name of the voluntary agency (VOLAG) which resettled you; 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.

(2) You are not eligible to receive RCA if you:

(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 a full-time student in an institution of higher education.

(3) If you are a refugee family and have children who are United States citizens, we treat you as a single assistance unit under chapter 388-408 WAC.

(4) We determine your eligibility and benefit level for RCA using the TANF payment standards under WAC 388-478-0020.

(5) If you are eligible for RCA and are pregnant or have a dependent child you may also be eligible for additional requirements for emergent needs under WAC 388-436-0002.

(6) If you meet the requirements of this section you are eligible for refugee cash assistance only during the eight-month period beginning:

(a) The date asylum is granted if you are an asylee; or

(b) The first month you entered the United States if you are not an asylee.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 01-06-031, § 388-400-0030, filed 3/2/01, effective 4/1/01; 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), you must:

(a) Provide the name of the voluntary agency (VOLAG) which resettled you;

(b) Meet the immigration status requirements of WAC 388-466-0005;

(c) Meet monthly income standards up to two hundred percent of Federal Poverty Level (FPL). Spenddown is available for applicants whose income exceeds two hundred percent of FPL (see WAC 388-519-0110);

(d) Receive refugee cash assistance (RCA); or

(e) Be eligible for, but choose not to apply for or receive RCA.

(2) You are not eligible to receive RMA if you are:

(a) Eligible for Medicaid; or

(b) A full-time student in institution 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, are treated as single assistance units according to chapter 388-408 WAC.

(4) If you are meeting the requirements of this section, you are eligible for RMA only during the eight-month period beginning in the first month you entered the United States (see WAC 388-466-0130).

(5) A recipient of RMA whose earned income goes above the income standard remains eligible for RMA benefits until the end of the RMA eligibility period.

(6) A refugee recipient of Medicaid, whose eligibility ended due to excess earned income, is transferred to RMA without eligibility determination for the remainder of the RMA eligibility period.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.320, and 74.20A.310. 01-13-046, § 388-400-0035, filed 6/14/01, effective 7/1/01. 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.]

Chapter 388-404 WAC
AGE REQUIREMENTS

WAC

388-404-0005 How does a child's age and attendance in school affect their eligibility for TANF and SFA?

WAC 388-404-0005 How does a child's age and attendance in school affect their eligibility for TANF and SFA? (1) To be eligible for temporary assistance for needy families (TANF) or state family assistance (SFA), a child must be:

(a) Under age eighteen; or

(b) Under age nineteen, and participating full-time in a secondary school program or the same level of vocational or technical training.

(i) "Participating" means the educational or training institution finds that the child:

(A) Meets the school's attendance requirements; and

(B) Is making acceptable progress in finishing the program.

(ii) The educational or training institution sets the definition of "full-time" attendance and the number of classes a child must take.

(iii) A secondary education includes high school, a GED program, and state-approved home schools.

(2) If a child age eighteen or older has already met the requirements to finish the educational program, the child is no longer eligible for TANF or SFA.

(3) If the child does not qualify for assistance under subsection (1) of this section, they may qualify for SFA if the child is under age twenty-one and:

(a) Gets an education due to their disability as stated in RCW 28A.155.020; or

(b) Participates full-time in a secondary education program or an equal level of vocational training as defined in (1)(b) above.

(4) If a child that gets SFA is age nineteen or over, they are not eligible for family medical or SFA-related medical.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-404-0005, filed 1/22/01, effective 3/1/01. 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.]

Chapter 388-406 WAC
APPLICATIONS

WAC

388-406-0015 Can I get food assistance right away?

WAC 388-406-0015 Can I get food assistance right away? (1) When the department gets your food assistance application, we look at your circumstances to see if you can get benefits within five calendar days. This is called "expedited service."

(2) To get expedited service, you must provide proof of who you are 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 shelter costs such as your rent or mortgage and utilities; or

(c) You are a destitute migrant or seasonal farm worker household, as defined in WAC 388-406-0021, and your household's available cash does not exceed one hundred dollars.

(3) To determine the amount of utilities to use to decide if you can get expedited services, we allow:

(a) The standard utility allowance (SUA) under WAC 388-450-0195, if you have heating or cooling costs and the SUA is greater than the amount you pay; or

(b) The amount you pay, if it is greater than the SUA.

(4) If you are eligible for expedited service and are not required to have an office interview, you can:

(a) Have a telephone interview or a home visit; and

(b) Still get benefits within five-days.

(5) If you are an applicant, "day one" of your five-day expedited service period starts on the:

(a) Day after the date your application is filed; or

(b) Date of the rescheduled interview when you are screened as expedited service eligible but do not show up for your initial interview; or

(c) Date you are released from a public institution if you are an SSI recipient; or

(d) Date of your interview when you:

(i) Waive your expedited interview and are found eligible for expedited service during your rescheduled interview; or

(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.

(6) If you get expedited service, we give you benefits for no more than two months. If we need additional information to decide if you are eligible for continued benefits, you have up to thirty days from the date of application to give us the information.

(7) 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) Gave us all the information we needed to prove eligibility for your last expedited service benefit period; or

(b) Were certified under normal processing standards after your last expedited certification.

(8) If you reapply and request expedited service before your certification period ends, you are not eligible for expedited service.

(9) If you reapply after your certification period ends and request expedited service, your five-day expedited service period is the same as a new application.

(10) If you are denied expedited service, you can ask for a department review of your case. We review the decision within two working days from the date we denied you expedited service.

[Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-036, § 388-406-0015, filed 8/28/01, effective 10/1/01. 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.]

Chapter 388-408 WAC
ASSISTANCE UNITS

WAC

WAC 388-408-0005 What is a cash assistance unit? (1) For all sections of this chapter:

(a) **"We"** means the department of social and health services.

(b) **"You"** means a person that is applying for or getting benefits from the department.

(c) **"Assistance unit"** or **"AU"** is the group of people who live together and whose income or resources we count to decide your eligibility for benefits and the amount of benefits you get.

(2) For GA-U, we decide who is in the AU under WAC 388-480-0010.

(3) For TANF or SFA, we decide who is in the AU by taking the following steps:

(a) We start with who must be in the AU under WAC 388-408-0015;

(b) We add those you choose to have in the AU under WAC 388-408-0025; and

(c) We remove those who are not allowed in the AU under WAC 388-408-0020.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0005, filed 1/22/01, effective 3/1/01. 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 Who is in my assistance unit for general assistance? (1) If you are an adult that is incapaci-

tated as defined in WAC 388-448-0001, you can be in a GA-U AU;

(2) If you are married and live with your spouse, we decide who to include in the AU based on who is incapacitated:

(a) If you are both incapacitated as defined in WAC 388-448-0001, we include both of you in the same AU.

(b) If only one spouse is incapacitated, we include only the incapacitated spouse in the AU. We count some of the income of the spouse that is not in the AU as income to the AU under WAC 388-450-0135.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0010, filed 1/22/01, effective 3/1/01. 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 Who must be in my assistance unit for temporary assistance for needy families (TANF) or state family assistance (SFA)? If you live with any of the following people, we must include them in your TANF, SFA, or combination TANF/SFA AU:

(1) The child you are applying for and:

(a) The child's full, half or adoptive sibling(s);

(b) The child's natural or adoptive parent(s) or stepparent(s); and

(c) If you are a pregnant minor or minor who is a parent and you live with your parent(s), we include your parent(s) if they:

(i) Need assistance; and

(ii) Provide the primary care for you, your child, or your siblings. We count full, half, or adoptive siblings as your sibling.

(2) If you are pregnant and you do not have a dependent child living with you, we include only you in the AU.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0015, filed 1/22/01, effective 3/1/01. 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 When am I not allowed to be in a TANF or SFA assistance unit? Some people cannot be in an AU for TANF or SFA. This section describes who cannot be in your TANF or SFA AU and how this will affect your benefits.

(1) We do not include the following people in your TANF or SFA AU:

(a) An adopted child if:

(i) The child gets federal, state, or local adoption assistance; and

(ii) Including the child in the AU and counting the adoption assistance income would reduce your AU's benefits.

(b) A minor parent or child who has been placed in Title IV-E, state, or locally-funded foster care unless the placement is a temporary absence 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) We decide that your living arrangement is not appropriate under WAC 388-486-0005.

(d) A court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis* (in the place of a parent) if they are not a relative of one of the children in the AU as defined under WAC 388-454-0010; or

(e) Someone who gets SSI benefits.

(2) If someone that lives with you cannot be in the AU:

(a) We do not count them as a member of the AU when we determine the AU's payment standard; and

(b) We do not count their income unless they are financially responsible for a member of the AU under WAC 388-450-0095 through 388-450-0130.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0020, filed 1/22/01, effective 3/1/01. 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 When can I choose who is in my TANF or SFA assistance unit? If you are a child's caretaker relative (a relative who cares for the child's basic needs), use the table below to find who you may choose to include or exclude in your TANF or SFA AU. If you include a child in your AU, it could cause you to get more or less benefits. If someone is not allowed in the AU under WAC 388-408-0020, you cannot choose to include them in your TANF or SFA AU.

(1) If you are the parent of the child, you may choose whether or not to include:	(a) Yourself in the AU if the child gets SSI; and (b) The child in the AU if: (i) You already receive TANF or SFA; (ii) You are not married to the child's other parent; and (iii) The child lives with both parents.
(2) If you are not the child's parent, and do not live with the parents of the child, you may choose to include either:	(a) Yourself if you are a relative defined in WAC 388-454-0010; or (b) Someone else that cares for the child and is a relative defined in WAC 388-454-0010.
(3) You may choose whether or not to include any of the following children:	(a) Brothers or sisters of a child who gets SSI; (b) Stepsisters and stepbrothers of a child; and (c) Other children that are not the child's brother or sister.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0025, filed 1/22/01, effective 3/1/01. 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 What children must be in the same TANF or SFA assistance unit? A child who applies for or gets TANF or SFA must be in the same AU as other children who get TANF or SFA and live with the same:

(1) Caretaker relative;

(2) Court-ordered guardian or court-ordered custodian; or

(3) Adult acting *in loco parentis*.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0030, filed 1/22/01, effective 3/1/01. 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 388-408-0034 What is an assistance unit for food assistance? For all sections of this chapter:

"We" means the department of social and health services;

"You" means the person applying for or receiving benefits from the department;

"Assistance unit" or **"AU"** is the group of people who live together and whose income and resources we count to decide if you are eligible for benefits and the amount of benefits you get.

"Boarder" means a person who:

(1) We decide pays a reasonable amount for lodging and meals; or

(2) Is in foster care.

"Live-in attendant" means a person who lives in the home and provides medical, housekeeping, childcare, or similar personal services an AU member needs because:

(1) A member is aged, incapacitated, or disabled;

(2) A member of the AU is ill; or

(3) A minor child in the AU needs childcare.

"Parent" means a natural, step, or adoptive parent. A stepparent is not a parent to a child if the marriage to the child's natural parent ends due to divorce or death.

A person who lives with you pays a **"reasonable amount"** for meals if:

(1) You provide two or more meals a day and they pay at least the maximum allotment under WAC 388-478-0060 for their AU size; or

(2) You provide one meal a day and they pay at least two-thirds the maximum allotment under WAC 388-478-0060 for their AU size.

"Roomer" means a person who pays for lodging, but not meals;

A person has a **"separate residence"** from an AU if they have separate living, cooking, and sanitation facilities.

"Spouse" means your husband or wife through a legally recognized marriage.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0034, filed 10/16/01, effective 12/1/01.]

WAC 388-408-0035 Who is in my assistance unit for food assistance? (1) For food assistance, a person must be in your assistance unit (AU) if they:

(a) Live in the same home as you; and

(b) Usually purchase and prepare food with you.

(2) If the following people live with you, they must be in your AU even if you do not usually purchase and prepare food together:

(a) Your spouse;

(b) Your parents if you are under age twenty-two (even if you are married);

(c) Your children under age twenty-two;

(d) A child under age eighteen who doesn't live with their parent unless the child:

(i) Is emancipated;

(ii) Gets a TANF grant in their own name; or

(iii) Gets income in their own name of at least the TANF payment standard under WAC 388-478-0020(2) before taxes or other withholdings.

(e) Someone not listed in (a) through (d) above if:

(i) You provide meals for them; and

(ii) They pay less than a reasonable amount for meals.

(3) Anyone who must be in your AU under subsection (2) or (3) is an ineligible AU member if they:

(a) Are disqualified for an intentional program violation (IPV) under WAC 388-446-0015;

(b) Did not meet ABAWD work requirements under WAC 388-444-0030.

(c) Did not meet work requirements under WAC 388-444-0055;

(d) Did not provide a social security number under WAC 388-476-0005;

(e) Did not meet the citizenship or alien status requirements under chapter 388-424 WAC;

(f) Are fleeing a felony charge or violating a condition of parole or probation under WAC 388-442-0010;

(g) Are disqualified for a drug-related felony under WAC 388-442-0010.

(4) If your AU has an ineligible member:

(a) We count the ineligible member's income to the AU under WAC 388-450-0140;

(b) We count all the ineligible members resources to the AU; and

(c) We do not use the ineligible member to determine the AU's size for the maximum income amount or allotment under WAC 388-478-0060.

(5) If the following people live in the same home as you, you can choose if we include them in the AU:

(a) A permanently disabled person who is age sixty or over and cannot make their own meals if the total income of everyone else in the home (not counting the elderly and disabled person's spouse) is not more than the one hundred sixty-five percent standard under WAC 388-478-0060;

(b) A boarder. If you do not include a boarder in your AU, the boarder cannot get food assistance in a separate AU;

(c) A person placed in your home for foster care. If you do not include this person in your AU, they cannot get food assistance in a separate AU;

(d) Roomers; or

(e) Live-in attendants even if they purchase and prepare food with you.

(6) If someone in your AU is out of your home for a full issuance month, they are not eligible for benefits as a part of your AU.

(7) The following people who live in your home are not members of your AU. If they are eligible for food assistance, they may be a separate AU:

(a) Someone who usually purchases and prepares meals separately from your AU if they are not required to be in your AU; or

(b) Someone who lives in a separate residence.

(8) A student who is ineligible for food assistance under WAC 388-482-0005 is not a member of the AU.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0035, filed 10/16/01, effective 12/1/01. 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 How does living in an institution affect my eligibility for food assistance? (1) For food assistance, an "institution" means a place where people live that provides residents more than half of three meals daily as a part of their normal services.

(2) Most residents of institutions are not eligible for food assistance.

(3) If you live in one of the following institutions, you may be eligible for food assistance even if the institution provides the majority of meals:

(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.

(4) 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).

(5) Elderly or disabled individuals and their spouses may use food assistance benefits to buy meals from the following if FNS has approved them to accept food assistance benefits:

(a) Communal dining facility; or

(b) Nonprofit meal delivery service.

(6) If you are homeless, you may use your food assistance benefits to buy prepared meals from meal providers for the homeless.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0040, filed 10/16/01, effective 12/1/01. 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 Am I eligible for food assistance if I live in a shelter for battered women and children? (1) You may be eligible for food assistance if you live in a shelter for battered women and children.

(2) If you live in a shelter for battered women and children and you left an assistance unit (AU) that included the abuser, we certify you a separate AU for food assistance:

(a) You may get additional amount of food assistance benefits even if you received benefits with the abuser.

(b) The department will decide your eligibility and benefits based on:

(i) The income and resources you have access to; and

(ii) The expenses you are responsible for.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0045, filed 10/16/01, effective 12/1/01. 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 Does the department consider me homeless for food assistance benefits? The department considers you as homeless if you do not have a regular nighttime residence or when you stay primarily in a:

(1) Supervised shelter that provides temporary living or sleeping quarters;

(2) Halfway house that provides a 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 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0050, filed 10/16/01, effective 12/1/01. 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.]

Chapter 388-410 WAC
BENEFIT ERROR

WAC

WAC 388-410-0020 What are the types of food assistance overpayments? (1) If you have an overpayment, you received more benefits than you were supposed to receive. Your overpayment can be:

(a) An administrative error overpayment if caused by an action or failure to take action by the department; or

(b) An inadvertent household error overpayment if caused by either your misunderstanding or unintended error; or

(c) An intentional program violation overpayment if caused by something you did on purpose. See chapter 388-446 WAC.

(2) We set up an administrative overpayment when we:

(a) Discover the overpayment within twelve months of its occurrence; and

(b) Mail the household a recovery demand letter and the overpayment calculation within twenty-four months of discovery date.

(3) We set up an inadvertent household error overpayment when we:

(a) Discover the overpayment within twenty-four months of its occurrence; and

(b) Mail the household a recovery demand letter and the overpayment calculation within twenty-four months of discovery date.

(4) We set up an intentional program violation overpayment when we:

(a) Discover the overpayment within seventy-two months of its occurrence; and

(b) Mail the household a recovery demand letter and the overpayment calculation within twenty-four months of discovery date.

[Statutory Authority: RCW 74.04.510. 01-14-032, § 388-410-0020, filed 6/28/01, effective 8/1/01. 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 Who is responsible for food assistance overpayments? (1) When your assistance unit receives more food assistance benefits than it was entitled to receive, the department sets up an overpayment claim.

(2) All adult members of your assistance unit at the time of a food assistance overpayment are each responsible for the total overpayment amount until the overpayment is paid. You remain responsible even if you change assistance units.

[Statutory Authority: RCW 74.04.510. 01-14-032, § 388-410-0025, filed 6/28/01, effective 8/1/01. 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 How does the department calculate and recover a food assistance overpayment? (1) The department calculates the amount of your food assistance overpayment by counting the difference between:

(a) The benefits actually authorized; and

(b) The benefits that should have been authorized.

(2) We reduce your overpayment by an underpayment if the underpayment amount was:

(a) Not previously returned to you; and

(b) Not already used to reduce a different overpayment.

(3) We establish and take action to collect all overpayments discovered through the department's quality control system regardless of:

(a) The overpayment amount; and

(b) Whether or not you are currently receiving food assistance.

(4) Except for subsection (4) of this section, we take action to collect all inadvertent household or administrative error claims unless:

(a) The entire overpayment claim is canceled by an underpayment;

(b) The claim is one hundred twenty-five dollars or less and the claim cannot be recovered by benefit reduction;

(c) The department cannot locate a responsible assistance unit member; or

(d) The department determines collection action will negatively affect an inadvertent household error case referred for possible prosecution or administrative disqualification.

(5) We take action to collect an intentional program violation overpayment unless:

(a) Your assistance unit has repaid the overpayment;

(b) Responsible assistance unit members cannot be located; or

(c) The department determines collection action will negatively affect the case against an assistance unit member referred for prosecution.

(6) You may repay an overpayment by:

(a) A lump sum;

(b) Regular installments under a payment schedule as specified in subsection (8) of this section; or

(c) Benefit reduction.

(7) Currently participating assistance units responsible for an overpayment may repay by a negotiated monthly installment amount. The repayment amount must be greater than the amount that could be recovered through benefit reduction. The payment schedule may be renegotiated by either the department or the assistance unit.

(8) We automatically reduce your monthly benefits when you are responsible for an administrative or inadvertent household error; and you:

(a) Fail to notify us of your chosen repayment agreement; or

(b) Fail to request a fair hearing and continued benefits within ten days of receipt of the department's collection action notice.

(9) Except for your initial benefits when first certified, we can reduce your monthly benefits to repay the overpayment.

(a) If you have an administrative or inadvertent household error overpayment, we reduce your benefits by the greater of:

(i) Ten percent of your monthly benefits; or

(ii) Ten dollars per month.

(b) If you have an intentional program violation overpayment, we reduce your benefits by the greater of:

(i) Twenty percent of your monthly benefits; or

(ii) Twenty dollars per month.

(10) If you are responsible for an intentional program violation claim, you must chose a repayment agreement within ten days of receipt of your collection action notice. Failing to do so will subject you to involuntary reduction of your current benefit amount.

(11) We automatically reduce your current food assistance benefits when you fail to meet the terms of an agreed repayment schedule unless you:

(a) Catch up with all overdue payments; or

(b) Request renegotiation of the payment schedule.

(12) If you are no longer receiving food assistance, we must refer your overpayment claim for federal collection if the claim is delinquent for one hundred eighty or more days. Federal collection includes reducing your income tax refund or social security benefits. Your claim is delinquent if you have not:

(a) Repaid the entire overpayment by the due date; or

(b) Met the requirements of your scheduled repayment agreement.

(13) If you are no longer receiving food assistance, we can garnish your wages, file a lien against your personal or real property, or otherwise access your property to collect the overpayment amount.

(14) We suspend collection action when:

(a) A responsible assistance unit member cannot be located; or

(b) Cost of further collection action is likely to exceed the amount that can be recovered.

(15) We can negotiate the amount of an overpayment if the amount offered approximates the net amount expected to be collected prior to the end of the legal collection period.

(16) At the end of the collection period, we write off unpaid overpayments and release any applicable liens 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.

(17) We may collect an assistance unit's overpayments from another 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 74.04.510. 01-14-032, § 388-410-0030, filed 6/28/01, effective 8/1/01. 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.]

Chapter 388-412 WAC
BENEFIT ISSUANCES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-412-0045 General information about cash and food assistance issued by electronic benefits transfer. [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.] Repealed by 01-18-054, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.510 and 74.08.090.

WAC 388-412-0005 General information about your cash benefits. (1) Each separate cash assistance unit (AU) gets a separate benefit amount. If several AUs live in the same house, each AU gets a separate benefit amount.

(2) If you are married and both you and your spouse get general assistance, you and your spouse are one AU.

(3) Your grant is rounded down to the next whole dollar amount unless:

(a) You get a clothing and personal incidental (CPI) allowance; or

(b) Your benefits are reduced to pay an overpayment.

(4) We do not issue any cash benefits if you are eligible for less than ten dollars unless:

(a) You get a CPI allowance;

(b) Your benefits are reduced to pay an overpayment; or

(c) You get Supplemental Social Security (SSI) interim assistance payments.

[Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-054, § 388-412-0005, filed 8/30/01, effective 9/30/01; 99-16-024, § 388-412-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0005, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0015 General information about your food assistance allotments. (1) Your monthly food assistance benefit is called an allotment. An allotment is the total dollar value of benefits your eligible assistance unit (AU) gets for a calendar month.

(2) You get the maximum allotment if your AU does not have any countable net income. See WAC 388-478-0060 for the maximum allotments.

(3) If your AU has countable net income, your allotment is computed by:

(a) Multiplying your AU's countable net monthly income by thirty percent;

(b) Rounding this amount up to the next whole dollar; and

(c) Subtracting the results from the maximum allotment.

(4) You get benefits from the date your AU is determined eligible through the end of the month except for AUs described in WAC 388-406-0055. This is called proration and is based on a thirty-day month.

(5) You get benefits for both the month of application and the following month in one allotment if you are eligible for both months and you applied on or after the sixteenth of the month.

(6) You do not get an allotment in the first month you are eligible if your allotment is less than ten dollars.

(7) You get a minimum allotment of ten dollars each month if your AU has a total of one or two members unless:

(a) It is the first month of your certification period; and

(b) Your AU is eligible for only a partial month.

[Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-054, § 388-412-0015, filed 8/30/01, effective 9/30/01; 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 When do I get my benefits? (1) You get your on-going cash benefits on the first of the month.

(2) You get your on-going food assistance within the first ten days of the month. The day of the month that you get your benefits is the same as the last number of your food assistance AU number. If the last number of your AU number is zero, you get your benefits on the tenth.

[Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-054, § 388-412-0020, filed 8/30/01, effective 9/30/01. 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 How do I get my benefits? (1) Your cash benefits are sent to you by:

(a) Electronic benefit transfer (EBT);

(b) Direct deposit into you own bank account (electronic funds transfer-EFT); or

(c) Warrant if you have a payee who is not approved for direct deposit or you receive ADATSA, diversion, additional requirements or clothing and personal incidentals (CPI) payments.

(2) You use a quest card to access your benefits in your EBT account. You get a personal identification number (PIN) that you must enter when using this card.

(3) Your food assistance benefits are deposited into your EBT account.

(4) We establish an EBT account for each AU that receives their benefits by EBT.

(5) Your EBT account becomes inactive when you do not use it for ninety days. If you want to use the account after it becomes inactive, you must contact your local office and ask us to reactivate it.

(6) Your cash and food assistance are canceled when you do not use your EBT benefits for three hundred sixty-five days. Your food assistance benefits cannot be replaced.

(7) We convert your food assistance to coupons when you move to a state where you cannot use your EBT account. There may be up to one dollar and ninety-nine cents left in your EBT account after conversion. You must use the remaining balance left in your EBT account within seven days after we convert your benefits from EBT to coupons. We cancel these benefits if you do not use them.

(8) Cash benefits cannot be converted to warrants. You must use your cash benefits from your EBT account.

[Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-054, § 388-412-0025, filed 8/30/01, effective 9/30/01. 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 388-412-0040 Can I get my benefits replaced? Under certain conditions, we may replace your benefits.

(1) You may get your EBT benefits replaced if:

(a) We make a mistake that causes you to lose benefits;

(b) Both your EBT card and personal identification number (PIN) are stolen from the mail; you never had the ability to use the benefits; and you lost benefits;

(c) You left a drug or alcohol treatment on or before the fifteenth of the month and the facility does not have enough food assistance funds in their EBT account for one-half of the allotment that they owe you;

(d) Your EBT benefits that were recently deposited into an inactive EBT account were canceled by mistake along with your state benefits; or

(e) Your food that was purchased with food assistance benefits was destroyed in a disaster.

(2) You may get food coupons replaced if:

(a) You did not get your food coupons as they were either lost or stolen in the mail; or

(b) Your food coupons or food purchased with food coupons were destroyed in a disaster.

(3) If you want a replacement, you must:

(a) Report the loss to your local office within ten days from the date of the loss; and

(b) Sign a department affidavit form stating you had a loss of benefits.

(4) For food assistance, we replace the loss up to a one month benefit amount.

(5) Your request for a replacement is denied if the reason for the loss is not listed in subsection (1) and (2) above or:

(a) We decided that you request is fraudulent;

(b) Your certified mail coupons are signed for by any person living or visiting at your address;

(c) Your food coupons were lost, stolen or misplaced after you received them;

(d) You already got two countable food assistance replacements within the prior five months; or

(e) You got disaster food stamp benefits for the same month you requested a replacement for food assistance.

(6) Your replacement does not count if:

(a) Your benefits are returned to us;

(b) We replaced your benefits because we made an error; or

(c) The food coupons you got are improperly made or are mutilated. You must have at least three-fifths of each coupon in order for us to replace them.

[Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-054, § 388-412-0040, filed 8/30/01, effective 9/30/01. 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 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-414 WAC
CATEGORICAL ELIGIBILITY FOR FOOD ASSISTANCE

WAC

WAC 388-414-0001 Some food assistance units do not have to meet all eligibility requirements. (1) What is "categorical eligibility" (CE)?

(a) Some food assistance units do not have to meet all of the eligibility requirements for food assistance. The department calls this CE. If your food assistance unit is CE, you do not have to meet the following food assistance requirements because you have met them for another program:

(i) Resources;

(ii) Gross and net income standards;

(iii) Residency; and

(iv) Sponsored alien information.

(b) If you are a CE food assistance unit, you will still have your income budgeted to determine the amount of food stamps your assistance unit is eligible for.

(2) **Who is CE for food assistance?**

Your household is CE when:

(a) All members of your food assistance unit are getting general assistance (GA) and/or Supplemental Security Income (SSI) cash benefits on their own behalf;

(b) A member of your food assistance unit is getting or is authorized to get payments 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); or

(iii) Diversion cash assistance (DCA). You are CE for the month you receive DCA and the three following months as long as you have one adult relative caretaker with a dependent child in the food assistance unit.

(c) You are receiving TANF/SFA cash assistance and no longer get assistance because your earnings are over the earned income limit in WAC 388-478-0035. You are CE for twenty-four months after your TANF/SFA cash assistance

ends as long as you have one adult relative caretaker with a dependent child in the food assistance unit.

(3) **Who are not considered CE even though the above criteria is met?**

(a) A member of your food assistance unit is not CE who:

(i) Is not eligible because of his/her alien or student status;

(ii Fails to follow work requirements;

(iii) Fails to provide or apply for a Social Security Number;

(iv) Is a SSI recipient in a cash-out state (state where SSI payments are increased to include the value of the food stamp allotment);

(v) Is not eligible for SSI on his/her own behalf since he/she is getting SSI as an essential person or as an ineligible spouse; or

(vi) Is living in an institution.

(b) If a person is not CE, he/she is not included as member in your CE food assistance unit.

(c) Your entire food assistance unit is not CE when your assistance unit:

(i) Is not eligible because of striker provisions;

(ii) Knowingly transferred resources for the purpose of qualifying for benefits;

(iii) Refuses to cooperate in providing information that is needed to determine your eligibility;

(iv) Has a head of the household that failed to meet work requirements; or

(v) Has a member that is not qualified because of an intentional program violation.

[Statutory Authority: RCW 74.08.090, 74.04.510. 01-07-054, § 388-414-0001, filed 3/16/01, effective 3/29/01; 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 How long can I get food assistance? (1) The length of time the department determines your assistance unit (AU) is eligible to get food assistance is called a certification period. The department (we) may certify your AU for up to:

(a) Twenty-four months if everyone in your AU is elderly and no one in your AU has earned income or cash assistance.

(b) Twelve months if everyone in your AU is disabled or elderly and no one in your AU has earned income.

(c) Six months if your AU has:

(i) Cash assistance; or

(ii) Earned income; or

(iii) Income, household circumstances, and deductions that are not likely to change.

(d) Three months for all other AUs, including AUs with:

(i) A migrant or seasonal farmworker;

(ii) An able-bodied adult without dependents (ABAWD);

(iii) No income or cash assistance;

(iv) Expenses that are more than the income the AU gets;

(v) Homeless individuals or AU members staying in an emergency or family violence shelter;

(vi) An AU member who is staying in a non-ADATSA drug and alcohol treatment center.

(2) We may shorten or lengthen your certification period to match your cash or medical assistance end date unless you have already received the maximum certification allowable for your AU.

(3) We terminate your certification period when:

(a) We get proof of a change that makes your AU ineligible; or

(b) We get information that your AU is ineligible; and

(c) You do not provide needed information to verify your AU's circumstances.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-11-107, § 388-416-0005, filed 5/21/01, effective 7/1/01; 99-16-024, § 388-416-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-418 WAC
CHANGE OF CIRCUMSTANCE

WAC

WAC 388-418-0005 What type of changes must I report for cash, food, and medical assistance? For purposes of this section, an "assistance unit" or "AU" is a group of people who live together and whose income or resources we count to decide what benefits the AU gets. Even if someone in your AU is not eligible to get a benefit, we still count that person's income or resources if they are financially responsible for you or someone in your AU, such as a common child. If you are a parent of a child who gets long-term care benefits, you need only report changes in income or resources that are actually contributed to the child. Tables one, two and three below show the types of changes you must report based on the type of assistance you get. Use table one to see if you must report a change for cash or food assistance. Use table two to see if you must report a change for children's, pregnant women's, or family medical assistance. Use table three to see if you must report a change for SSI-related medical or long-term care medical assistance.

Table 1 - Cash Assistance and Food Assistance

Type of change to report when you or anyone in your assistance unit AU):	Do I have to report this change for cash assistance?	Do I have to report this change for food assistance?
(1) Starts to get money from a new source;	Yes	Yes

Table 1 - Cash Assistance and Food Assistance		
Type of change to report when you or anyone in your assistance unit AU):	**Do I have to report this change for cash assistance?**	**Do I have to report this change for food assistance?**
(2) Has unearned income that changed by more than twenty-five dollars from amount we budgeted;	Yes	Yes
(3) Moves into or out of your home, including newborns or if an AU member dies. This also includes when someone temporarily moves in or out;	Yes	Yes
(4) Moves to a new residence;	Yes	Yes
(5) Has a change in shelter costs;	Yes, but only if you went from having no shelter costs to having a shelter cost, or from having shelter costs to not having to pay anything. You don't have to report a change in the amount you pay.	Yes, report the change at your recertification. If your shelter costs go up, you could get more food assistance benefits. Report the change sooner to see if you will get more benefits.
(6) Gets married, divorced, or separated;	Yes	Yes
(7) Gets a vehicle;	Yes	Yes
(8) Has a disability that ends;	Yes	Yes
(9) Has countable resources that are more than the resource limits under WAC 388-470-0005;	Yes	Yes
(10) Gets a job or changes employers;	Yes	Yes
(11) Changes from part-time to full-time or full-time to part-time work. We use your employer's definition of part-time and full-time work;	Yes	Yes
(12) Has a change in hourly wage rate or salary;	Yes	Yes
(13) Stops working;	Yes	Yes
(14) Has a pregnancy that begins or ends;	Yes	No

Table 1 - Cash Assistance and Food Assistance		
Type of change to report when you or anyone in your assistance unit AU):	**Do I have to report this change for cash assistance?**	**Do I have to report this change for food assistance?**
(15) Has a change in uncovered medical expenses;	No	Yes, report this change only at your next eligibility review. If you are elderly or disabled and you have an increase in uncovered medical expenses, report this change sooner as you may be eligible to get more benefits.

Table 2 - Medical Assistance		
Type of change to report when you or anyone in your assistance unit (AU):	**Do I have to report this change for family medical assistance (i.e., TANF/SFA-related)?**	**Do I have to report this change for children's medical and/or pregnancy medical?**
(16) Starts to get money from a new source;	Yes	No
(17) Has unearned income that changed;	Yes	No
(18) Moves into or out of your home, including newborns or if an AU member dies. This also includes when someone temporarily moves in or out;	Yes	Yes
(19) Moves to a new residence;	Yes	Yes
(20) Has a change in shelter costs;	No	No
(21) Gets married, divorced, or separated;	Yes	No
(22) Gets a vehicle;	No	No
(23) Has a disability that ends;	No	No
(24) Has countable resources that are more than the resource limits under WAC 388-470-0005;	No	No
(25) Gets a job or changes employers;	Yes	No

Table 2 - Medical Assistance		
Type of change to report when you or anyone in your assistance unit (AU):	**Do I have to report this change for family medical assistance (i.e., TANF/SFA-related)?**	**Do I have to report this change for children's medical and/or pregnancy medical?**
(26) Changes from part-time to full-time or full-time to part-time work. We use your employer's definition of part-time and full-time work;	Yes	No
(27) Has a change in hourly wage rate or salary;	Yes	No
(28) Stops working;	Yes	No
(29) Has a pregnancy that begins or ends;	Yes	Yes
(30) Has a change in uncovered medical expenses.	No	Yes, but only if an AU member has a spend-down.

Table 3 - SSI-Related Medical Assistance and Long-Term Care		
Type of change to report when you or anyone in your assistance unit (AU):	**Do I have to report this change for SSI-related medical assistance?**	**Do I have to report this change for long-term care (i.e., COPES, CAP, or nursing home)**
(31) Starts to get money from a new source;	Yes	Yes
(32) Has unearned income that changed;	Yes	Yes
(33) Has a change in earnings or stops working	Yes	Yes
(34) Moves into or out of your home, including newborns or if an AU member dies. This also includes when someone temporarily moves in or out;	Yes	Yes
(35) Moves to a new residence;	Yes	Yes

Table 3 - SSI-Related Medical Assistance and Long-Term Care		
Type of change to report when you or anyone in your assistance unit (AU):	**Do I have to report this change for SSI-related medical assistance?**	**Do I have to report this change for long-term care (i.e., COPES, CAP, or nursing home)**
(36) Has a change in shelter costs;	No, unless you went from paying rent to not paying any rent. You do not need to report if your rent amount changes.	Yes, if client or community spouse live in their own home
(37) Gets married, divorced, or separated;	Yes	Yes
(38) Gets a vehicle;	Yes, but only if that person or their spouse gets SSI-related medical	Yes, but only if that person gets long-term care
(39) Has a disability that ends;	Yes	Yes
(40) Has countable resources that are more than the resource limits, under WAC 388-470-0005 or 388-513-1350;	Yes, but only if that person or their spouse get SSI-related medical	Yes, but only if that person gets long-term care
(41) Has a change in uncovered medical expenses.	Yes, but only if an AU member has a spenddown.	Yes.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-11-109, § 388-418-0005, filed 5/21/01, effective 7/1/01; 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 388-418-0007 When do I have to report changes in my circumstances? (1) If you are applying for cash and/or food assistance and have had a change:

(a) After the date you applied but before your interview, you must report the change at the time of your interview; or

(b) After you have been interviewed, you must report the change within ten days of the date of your approval notice.

(2) If you get TANF/SFA, you must report within five calendar days from the day you learn that a child in the AU will be gone from your home longer than ninety days. If you do not report this within five days:

(a) You are not eligible for cash benefits for one month; and

(b) All of your countable income as described in WAC 388-450-0162 is budgeted against the cash benefits for the remaining AU members.

(3) If you receive cash and/or food assistance, all other changes described in WAC 388-417-0005 must be reported

within ten days from the day you become aware of the change.

(4) If you receive medical assistance you must report the changes described in WAC 388-418-0005 within twenty days from the day you become aware of the change.

(5) If you report changes late, you may get the wrong amount or wrong type of benefits. If you get more benefits than you are eligible for, you may have to pay them back as described in chapter 388-410 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-11-109, § 388-418-0007, filed 5/21/01, effective 7/1/01.]

Chapter 388-432 WAC
DIVERSION ASSISTANCE

WAC

WAC 388-432-0005 Can I get help from DSHS for a family emergency without receiving monthly cash assistance? DSHS has a program called diversion cash assistance (DCA). If your family needs an emergency cash payment but does not need ongoing monthly cash assistance, you may be eligible for this program.

(1) To get DCA, you must:

(a) Meet all the eligibility rules for temporary assistance for needy families (TANF)/state family assistance (SFA) except:

(i) You do not have to participate in WorkFirst requirements as defined in chapter 388-310 WAC; and

(ii) You do not have to assign child support rights or cooperate with division of child support as defined in chapter 388-422 WAC.

(b) Have a current bona fide or approved need for living expenses;

(c) Provide proof that your need exists; and

(d) Have or expect to get enough income or resources to support yourselves for at least twelve months.

(2) You may get DCA to help pay for one or more of the following needs:

(a) Child care;

(b) Housing;

(c) Transportation;

(d) Expenses to get or keep a job;

(e) Food costs, but not if an adult member of your family has been disqualified for food stamps; or

(f) Medical costs, except when an adult member of your family is not eligible because of failure to provide third party liability (TPL) information as defined in WAC 388-505-0540.

(3) DCA payments are limited to:

(a) One thousand five hundred dollars once in a twelve-month period which starts with the month the DCA benefits begin; and

(b) The cost of your need.

(4) We do not budget your income or make you use your resources to lower the amount of DCA payments you can receive.

(5) DCA payments can be paid:

(a) All at once; or

(b) As separate payments over a thirty-day period. The thirty-day period starts with the date of your first DCA payment.

(6) When it is possible, we pay your DCA benefit directly to the service provider.

(7) You are not eligible for DCA if:

(a) Any adult member of your assistance unit got DCA within the last twelve months;

(b) Any adult member of your assistance unit gets TANF/SFA;

(c) Any adult member of your assistance unit is not eligible for cash assistance for any reason unless one parent in a two-parent-assistance unit is receiving SSI; or

(d) Your assistance unit does not have a needy adult (such as when you do not receive TANF/SFA payment for yourself but receive it for the children only).

(8) If you apply for DCA after your TANF/SFA grant has been terminated, we consider you an applicant for DCA.

(9) If you apply for TANF/SFA and you received DCA less than twelve months ago:

(a) We set up a DCA loan.

(i) The amount of the loan is one-twelfth of the total DCA benefit times the number of months that are left in the twelve-month period.

(ii) The first month begins with the month DCA benefits began.

(b) We collect the loan only by reducing your grant. We take five percent of your TANF/SFA grant each month.

(10) If you stop getting TANF/SFA before you have repaid the loan, we stop collecting the loan unless you get back on TANF/SFA.

[Statutory Authority: RCW 74.08.090, 74.04.050. 01-03-066, § 388-432-0005, filed 1/12/01, effective 3/1/01.]

Chapter 388-434 WAC
ELIGIBILITY REVIEWS AND RECERTIFICATIONS

WAC

WAC 388-434-0010 How do I get recertified for food assistance benefits? (1) To complete the recertification process you must:

(a) Submit an application; and

(b) Complete an interview; and

(c) Submit needed proof of your circumstances if we (the department) ask for it.

(2) You have thirty days after your certification period ends to complete the recertification process. However, if you reapply timely and complete the recertification process before your certification period ends, your benefits continue to be deposited into your EBT (electronic benefit transfer) account on the same day of the month. To reapply timely, we must get your application no later than:

(a) The fifteenth day of the last month of your certification period; or

(b) The fifteenth day after you get a notice of eligibility when your certification period is two months or less.

(3) If you reapply timely and complete the recertification process you get a notice of approval or denial:

(a) By the end of your current certification period; or

(b) By the thirtieth day after you got your last benefit amount in [if] you were certified for one month.

(4) If you reapply before your certification period ends, but fail to take a required action such as completing an interview or providing proof of your eligibility, we may deny your benefits:

(a) At that time; or

(b) At the end of the certification period; or

(c) At the end of thirty days.

(5) If you take the required action before your certification period ends, we start your food assistance from the first of the month of your new certification period.

(6) If you take the required action within thirty days after your certification period ends, we start your food assistance from:

(a) The first of the month of your new certification period if we caused the delay; or

(b) The first of the month of your new certification period if we rescheduled a second interview per your request and you attended the rescheduled interview; or

(c) The date you take the required action.

(7) If you reapply after your certification period ends, your request is treated like an initial application and will be approved or denied under WAC 388-406-0035.

(8) See chapter 388-458 WAC for adequate notice and translation requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.05.057, and 74.08.090. 01-15-011, § 388-434-0010, filed 7/6/01, effective 8/1/01; 98-16-044, § 388-434-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-438 WAC
EMERGENCY ASSISTANCE FOR MEDICAL NEEDS

WAC

388-438-0110 The alien emergency medical (AEM) program.

WAC 388-438-0110 The alien emergency medical (AEM) program. (1) The alien emergency medical (AEM) program is a federally-funded program. It is for aliens who are ineligible for other Medicaid programs, due to citizenship or alien status requirements described in WAC 388-424-0005 and 388-424-0010.

(2) Except for the Social Security Number, citizenship, or alien status requirements, an 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 are age sixty-five or over or who meet SSI disability criteria. See WAC 388-519-0100.

(4) To qualify for the AEM program, the alien must have:

(a) An emergency medical condition as described in WAC 388-500-0005; or

(b) Been approved by the department as requiring nursing facility or COPES level of care.

(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 and C.F.R. 436.128, 436.406(c) and 440.255. 01-05-041, § 388-438-0110, filed 2/14/01, effective 3/17/01. 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 388-444 WAC
FOOD STAMP EMPLOYMENT AND TRAINING

WAC

388-444-0075 What are the disqualification periods for quitting a job without good cause?

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 reestablish eligibility after the disqualification, if otherwise eligible by:

(a) Getting a new job;

(b) In nonexempt areas, participating in the FS E&T program;

(c) Participating in Workfare as provided in WAC 388-444-0040;

(d) In an exempt area, serving the penalty period.

(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. 01-05-006, § 388-444-0075, filed 2/7/01, effective 3/1/01; 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 388-448 WAC
INCAPACITY

WAC

WAC 388-448-0020 How and from whom you can get medical evidence for incapacity determination. Before we can decide if you are eligible for GAU, 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 and you are otherwise eligible according to WAC 388-400-0025, 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 agency and meets the minimum mental health professional qualifications set by them, which consist of having a Master's 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) State institutions and agencies that are providing or have provided services to you.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0020, filed 6/29/01, effective 8/1/01. 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 388-448-0070 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 thirteen "body systems." The thirteen body systems consist of:

(a) Musculo-skeletal,

(b) Special senses and speech,

(c) Respiratory,

(d) Cardiovascular,

(e) Digestive,

(f) Genito-urinary,

(g) Hemic and lymphatic,

(h) Skin,

(i) Endocrine and obesity,

(j) Neurological,

(k) Mental disorders,

(l) Neoplastic, and

(m) 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
(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, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0070, filed 6/29/01, effective 8/1/01. 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 388-448-0120 How we decide how long you are incapacitated. We use the medical evidence and expected length of recovery from the incapacitating condition to decide the length of time you are eligible for GAU as follows:

(1) If you are eligible for GAU, a maximum of twelve months; or

(2) If we decide you are eligible for general assistance expedited Medicaid (GAX), a maximum of thirty-six months from the date of the latest incapacity approval.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0120, filed 6/29/01, effective 8/1/01. 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 for available medical treatment or other agencies for treatment, rehabilitation or work activities when we decide it will improve your ability to be gainfully employed or reduce your need for GAU. **"Available medical treatment"** means medical, surgical, chemical dependency, or mental health services, or a combination of them.

(1) When you are first approved and at each review determination, we give you written information regarding your treatment requirements.

(2) You must accept and follow through on required medical treatment and referrals to other agencies and services, including applying for SSI, unless you have good cause for not doing so. Examples of good cause are found in WAC 388-448-0140.

(3) We may require you to undergo alcohol or drug treatment before reviewing your eligibility for GAU.

(4) You may request a fair hearing if you disagree with the treatment or referral requirements we set for you (see WAC 388-458-0040).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0130, filed 6/29/01, effective 8/1/01. 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 proof to support your good cause claim. Valid reasons for refusing treatment and other agency referrals include, but are not limited to, the following:

(1) Valid reasons for refusing 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) Valid reasons for refusing treatment or other agency referrals:

(a) We did not give you enough information about the requirement;

(b) You did not receive written notice of the requirement;

(c) The requirement was made in error;

(d) You are temporarily unable to participate because of documented interference, or

(e) Your medical condition or limitations are consistent with the definition of necessary supplemental accommodation (NSA), WAC, 388-472-0020 and your condition or limitations contributed to your refusal, per WAC 388-472-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0140, filed 6/29/01, effective 8/1/01. 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 388-448-0180 How and when we redetermine your eligibility if we decide you are eligible for GAX. When we decide you are eligible for GAX, we may extend your incapacity period up to thirty-six months from the date of the last incapacity decision without requesting additional medical documentation.

(1) If you remain on GAX at the end of the thirty-six-month period, we determine your eligibility using current medical evidence.

(2) If your application for SSI is denied, and the denial is upheld by an SSI/SSA administrative hearing before the end of the thirty-six-month incapacity period, we change your program eligibility from GAX to GAU and adjust the incapacity review date to be sixty days after the administrative hearing date.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0180, filed 6/29/01, effective 8/1/01. 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 388-448-0200 Eligibility for general assistance unemployable pending SSI eligibility. If we approve you for GAX, benefits are authorized through the month SSI payments begin if you:

(1) Apply for SSI, follow through with your application, and do not withdraw your application;

(2) Agree to assign the initial or reinstated SSI payment to DSHS as provided under WAC 388-448-0210; and

(3) Are otherwise eligible according to WAC 388-400-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0200, filed 6/29/01, effective 8/1/01. 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.]

Chapter 388-450 WAC
INCOME

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-450-0090 Self-employment expenses that are not allowed as income deductions. [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.] Repealed by 01-19-020, filed 9/11/01, effective 10/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-450-0125 Allocating the income of the father of the unborn child to a pregnant woman. [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.] Repealed by 01-11-108, filed 5/21/01, effective 7/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.200.

WAC 388-450-0015 Excluded and disregarded income. This section applies to TANF/SFA, RCA, and GA cash programs, medical programs for children, pregnant women and families, 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) When determining the eligibility of a Holocaust survivor for a medical program for children, pregnant women, or families, the department does not count the recoveries of:

(a) Insurance proceeds; and

(b) Other income.

(3) 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.

(4) All income that is not excluded is considered to be part of an assistance unit's gross income.

(5) 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.

(6) 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 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 2000 2nd sp.s. c 1 § 210(12). 01-18-006, § 388-450-0015, filed 8/22/01, effective 9/22/01. 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 388-450-0050 How are your cash assistance and food assistance benefits determined when you are participating in the community jobs (CJ) program? (1) When you work in the community jobs (CJ) program, you get part of your money from the job and part as a TANF grant. The department estimates your total monthly income from your CJ position based on the number of hours you, your case manager and the CJ contractor expect you to work for the month. We multiply the number of hours by the federal or state minimum wage, whichever is higher, to get your monthly income.

(2) Once we determine what your total monthly income is expected to be, we do not change your TANF grant if your actual hours are more or less than anticipated.

(3) We treat the total income we expect you to get each month from your CJ position as:

(a) Earned income for cash assistance.

(b) Unearned income for food assistance.

(4) For cash assistance, we do not count any of the CJ income that you get in the first month that you work in the CJ position.

(5) If your anticipated CJ income is more than your grant amount, your cash grant is suspended. This means that you are considered to be a TANF/SFA recipient, but you do not get a grant.

(a) The grant suspension can be up to a maximum of nine months.

(b) As long as you would be eligible for a grant if we did not count your CJ income, you can keep participating in CJ even though your grant is suspended.

(c) The months your grant is suspended do not count toward your sixty month lifetime limit.

(6) If your income from other sources alone not counting CJ income makes you ineligible for a cash grant, we terminate your grant and end your participation in CJ.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510. 01-23-044, § 388-450-0050, filed 11/15/01, effective 1/1/02. 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 388-450-0080 What is self-employment income? This section applies to TANF/SFA, GA, RCA, food assistance, and medical programs for children, pregnant women and families.

(1) Self-employment income is income you earn from a business you own or operate rather than income from an employer. It does not have to be a licensed business to qualify as self-employment. Some examples of self-employment include:

(a) Childcare;

(b) Operating an adult family home;

(c) Farming/fishing;

(d) Driving a taxi cab;

(e) Selling self-produced or supplied items;

(f) Working as a subcontractor; and

(g) Operating a lodging for roomers and/or boarders. Roomer income includes money paid to you for shelter costs by someone who lives with you if you:

(i) Own your residence; or

(ii) Rent your residence and charge the other people more than the total rent.

(2) Most self-employment income is considered earned income as described in WAC 388-450-0030.

(3) For TANF/SFA and food assistance there are special rules about renting or leasing out property or real estate that you own.

(a) We count the income you get as unearned income unless you spend at least twenty hours per week managing the property.

(b) For TANF/SFA, we count the income as unearned income unless the use of the property is a part of your approved individual responsibility plan.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-19-020, § 388-450-0080, filed 9/11/01, effective 10/1/01; 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 How we count your self-employment income? This section applies to TANF/SFA, GA, RCA, food assistance, and medical programs for children, pregnant women and families.

(1) We decide how much of your self-employment income to count by:

(a) Adding together your gross self-employment income and your capital gains (all of the income you receive from the sale of your business property or equipment);

(b) Subtracting your business expenses as described in subsection (2) below; and

(c) Dividing the remaining amount of self-employment income by the number of months over which the income will be averaged.

(2) We automatically subtract one hundred dollars as a business expense. If you want to claim more than one hundred dollars, you must itemize and provide proof of your expenses in order for us to count them. We never allow the following expenses:

(a) Federal, state, and local income taxes;

(b) Money set aside for retirement purposes;

(c) Personal work-related expenses (such as travel to and from work);

(d) Net losses from previous periods;

(e) Depreciation; or

(f) Any amount that exceeds the payment you get from a boarder for lodging and meals.

(3) If you have worked at your business for less than a year, we figure your gross self-employment income by averaging:

(a) The income over the period of time the business has been in operation; and

(b) The monthly amount estimated for the coming year.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-19-020, § 388-450-0085, filed 9/11/01, effective 10/1/01; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-450-0125 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-450-0140 How does the income of an ineligible assistance unit member affect my eligibility and benefits for food assistance? The department decides who must be in your assistance unit (AU) under WAC 388-408-0035. If someone who is in your AU is an ineligible AU member, we decide how this affects your AU's eligibility and benefits as follows:

(1) We do not count the ineligible member to determine your AU size for the gross monthly income limit, net monthly income limit, or maximum allotment under WAC 388-478-0060.

(2) If the AU member is ineligible because they are disqualified for an intentional program violation (IPV), they failed to meet work requirements under chapter 388-444

WAC, or they are ineligible felons under WAC 388-442-0010:

(a) We count all of the ineligible member's gross income as a part of your AU's income; and

(b) We count all of the ineligible member's allowable expenses as part of your AU's expenses.

(3) If the AU member is ineligible because they are an ineligible ABAWD under WAC 388-444-0030, ineligible due to their alien status, they failed to sign the application to state their citizenship or alien status, or they refuse to get or provide us a Social Security number:

(a) We prorate the ineligible member's gross income by:

(i) Dividing the ineligible member's income by the total number of people in the AU;

(ii) Subtracting the ineligible member's share of the income; and

(iii) Counting the remaining income to the other members of the AU; and

(iv) Allowing the twenty percent earned income deduction for the ineligible member's countable earned income.

(b) If the AU is eligible for a utility allowance under WAC 388-450-0195, we include the ineligible member to determine the allowance. This includes using the ineligible member to determine the standard utility allowance (SUA).

(c) We prorate the ineligible member's expenses other than utilities by:

(i) Dividing the ineligible member's allowable expenses by the total number of people in the AU;

(ii) Subtracting the ineligible member's share of the expenses; and

(iii) Counting the remaining expenses to the other members of the AU.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-450-0140, filed 10/16/01, effective 12/1/01. 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 388-450-0155 How does being a sponsored immigrant affect my eligibility for cash, medical, and food assistance programs? (1) The following definitions apply to this section:

(a) **"INS"** means the United States Immigration and Naturalization Service.

(b) **"Sponsor"** means a person who agreed to meet the needs of a sponsored immigrant by signing an INS Affidavit of Support form I-864 or I-864A. This includes a sponsor's spouse if the spouse signed the affidavit of support.

(c) **"Sponsored immigrant"** means a person who must have a sponsor under the Immigration and Nationality Act (INA) to be admitted into the United States for residence.

(d) **"Deeming"** means the department counts a part of the sponsor's income and resources as available to the sponsored immigrant.

(e) **"Exempt"** means you meet one of the conditions of WAC 388-450-0156. If you are exempt:

(i) You do not need to provide us information about your sponsor's income and resources; and

(ii) We do not deem your sponsor's income or resources to you.

(2) If you are a sponsored immigrant and you are **not** exempt, you must do the following to be eligible for benefits even if your sponsor is not supporting you:

(a) Give us the name and address of your sponsor;

(b) Get your sponsor to provide us the information we need about their income and resources; and

(c) Give us the information and proof we need to decide:

(i) If we must deem income to your assistance unit (AU); and

(ii) The amount of income we deem to your AU.

(3) If you are not eligible for benefits because we do not have the information we need about your sponsor, we do not delay benefits to the unsponsored people in your AU who are eligible for benefits. We do not count your needs when we decide if your AU is eligible for benefits, but we count:

(a) All earned or unearned income you have that is not excluded under WAC 388-450-0015; and

(b) All deductions you would be eligible for under chapter 388-450 WAC.

(4) If you refuse to provide us with the information we need about your sponsor, the other adult members in your AU must provide the information. If the same person sponsored everyone in your AU, your AU is not eligible for benefits until someone in your AU provides us the information we need.

(5) If you are an ineligible member of your AU, but you must be the AU under chapter 388-408 WAC, we do not deem your sponsor's income or resources to the AU.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-450-0155, filed 10/9/01, effective 11/1/01. 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 388-450-0156 When am I exempt from the deeming process? (1) If you meet any of the following conditions, you are **permanently** exempt from deeming and we do not count your sponsor's income or resources against your benefits:

(a) The Immigration and Nationality Act (INA) does not require you to have a sponsor. Immigrants who are not required to have a sponsor include those with the following status with Immigration and Naturalization Service (INS):

(i) Refugee;

(ii) Parolee;

(iii) Asylee;

(iv) Cuban entrant; or

(v) Haitian entrant.

(b) You were sponsored by an organization or group as opposed to an individual;

(c) You do not meet the alien status requirements to be eligible for benefits under chapter 388-424 WAC;

(d) You have worked or can get credit for forty qualifying quarters of work under Title II of the Social Security Act. We do not count a quarter of work toward this requirement if the person working received TANF, food stamps, SSI, CHIP, or nonemergency Medicaid benefits. We count a quarter of work by the following people toward your forty qualifying quarters:

(i) Yourself;

(ii) Each of your parents for the time they worked before you turned eighteen years old (including the time they worked before you were born); and

(iii) Your spouse if you are still married or your spouse is deceased.

(e) You become a United States (U.S.) Citizen;

(f) Your sponsor is dead; or

(g) If INS or a court decides that you, your child, or your parent was a victim of domestic violence from your sponsor and:

(i) You no longer live with your sponsor; and

(ii) Leaving your sponsor caused your need for benefits.

(2) You are exempt from the deeming process while you are in the same AU as your sponsor;

(3) For state family assistance, general assistance, the food assistance program for legal immigrants, and state-funded medical assistance for legal immigrants you are exempt from the deeming process if:

(a) Your sponsor signed the affidavit of support more than five years ago;

(b) Your sponsor becomes permanently incapacitated; or

(c) You are a qualified alien according to WAC 388-424-0005 and you:

(i) Are on active duty with the U.S. armed forces or you are the spouse or unmarried dependent child of someone on active duty;

(ii) Are an honorably-discharged veteran of the U.S. armed forces or you are the spouse or unmarried dependent child of a honorably-discharged veteran;

(iii) Were employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or

(iv) Are a victim of domestic violence and you have petitioned for legal status under the Violence Against Women Act.

(4) If you, your child, or your parent was a victim of domestic violence, you are exempt from the deeming process for twelve months if:

(a) You no longer live with the person who committed the violence; and

(b) Leaving this person caused your need for benefits.

(5) If your AU has income at or below one hundred thirty percent of the Federal Poverty Level (FPL), you are exempt from the deeming process for twelve months. For this rule, we count the following as income to your AU:

(a) Earned and unearned income your AU receives from any source; and

(b) Any noncash items of value such as free rent, commodities, goods, or services you receive from an individual or organization.

(6) If you are exempt from deeming because your AU does not have income over one hundred thirty percent of the FPL, we give the United States Attorney General the following information:

(a) The names of the sponsored people in your AU;

(b) That you are exempt from deeming due to your income; and

(c) Your sponsor's name.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-450-0156, filed 10/9/01, effective 11/1/01.]

WAC 388-450-0160 How does the department decide how much of my sponsor's income to count against my benefits? (1) We must count some of your sponsor's income as unearned income to your assistance unit (AU) if:

(a) Your sponsor signed the INS affidavit of support form I-864 or I-864A; and

(b) You are not exempt from the deeming process under WAC 388-450-0156.

(2) We take the following steps to decide the monthly amount of your sponsor's income we deem as your income and count against your benefits:

(a) We start with your sponsor's earned and unearned income that is not excluded under WAC 388-450-0015;

(b) If your sponsor's spouse signed the affidavit of support, we add all of the spouse's earned and unearned income that is not excluded under WAC 388-450-0015;

(c) We subtract twenty percent of the above amount that is earned income under WAC 388-450-0030;

(d) For cash and medical assistance, we subtract the need standard under WAC 388-478-0015. We count the following people who live in your sponsor's home as a part of your sponsor's AU to decide the need standard:

(i) Your sponsor;

(ii) Your sponsor's spouse; and

(iii) Everyone else in their home that they could claim as a dependent for Federal income tax purposes.

(e) For food assistance, we subtract the maximum gross monthly income under WAC 388-478-0060. We count the following people that live in your sponsor's home as a part of your sponsor's AU to decide the maximum gross monthly income:

(i) Your sponsor;

(ii) Your sponsor's spouse; and

(iii) Everyone else in their home that they could claim as a dependent for Federal income tax purposes.

(f) If you can show that your sponsor has sponsored other people as well, we divide the result by the total number of people who they sponsored.

(3) After we have decided how much income to deem to you, we count the greater amount of the following against your benefits:

(a) The amount of income calculated from deeming; or

(b) The amount of money your sponsor actually gives you for your needs.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-450-0160, filed 10/9/01, effective 11/1/01. 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 388-450-0190 How does the department figure my shelter cost income deduction for food assistance? The department calculates your shelter cost income deduction as follows:

(1) First, we add up the amounts your assistance unit (AU) must pay each month for shelter. We do not count any

overdue amounts, late fees, penalties or any amount you pay ahead of time as an allowable cost. We count the following expenses as an allowable shelter cost:

(a) Ongoing rent, lease, and mortgage payments;

(b) Property taxes;

(c) Homeowner's insurance for the building only;

(d) Utility allowance your AU is eligible for under WAC 388-450-0195;

(e) Out-of-pocket repairs for the home if it was substantially damaged or destroyed due to a natural disaster such as a fire or flood;

(f) Expense of a temporarily unoccupied home because of employment, training away from the home, illness, or abandonment caused by a natural disaster or casualty loss if your:

(i) AU intends to return to the home;

(ii) AU has current occupants who are not claiming the shelter costs for food assistance purposes; and

(iii) AU's home is not being leased or rented during your AU's absence.

(2) Second, we subtract all deductions your AU is eligible for under WAC 388-450-0185 (1) through (5) from your AU's gross income. The result is your AU's net income.

(3) Finally, we subtract one-half of your AU's net income from your AU's total shelter costs. The result is your excess shelter costs. Your AU's shelter cost deduction is the excess shelter costs:

(a) Up to a maximum of three hundred dollars if no one in your AU is elderly or disabled and you were found eligible for benefits prior to March 1, 2001; or

(b) Up to a maximum of three hundred fifty-four dollars if no one in your AU is elderly or disabled and you were found eligible for benefits or were recertified for benefits either on or after March 1, 2001; or

(c) The entire amount if someone in your AU is elderly or disabled, even if the amount is over three hundred fifty-four dollars.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-450-0190, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-06-030, § 388-450-0190, filed 3/2/01, effective 4/2/01; 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	$249
2	$256
3	$264
4	$271
5	$279
6 or more	$287

(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 ninety-eight dollars.

(5) If your AU has only telephone costs and no other utility costs, you get a telephone utility allowance (TUA) of thirty-three dollars.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-450-0195, filed 10/16/01, effective 12/1/01. 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.]

Chapter 388-452 WAC
INTERVIEW REQUIREMENTS

WAC

WAC 388-452-0005 Do I have to be interviewed in order to get benefits? (1) Unless you are applying for medical only or meet certain hardship criteria listed in subsection (8) below, you or your authorized representative must have a face-to-face interview with the department:

(a) At initial certification; and

(b) At least once every twelve months if your assistance unit (AU) is certified for twelve months or less.

(2) You are not required to attend an interview when your application or review is just for medical benefits. If we (the department) 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) If you are pregnant;

(b) If you are a child under the age of nineteen;

(c) If you have a family with children under the age of nineteen; or

(d) If we have enough information to determine if you are eligible or can get the information by mail.

(3) You will have only a single interview even when you apply for or have a review for more than one assistance program.

(4) If you are not interviewed on the same day that we get your application, we schedule an interview appointment for you. We schedule your appointment the day we get your application or on the next business day if we get your application on a holiday or a weekend.

(5) We schedule an interview so your AU has at least ten days after the interview to provide needed verification:

(a) Before the end of the thirty-day processing period for applications; or

(b) Before your certification period ends for eligibility reviews.

(6) If you miss your first interview and request another interview within thirty days of the date of your application for benefits, we schedule a second interview for you.

(7) You or another person who can give information about your AU 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.

(8) 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 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. 01-14-060, § 388-452-0005, filed 6/29/01, effective 8/1/01; 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.]

Chapter 388-454 WAC
LIVING WITH A RELATIVE

WAC

WAC 388-454-0005 Can I get TANF or SFA benefits for the child living with me? (1) You can get temporary assistance for needy families (TANF) or state family assistance (SFA) for a child you live with if you are responsible for the care and control of the child and you are the child's:

(a) Parent or other relative as defined in WAC 388-454-0010;

(b) Court-ordered guardian or court-ordered custodian; or

(c) Other adult acting *in loco parentis* (in the place of a parent).

(2) If a child lives with more than one relative or parent because the relatives share custody of the child:

(a) We include the child in the assistance unit (AU) of the parent or relative that the child lives with for the majority of the time; or

(b) If relatives share physical custody of the child in equal amounts, we include the child in the AU of the parent or relative that first applies for assistance for the child.

(3) If you or the child in your AU is temporarily absent from the home according to WAC 388-454-0015 and 388-454-0020, you can still get TANF or SFA during the absence.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-454-0005, filed 1/22/01, effective 3/1/01. 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 388-454-0006 The department makes background checks on adults who are acting in place of a parent without court-ordered custody. (1) We check your background when you ask for TANF or SFA benefits for a child who:

(a) Is not related to you; and

(b) Lives with you but you do not have a court order that gives you legal custody of the child.

(2) A child who is not related to you cannot receive TANF/SFA benefits while living with you until we have completed a background check and the results of the background check meet the criteria in subsection (3) through (5).

(3) A child who is not related to you cannot receive benefits while living with you if:

(a) You have been convicted of a crime listed in WAC 388-06-0170; or

(b) You have been convicted of a crime listed in WAC 388-06-0180 within the last five years.

(4) We review your background when you have been convicted of a crime listed in WAC 388-06-0180 more than five years ago to determine your character, suitability, and competence to receive benefits for a child not related to you. We consider the following factors:

(a) The amount of time that has passed since you were convicted;

(b) The seriousness of the crime that led to the conviction;

(c) The number and types of convictions in your background; and

(d) Your age at the time of the conviction.

(5) When you have a conviction for a crime other than those listed in WAC 388-06-0170 or 388-06-0180 we review your background as described in subsection (4) above.

(6) Expunged or sealed conviction records do not count against you.

[Statutory Authority: RCW 13.32A.080, 13.32A.082, 74.04.050, 74.08.090, 74.12.290, 74.12.450, 74.12.460. 02-01-011, § 388-454-0006, filed 12/7/01, effective 1/7/02.]

WAC 388-454-0010 Do I have to be related to a child in order to get TANF or SFA for the child? To get TANF or SFA, a child must live with a parent, other relative, court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis*.

(1) We consider the following people as parents for TANF and SFA:

(a) The child's natural or adoptive parent; or

(b) A stepparent who is legally obligated to support the child.

(2) We consider a man as a child's natural father if the relationship is:

(a) Made under a judgment or order under RCW 26.26.130 that set the relationship between the parent and child; or

(b) Presumed under the Uniform Parentage Act (RCW 26.26.040).

(3) When a child lives with a relative, the relative must be one of the following relationships to the child in order for that child to be eligible for TANF or SFA:

(a) The following blood relatives (including relatives of half blood) or their spouses: Siblings, first cousins (including first cousins once removed), nephews and nieces, and persons of earlier generations (including aunts, uncles and grandparents) as shown by the prefixes of great, great-great, or great-great-great;

(b) A natural parent whose parental rights were terminated by a court order;

(c) A stepparent who no longer has to support the child because:

(i) The child's natural or adoptive parent died; or

(ii) Divorce or dissolution ended the marriage between the stepparent and the child's natural or adoptive parent.

(d) A step sibling even if the marriage between the step sibling's parent and the child's natural or adoptive parent ended by death, divorce or dissolution.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-454-0010, filed 1/22/01, effective 3/1/01. 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 388-454-0025 The department notifies a child's parent when we approve assistance and the child is living with someone other than their parent. (1) The department makes a reasonable effort to contact the parent with whom the child last lived when we find out that a child applying for assistance lives with someone other than the child's parent. We tell the parent:

(a) Within seven days of the date we approve assistance for the child;

(b) How to ask for family reconciliation services from the department; and

(c) How to request the child's address and location as allowed under WAC 388-428-0010.

(2) We do not notify the parent when there is evidence to support a claim that the parent has abused or neglected the child.

[Statutory Authority: RCW 13.32A.080, 13.32A.082, 74.04.050, 74.08.090, 74.12.290, 74.12.450, 74.12.460. 02-01-011, § 388-454-0025, filed 12/7/01, effective 1/7/02. 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 388-458 WAC
NOTICES TO CLIENTS

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-458-0001	How the department requests information or action needed when a client applies for assistance or reports a change. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0001, filed 11/10/99, effective 1/1/00.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-458-0005	Adequate notice of denial or withdrawal. [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.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-458-0010	Adequate notice of adverse action to recipients. [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.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-458-0015	Translation of written communications with limited English proficient clients. [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.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-458-0001 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-458-0002 The department of social and health services (DSHS) sends you letters to tell you about your case. (1) When you apply for or get benefits, we send you letters to tell you about your case.

(2) If you speak another language and cannot read English, we send letters to you in your primary language.

(3) There are seven basic types of letters that we send to you:

(a) Withdrawals;

(b) Denials;
(c) Approvals;
(d) Requests;
(e) Changes;
(f) Terminations; and
(g) Other.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0002, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0005 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-458-0006 DSHS sends you a letter when you withdraw your application. (1) We send you a withdrawal letter when you tell us that you no longer want to apply for benefits.

(2) On this letter, we tell you:

(a) The date we stopped processing your application; and

(b) Your right to have your case reviewed or ask for a fair hearing.

(3) We send this letter to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0006, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0010 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-458-0011 DSHS sends you a denial letter when you can't get benefits. (1) When we finish processing your application, we send you a denial letter if you cannot get benefits.

(2) On this letter, we tell you:

(a) Why you cannot get benefits;

(b) The rules that support our decision;

(c) The date we stopped processing your application; and

(d) Your right to have your case reviewed or ask for a fair hearing.

(3) If we are denying your application because you did not give us some information that we needed and we can't figure out if you are eligible without it, we also tell you on the letter:

(a) What information you didn't give to us;

(b) The date we asked for the information and the date it was due;

(c) That we cannot figure out if you can get benefits without this information; and

(d) That we will review your eligibility if:

(i) For cash and medical, you give us the information within thirty days of the date of the notice;

(ii) For food assistance, you give us the information within sixty days of the date you applied; and

(iii) Your circumstances have not changed.

(4) We send denial letters to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0011, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0015 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-458-0016 DSHS sends you an approval letter when you can get benefits. (1) When we finish processing your application, we send you an approval letter if you can get benefits.

(2) On this letter, we tell you:

(a) What kind of benefits you get;

(b) If you applied for cash or food assistance, the amount of benefits you get;

(c) If you applied for medical, what type of medical;

(d) How long you will get the benefits; and

(e) Your right to have your case reviewed or ask for a fair hearing.

(3) We send approval letters to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0016, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0020 You get a request letter when we need more information. (1) We send a request letter to you when we need some information from you or you have to do something in order to get benefits.

(2) On the letter, we tell you:

(a) What is needed;

(b) The date it is due; and

(c) What will happen to your benefits if you don't do what we ask.

(3) You get at least ten days to give us the information or do the activity. You can ask for more time if you need it.

(4) If the tenth day is on a weekend or holiday, you have until the next business day to do what we need.

(5) If we don't get what we need by the due date, we may deny, reduce, or stop your benefits. We will send you another letter if this happens.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0020, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0025 We send you a change letter if the amount of benefits you are getting is changing. (1) We send you a change letter if the amount of benefits you are getting is changing.

(2) On the letter, we tell you:

(a) What your benefits are changing to;

(b) When the change is going to happen;

(c) The reason for the change;

(d) The rules that support our decision; and

(e) Your right to have your case reviewed or ask for a fair hearing.

(3) We send the letter to you before the change happens. If your benefits are going down, we give you at least ten days notice unless:

(a) You ask us to reduce your benefits;

(b) We have to change benefits for a lot of people at once because of a law change;

(c) For cash and food assistance:

(i) We told you on your approval letter that your benefits might change every month because you have fluctuating income; or

(ii) We already told you that the supplement would end.

(d) For cash assistance, we told you that the AREN payment described in WAC 388-436-0002 was for one month only.

(4) The ten-day count starts on the day we mail or give you the letter and ends on the tenth day.

(5) If we don't have to give you ten days notice, we send the letter to you:

(a) For cash and medical, by the date of the action.

(b) For food assistance, by the date you normally get your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0025, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0030 We send you a termination letter when your benefits stop. (1) We send you a termination letter when your benefits stop.

(2) On the letter, we tell you:

(a) When your benefits are going to end;

(b) The reason they are ending;

(c) The rules that support our decision; and

(d) Your right to have your case reviewed or ask for a fair hearing.

(3) We tell you at least ten days before your benefits end unless;

(a) You asked us to stop your benefits;

(b) We have proof that everyone in your assistance unit has moved to another state or will move to another state before the next benefits are issued;

(c) We have proof that everyone in your assistance unit has died;

(d) We have to change benefits for a lot of people at once because of a law change; or

(e) For food assistance, your certification period is ending.

(4) The ten-day count starts on the day we mail or give you the letter and ends on the tenth day.

(5) If we don't have to give you ten days notice, we send the letter to you:

(a) For cash and medical, by the date of the action.

(b) For food assistance, by the date you normally get your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0030, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0035 Why do you give me ten days notice before you reduce or stop my benefits? (1) We give you ten days notice before reducing or stopping your benefits so that you have some time to either:

(a) Get the needed information to us; or

(b) Prepare yourself and your family for the change.

(2) You can also use this time to request a fair hearing.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0035, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0040 What happens if I ask for a fair hearing before the change happens? (1) If you ask for a fair hearing within the ten-day notice period, you may keep getting the amount of benefits you were getting before the change. This is called continued benefits.

(2) If the tenth day falls on a weekend or holiday, you have until the next business day to ask for a fair hearing and still be able to get continued benefits.

(3) If the tenth day happens before the end of the month, you have until the end of the month to ask for a fair hearing and still be able to get continued benefits.

(4) For food assistance, you cannot get continued benefits if your certification period is ending.

(5) If you get continued benefits, you keep getting them through the end of the month the fair hearing decision is mailed unless:

(a) You:

(i) Tell us in writing that you do not want continued benefits;

(ii) Withdraw your fair hearing request in writing; or

(iii) Do not follow through with the fair hearing process.

(b) An administrative law judge (ALJ) tells us in writing to stop your continued benefits before the hearing.

(c) For food assistance, your certification period ends.

(6) After the fair hearing, you have to pay back continued benefits you get, as described in chapter 388-410 WAC, if the ALJ agrees with our decision.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0040, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0045 Will I get other kinds of letters? Yes. We also send you letters in special circumstances. These letters are specific to your situation. Here are some examples:

(1) Appointment letters;

(2) Overpayment letters; and

(3) Fair Hearing letters.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0045, filed 7/25/01, effective 9/1/01.]

Chapter 388-462 WAC
PREGNANCY

WAC

WAC 388-462-0020 Breast and cervical cancer treatment program (BCCTP) for women—Client eligibility. (1) Effective July 1, 2001, a woman is eligible for categorically needy (CN) coverage under the BCCTP only when she:

(a) Has been screened for breast or cervical cancer under the center for disease control (CDC) breast and cervical cancer early detection program (BCCEDP);

(b) Is found to require treatment for either breast or cervical cancer or for a related precancerous condition;

(c) Is under sixty-five years of age;

(d) Is not eligible for another CN Medicaid program;

(e) Is uninsured or does not otherwise have creditable coverage;

(f) Meets residency requirements as described in WAC 388-468-0005;

(g) Meets Social Security Number requirements as described in WAC 388-476-0005; and

(h) Meets citizenship and alien status requirements as described in:

(i) WAC 388-424-0005 (1)(a) and (b); or

(ii) WAC 388-424-0010 (1) or (2)(a) and (b).

(2) The certification periods described in WAC 388-416-0015 (1), (4), and (6) apply to the BCCTP. Eligibility for Medicaid continues throughout the course of treatment as certified by the CDC-BCCEDP.

(3) Income and asset limits are set by the CDC-BCCEDP.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and 74.09.510, and Public Law 106-354. 02-01-134, § 388-462-0020, filed 12/19/01, effective 1/19/02.]

Chapter 388-470 WAC
RESOURCES

WAC

WAC 388-470-0026 Excluded resources for family medical programs. "Continuously eligible" means, for the purposes of this chapter, there has not been a break of a calendar month or more in a client's eligibility since the date the client received resources in an amount 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 received while a client:

(a) Is eligible for and receiving coverage under a family medical program; and

(b) Remains continuously eligible for a family medical program.

(2) The department does 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 later found eligible for all months since the termination, which may include a retroactive period of up to three months.

(3) The department counts the resource increase 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) When determining the eligibility of a Holocaust survivor for a family medical program, the department does not count the recoveries of:

(a) Insurance proceeds; and

(b) Other assets.

(5) For the purposes of this section, family medical programs include the medical extension benefits as described in WAC 388-523-0100.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 2000 2nd sp.s. c 1 § 210(12). 01-18-006, § 388-470-0026, filed 8/22/01, effective 9/22/01.]

WAC 388-470-0060 How does the department decide how much of my sponsor's resources affect my eligibility for cash, medical, and food assistance benefits? (1) If you are a sponsored immigrant as defined in WAC 388-450-0155, and you are not exempt from deeming under WAC 388-450-0156, we count part of your sponsor's resources as available to you.

(2) We decide the amount of your sponsor's resources to count by:

(a) Totaling the countable resources of the sponsor and the sponsor's spouse (if the spouse signed the affidavit of support) under chapter 388-470 WAC;

(b) Subtracting fifteen hundred dollars; and

(c) Counting the remaining amount as a resource that is available to you.

(3) If you can show that your sponsor has sponsored other people as well, we divide the result by the total number of people who they sponsored.

(4) We continue to count your sponsor's resources when we determine your eligibility for benefits until you are exempt from deeming under WAC 388-450-0156.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-470-0060, filed 10/9/01, effective 11/1/01. 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 388-470-0075 How is my vehicle counted for food assistance? (1) If you own a licensed vehicle we (the department) exclude its entire value, even when you are temporarily unemployed, if the vehicle is:

(a) Used over fifty percent of the time for income-producing purposes such as a taxi, truck, or fishing boat. If you are a self-employed farmer or fisher and your self-employment ends, we continue to exclude your vehicle for one year from the date you end your self-employment.

(b) Used to produce income each year that is consistent with its fair market value (FMV), even if used on a seasonal basis.

(c) Necessary for long-distance travel, other than daily commuting, for the employment of a household member whose resources are considered available to the assistance unit (AU), such as an ineligible alien or disqualified person.

(d) Needed for hunting or fishing to support the household.

(e) Used as the AU'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 AU.

(g) Needed to transport a physically disabled AU member, no matter if the disability is permanent or temporary.

(h) Likely to produce an equity value (FMV less what is owed on the vehicle) of no more than one thousand five hundred dollars.

(2) If your licensed vehicle is not excluded in subsection (1) above and the FMV is:

(a) Less than four thousand six hundred fifty dollars, we exclude each vehicle less than four thousand six hundred fifty dollars no matter how it is used;

(b) Greater than four thousand six hundred fifty dollars, we count the amount in excess of four thousand six hundred fifty dollars toward the resource limit for:

(i) One vehicle for each adult household member no matter how it is used; and

(ii) Any vehicle a household member under age eighteen uses to drive to work, school, training, or to look for work.

(3) If you have other licensed vehicles, we count the larger value of the following toward the AU's resource limit:

(a) FMV greater than four thousand six hundred fifty dollars; or

(b) Equity value (FMV less what is owed on the vehicle).

(4) If you are a tribal member and drive an unlicensed vehicle on those reservations that don't require vehicle licensing, your vehicle will be treated like a licensed vehicle.

(5) For all other unlicensed vehicles we count the equity value towards the AU's resource limit unless the vehicle is:

(a) Used to produce income each year 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 a household member.

(6) When excluding vehicles due to their equity value, we do not add up the values of multiple vehicles together. Each vehicle is evaluated separately and compared to your resource limit. For vehicles evaluated using the FMV test, we add the values of multiple vehicles together and compare the result to your resource limit.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-134, § 388-470-0075, filed 7/31/01, effective 11/1/01; 01-15-078, § 388-470-0075, filed 7/17/01, effective 8/1/01; 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 What are my rights and responsibilities? For the purposes of this chapter, "we" and "us" refer to the administrations within the department of social and health services that provide cash and medical assistance benefits. "You" refers to the head of the household applicant or recipient.

The following rules apply to cash, food and medical assistance programs unless stated otherwise.

(1) If you apply for or receive benefits you have the right to:

(a) Be fully informed, in writing, of all legal rights and responsibilities in connection with benefits;

(b) Be treated politely and fairly without regard to race, color, political beliefs, national origin, religion, age, gender, disability or birthplace;

(c) Give us a written request for benefits using a form or alternative method designated by us. You have the right to get a receipt when leaving an application or other materials with us;

(d) Ask that the application be processed without delay if you are pregnant, in need of immediate medical care, experiencing an emergency such as having no money for food, or facing an eviction. If you are pregnant and request an interview, you have 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 decisions may take forty-five to sixty days. Pregnancy medical will be authorized within fifteen working days.

(ii) Food assistance will be authorized within thirty days if you are eligible. If you are eligible and have little or no money, food assistance will be authorized within five days.

(f) Have information you give us kept private. We share some facts with other agencies for efficient management of federal and state programs;

(g) For cash and medical assistance programs, ask us not to collect child support if the absent parent may harm you or your child;

(h) For some cash assistance programs, ask for extra money to help in an emergency, such as an eviction or a utility shutoff;

(i) Get a written notice, in most cases, at least ten days before we make changes to reduce or end your benefits;

(j) Ask for a fair hearing if you do not agree with us about a decision. You can also ask a supervisor or administrator to review our decision or action without affecting your right to a fair hearing;

(k) Have interpreter or translator services provided at no cost to you and without delay;

(l) Refuse to speak to a fraud investigator. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. Such a request will not affect your eligibility for benefits;

(m) If you are applying for or receiving medical assistance, limited casualty programs, medical care services, or children's health services you have the same rights as cash assistance clients; and

(n) Receive help from us to register to vote.

(2) You are responsible to:

(a) Report any changes to us within:

(i) Ten days for all cash and food assistance programs; and

(ii) Twenty days for all medical assistance programs.

(b) Give all the facts needed to determine eligibility;

(c) Give us proof of any facts for which proof is needed;

(d) For most cash or medical assistance programs related to children, cooperate with us to get child support or medical care support unless you show that cooperation may harm you or your child;

(e) Apply for and get any benefits from other agencies or programs prior to getting cash or medical assistance from us;

(f) Complete reports and reviews when asked to do so;

(g) Get a job or training if required;

(h) Show your medical identification card or other notification of eligibility from us to your medical care provider; and

(i) Cooperate with the quality assurance review process.

(3) You will be screened for and provided necessary supplemental accommodation services as described in this chapter.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0005, filed 5/1/01, effective 6/1/01. 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.]

WAC 388-472-0010 What are necessary supplemental accommodation services? Necessary supplemental accommodation (NSA) services are services provided to you if you have a mental, neurological, physical or sensory impairment or other problems that prevent you from getting program benefits in the same way that an unimpaired person would get them.

NSA services include but are not limited to:

(1) Arranging for or providing help to complete and submit forms to us;

(2) Helping you give or get the information we need to decide or continue eligibility;

(3) Helping you request continuing benefits;

(4) If you miss an appointment or deadline, contacting you about the reason before we reduce or end your benefits;

(5) Explaining to you the reduction in or ending of your benefits (see WAC 388-418-0020);

(6) If we know you have a person who helps you with your applications, notifying them when we need information or when we are about to reduce or end your benefits;

(7) Assisting you with requests for fair hearings;

(8) Providing protective payments if needed, according to WAC 388-265-1250; and

(9) On request, reviewing our decision to terminate, suspend or reduce your benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0010, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0020 How does the department decide if I am eligible for NSA services? When you, as head of household, apply for benefits either in person or by phone, we screen you to decide if you meet NSA requirements. We explain NSA services to you during the screening.

(1) We identify you as NSA if you:

(a) Say you need NSA services in order to have equal access to our programs and services;

(b) Have or claim to have a mental impairment;

(c) Have a developmental disability;

(d) Are disabled by alcohol or drug addiction;

(e) Are unable to read or write in any language; or

(f) Are a minor not residing with your parents.

(2) We identify you as NSA if we observe you to have cognitive limitations, whether or not you have a disability, which may prevent you from understanding the nature of NSA services or affect your ability to access our programs. Cognitive limitations are limitations in your ability to communicate, understand, remember, process information, exercise judgement and make decisions, perform routine tasks or relate appropriately with others.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0020, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0030 How can I get NSA services? (1) After we screen you for NSA eligibility and initially identify your case as NSA, we mark your case file with a uniform NSA identifier.

(2) After you are initially identified as NSA, we complete an assessment to confirm your NSA designation.

(3) If the assessment confirms your NSA designation, we develop an accommodation plan that specifies the services we will provide to you to improve your access to our programs and services.

(4) If you are designated as NSA according to WAC 388-472-0020 (1) and (2), we include all the NSA services listed in WAC 388-472-0010 in your accommodation plan.

(5) Based on your request or a change in your needs, the NSA designation and the accommodation plan may be assessed and changed.

(6) Even if you are eligible to receive NSA services you may refuse NSA services.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0030, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0040 What are the department's responsibilities in giving NSA services to me? (1) All of our staff are continually responsible to identify you as possibly NSA eligible and assist you with NSA services.

(2) We provide a grace period to continue your financial, food or medical assistance when:

(a) We stop a benefit because we are unable to tell if you continue to qualify; and

(b) You provide proof you still qualify for the benefit within the twenty days right after the benefit stops. We restore lost benefits as follows:

(i) We reopen your medical assistance from the first of the month; and

(ii) We recalculate your cash and food assistance and issue you the correct amount without taking away any benefits as long as you were eligible to receive them.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0040, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0050 What if I don't accept or follow through the program requirements because I'm not able to or I don't understand them? (1) We consider how your limitation or impairment affects your ability to accept and follow through on all program requirements. This can include, but is not limited to, your actions in failing to:

(a) Follow through with medical treatment;

(b) Follow through with referrals to other agencies;

(c) Provide timely income reports;

(d) Maintain employment;

(e) Participate in food assistance employment and training; or

(f) Participate in the WorkFirst program.

(2) If we decide your limitation was the cause of your refusal to accept or failure to follow through on these requirements, we will find that you have good cause and we will not take any adverse action.

(3) Following a finding of good cause not to have followed through with the requirement, we will review your accommodation plan to assure that all services necessary to enable you to meet the program requirements are being provided to you.

(4) If we are unable to accommodate your condition so that you are able to participate in program requirements, we will waive program requirements.

(5) If participation in program requirements is not waived, you must cooperate with program requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0050, filed 5/1/01, effective 6/1/01.]

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. The blind or disabled grandfathered clients must continue to meet the definition of blind or disabled that was in effect under the state plan in December 1973. These definitions can be found in the SSA program operations manual system (POMS). A person designated in January 1974 as essential to the care of a grandfathered SSI client will continue to be included in the SSI payment as long as the essential person continuously resides with the SSI client.

(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, 74.08.090, and 74.09.055. 01-06-042, § 388-474-0001, filed 3/5/01, effective 4/5/01. 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 388-474-0010 How does SSI affect eligibility for cash assistance programs? A person who is married to an SSI recipient but cannot get SSI in their own right is an "ineligible spouse."

(1) If you are an ineligible spouse, you cannot get the SSI state supplement (see WAC 388-478-0055) if you are:

(a) The caretaker relative of a child who receives TANF or SFA; and

(b) Required to be included in the TANF or SFA assistance unit with the child under WAC 388-408-0015.

(2) If you are an ineligible spouse and are eligible for the SSI state supplement, you are not eligible for general assistance benefits.

[Statutory Authority: RCW 74.08.090, 74.04.057, 74.04.050. 01-19-023, § 388-474-0010, filed 9/12/01, effective 11/1/01. 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.]

Chapter 388-475 WAC

HEALTHCARE FOR WORKERS WITH DISABILITIES (HWD) PROGRAM

WAC

WAC 388-475-1000 Healthcare for workers with disabilities (HWD)—Program description. This section describes the healthcare for workers with disabilities (HWD) program.

(1) The HWD program provides categorically needy (CN) Medicaid services as described in WAC 388-529-0200.

(2) The department approves HWD coverage for twelve months effective the first of the month in which a person applies and meets program requirements. See WAC 388-475-1100 for "retroactive" coverage for months before the month of application.

(3) A person who is eligible for another Medicaid program may choose not to participate in the HWD program.

(4) A person is not eligible for HWD coverage for a month in which the person received Medicaid benefits under the medically needy (MN) program.

(5) The HWD program does not provide long-term care (LTC) services described in chapter 388-513 and 388-515 WAC. LTC services include institutional, waivered, and hospice services. To receive LTC services, a person must qualify and participate in the cost of care according to the rules of those programs.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1000, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1050 Healthcare for workers with disabilities (HWD)—Program requirements. This section describes requirements a person must meet to be eligible for the healthcare for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must:

(a) Meet the general requirements for a medical program described in WAC 388-503-0505 (3)(a) through (f);

(b) Be age sixteen through sixty-four;

(c) Meet the federal disability requirements described in WAC 388-475-1150;

(d) Have net income at or below two hundred twenty percent of the federal poverty level (FPL) (see WAC 388-478-0075 for FPL amounts for medical programs); and

(e) Be employed full or part time (including self-employment) as described in WAC 388-475-1200.

(2) To determine net income, the department applies the following rules to total gross household income in this order:

(a) Deduct income exclusions described in WAC 388-450-0020; and

(b) Follow the CN income rules described in:

(i) WAC 388-450-0005 (3) and (4), Income—Ownership and availability;

(ii) WAC 388-450-0085, Self-employment income—Allowable
Expenses;

(iii) WAC 388-450-0150 (1), (2), (3), and (5), SSI-related income allocation;

(iv) WAC 388-450-0210 (4)(b), (e), and (h), Countable income for medical programs;

(v) WAC 388-506-0620, SSI-related medical clients; and

(vi) WAC 388-511-1130, SSI-related income availability.

(3) The HWD program does not require an asset test.

(4) Once approved for HWD coverage, a person must pay his/her monthly premium in the following manner to continue to qualify for the program:

(a) The department calculates the premium for HWD coverage according to WAC 388-475-1250;

(b) If a person does not pay four consecutive monthly premiums, the person is not eligible for HWD coverage for the next four months and must pay all premium amounts owed before HWD coverage can be approved again; and

(c) Once approved for HWD coverage, a person who experiences a job loss can choose to continue HWD coverage through the original twelve months of eligibility, if the following requirements are met:

(i) The job loss results from an involuntary dismissal or health crisis; and

(ii) The person continues to pay the monthly premium.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1050, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1100 Healthcare for workers with disabilities (HWD)—Retroactive coverage. This section describes requirements for retroactive coverage provided under the healthcare for workers with disabilities (HWD) program.

(1) Retroactive coverage refers to the period of up to three months before the month in which a person applies for the HWD program. The department cannot approve HWD coverage for a month that precedes January 1, 2002.

(2) To qualify for retroactive coverage under the HWD program, a person must first:

(a) Meet all program requirements described in WAC 388-475-1050 for each month of the retroactive period; and

(b) Pay the premium amount for each month requested within one hundred twenty days of being billed for such coverage.

(3) If a person does not pay premiums in full as described in subsection (2)(b) for all months requested in the retroactive period, the department denies retroactive coverage and refunds any payment received for those months.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1100, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1150 Healthcare for workers with disabilities (HWD)—Disability requirements. This section describes the disability requirements for the two groups of individuals that may qualify for the healthcare for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must meet the requirements of the Social Security Act in section 1902 (a) (10) (A) (ii):

(a) (XV) for the basic coverage group (BCG); or

(b) (XVI) for the medical improvement group (MIG).

(2) The BCG consists of individuals who:

(a) Meet federal disability requirements for the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) program; or

(b) Are determined by the division of disability determination services (DDDS) to meet federal disability requirements for the HWD program.

(3) The MIG consists of individuals who:

(a) Were previously eligible and approved for the HWD program as a member of the BCG; and

(b) Are determined by DDDS to have a medically improved disability. The term "medically improved disability" refers to the particular status granted to persons described in subsection (1)(b).

(4) When completing a disability determination for the HWD program, DDDS will not deny disability status because of employment.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1150, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1200 Healthcare for workers with disabilities (HWD)—Employment requirements. This section describes the employment requirements for the basic coverage group (BCG) and the medical improvement group (MIG) for the healthcare for workers with disabilities (HWD) program.

(1) For the purpose of the HWD program, employment means a person:

(a) Gets paid for working;

(b) Has earnings that are subject to federal income tax; and

(c) Has payroll taxes taken out of earnings received, unless self-employed.

(2) To qualify for HWD coverage as a member of the BCG, a person must be employed full or part time.

(3) To qualify for HWD coverage as a member of the MIG, a person must be:

(a) Working at least forty hours per month; and

(b) Earning at least the local minimum wage as described under section 6 of the Fair Labor Standards Act (29 U.S.C. 206).

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1200, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1250 Healthcare for workers with disabilities (HWD)—Premium payments. This section describes how the department calculates the premium amount a person must pay for healthcare for workers with disabilities (HWD) coverage. This section also describes program requirements regarding the billing and payment of HWD premiums.

(1) When determining the HWD premium amount, the department counts only the income of the person approved for the program. It does not count the income of another household member.

(2) When determining countable income used to calculate the HWD premium, the department applies the following rules:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the person's needs for food, clothing, and shelter, except as described in WAC 388-511-1130.

(b) Loans and certain other receipts are not considered to be income as described in 20 C.F.R. Sec. 416.1103, e.g., direct payment by anyone of a person's medical insurance premium or a tax refund on income taxes already paid.

(3) The HWD premium amount equals a total of the following (rounded down to the nearest whole dollar):

(a) Fifty percent of unearned income above the medically needy income level (MNIL) described in WAC 388-478-0070; plus

(b) Five percent of total unearned income; plus

(c) Two point five percent of earned income after first deducting sixty-five dollars.

(4) When determining the premium amount, the department will use the current income amount until a change in income is reported and processed.

(5) A change in the premium amount is effective the month after the change in income is reported and processed.

(6) For current and ongoing coverage, the department will bill for HWD premiums during the month following the month in which coverage is approved.

(7) For retroactive coverage, the department will bill the HWD premiums during the month following the month in which coverage is requested and necessary information is received.(8) If initial coverage for the HWD program is approved in a month that follows the month of application, the first monthly premium includes the costs for both the month of application and any following month(s).

(9) As described in WAC 388-475-1050 (4)(b), the department will close HWD coverage after four consecutive months for which premiums are not paid in full.

(10) If a person makes only a partial payment toward the cost of HWD coverage for any one month, the person remains one full month behind in the payment schedule.

(11) The department first applies payment for current and ongoing coverage to any amount owed for such coverage in an earlier month. Then it applies payment to the current month and then to any unpaid amount for retroactive coverage.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1250, filed 12/14/01, effective 1/14/02.]

Chapter 388-478 WAC
STANDARDS FOR PAYMENTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-478-0056	SSI state supplement standards. [Statutory Authority: RCW 74.04.620, 74.04.630. 00-24-056, § 388-478-0056, filed 11/30/00, effective 1/1/01.] Repealed by 01-08-015, filed 3/23/01, effective 5/1/01. Statutory Authority: RCW 74.08.090, 74.04.057.

WAC 388-478-0015 Need standards for cash assistance. The need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard
1	$ 797
2	1,008
3	1,247
4	1,467
5	1,690
6	1,918
7	2,215
8	2,452
9	2,693
10 or more	2,926

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard
1	$ 480
2	607
3	752
4	884
5	1,019
6	1,156
7	1,335
8	1,478
9	1,623
10 or more	1,764

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.200. 01-11-108, § 388-478-0015, filed 5/21/01, effective 7/1/01. 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 388-478-0055 SSI payment standards for eligible recipients. (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 added to the federal benefit level with state funds, known as the SSI state supplement. If you are found eligible for SSI, you will receive cash assistance based on the combined federal and state supplement benefit levels, minus countable income. An essential person is someone who lives with you and provides care and personal services that enable you to live in either your own home or the home of the essential person.

(2) The federal, state and combined benefit levels for an eligible individual and couple are:

(a) If you are living alone in area 1: King, Pierce, Snohomish, Thurston, and Kitsap Counties.

LIVING ALONE - In own household or alternate care, except nursing homes or medical institutions	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
Individual	$ 531.00	$ 25.90	$ 556.90
Individual with: One essential person	$ 797.00	$ 19.90	$ 816.90
Individual with: Multiple essential persons	$531 for the eligible individual plus $266 for each essential person (no state supplement)		
Individual with an ineligible spouse	$ 531.00	$ 166.10	$ 697.10
Couple	$ 796.00	$ 19.90	$ 815.90
Couple with one or more essential persons	$796 for eligible couple plus $266 for each essential person (no state supplement)		

(b) If you are living alone in area 2: All other counties.

LIVING ALONE - In own household or alternate care, except nursing homes or medical institutions	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
Individual	$ 531.00	$ 5.45	$ 536.45
Individual with: One essential person	$ 797.00	$ 0.00	$ 797.00
Individual with: Multiple essential persons	$531 for the eligible individual plus $266 for each essential person (no state supplement)		
Individual with an ineligible spouse	$ 531.00	$ 136.15	$ 667.15
Couple	$ 796.00	$ 0.00	$ 796.00
Couple with one or more essential persons	$796 for eligible couple plus $266 for each essential person (no state supplement)		

(c) If you are in shared living in either Area 1 or 2.

SHARED LIVING - In the home of another person	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
Individual	$ 354.00	$ 3.71	$ 357.71
Individual with: One essential person	$ 531.34	$ 4.20	$ 535.54
Individual with: Multiple essential persons	$354.00 for the eligible individual plus $177.00 for each essential person (no state supplement)		
Individual with an ineligible spouse	$ 354.00	$ 101.66	$ 455.66
Couple	$ 530.67	$ 4.20	$ 534.87
Couple with one or more essential persons	$530.67 for eligible couple plus $177.00 for each essential person (no state supplement)		

(d) If you are 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. You are "grandfathered" if you qualified for assistance from the state as aged, blind, or disabled, were converted from the state to federal disability assistance under SSI in January 1974, and have remained continuously eligible for SSI since that date.

If you are a MIL client, your combined federal/state SSI benefit level is the higher of the following:

(i) The state assistance standard you received in December 1973, except if you resided 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, 74.04.057. 01-19-024, § 388-478-0055, filed 9/12/01, effective 11/1/01; 01-08-015, § 388-478-0055, filed 3/23/01, effective 5/1/01. 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 and 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.]

WAC 388-478-0056 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-478-0057 Year-end adjustments to the SSI state supplement. For the purposes of this rule, "we" refers to the department of social and health services. We are required by federal law to maintain the total SSI state supplement payments at the same level each year, without an increase or decrease in total spending. This may result in adjustment to your SSI state supplement benefits at the end of the year.

(1) If there are unexpended funds, you will receive a one-time bonus payment, usually at the end of the calendar year.

(2) When there is a shortage in available funds, your state supplement benefits will be decreased. The decrease will usually be spread out over multiple months to reduce the negative impact on you.

[Statutory Authority: RCW 74.08.090, 74.04.057. 01-22-088, § 388-478-0057, filed 11/5/01, effective 12/6/01.]

WAC 388-478-0060 What are my income limits for food assistance? If your assistance unit (AU) meets all other eligibility requirements for food assistance, 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 10-1-2001

Column A Number of Eligible AU Members	Column B Maximum Gross Monthly Income	Column C Maximum Net Monthly Income	Column D Maximum Allotment	Column E 165% of Poverty Level
1	$931	$716	$135	$1,182
2	1,258	968	248	1,597
3	1,585	1,220	356	2,012
4	1,913	1,471	452	2,427
5	2,240	1,723	537	2,843
6	2,567	1,975	644	3,258
7	2,894	2,226	712	3,673
8	3,221	2,478	814	4,088
9	3,549	2,730	916	4,504
10	3,877	2,982	1,018	4,920
Each Additional Member	+328	+252	+102	+416

Exceptions:

(1) If your AU is categorically eligible as under WAC 388-414-0001, your AU does not have to meet the gross or net income standards in columns (B) and (C). However, we do budget your 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 cannot buy and cook your own meals because of a permanent disability, we will use column (E) to decide if you can be a separate AU.

(4) If your AU has zero income, your benefits are the maximum allotment in column (D), based on the number of eligible members in your AU.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-478-0060, filed 10/16/01, effective 12/1/01. 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 Categorically needy income level (CNIL) and resource standards for families. (1) The categorically needy income level (CNIL) standard for family 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 family 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 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0065, filed 8/30/01, effective 9/30/01. 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, 2001, the medically needy income level (MNIL) and MI monthly income standards are as follows:

(a) One person	$556.00
(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 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396R-5). 01-12-073, § 388-478-0070, filed 6/4/01, effective 7/5/01. 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;

(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, 2001, the monthly FPL standards are:

FAMILY SIZE	100% FPL	185% FPL	200% FPL	250% FPL
1	$716	$1325	$1432	$1790
2	$968	$1790	$1935	$2419
3	$1220	$2256	$2439	$3048
4	$1471	$2722	$2942	$3678
5	$1723	$3187	$3445	$4307
6	$1975	$3653	$3949	$4936
7	$2226	$4118	$4452	$5565
8	$2478	$4584	$4955	$6194
9	$2730	$5094	$5459	$6823
10	$2981	$5515	$5962	$7453
Add to the ten person standard for each person over ten:				
	$252	$466	$504	$630

(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 Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0075, filed 8/30/01, effective 9/30/01; 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, 2001, the CNIL monthly income standards are as follows:

	Area 1	Area 2
(a) Single person	$555.90	$535.45
(b) A legally married couple who are both eligible	$815.90	$796.00
(c) Supplied shelter	$357.05	$357.05

(2) The countable resource standards for the SSI-related CN medical program are:

(a) One person	$2,000
(b) A legally married couple	$3,000

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396R-5). 01-12-073, § 388-478-0080, filed 6/4/01, effective 7/5/01. 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 Federal Poverty Level (FPL). Beginning April 1, 2001, the QMB program's income standards are:

(a) One person	$716
(b) Two persons	$968

(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, 2001, the SLMB program's income standards are:

	Minimum	Maximum
(a) One person	$716.01	$859
(b) Two persons	$968.01	$1161

(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, 2001, the ESLMB program's income standards are:

	Minimum	Maximum
(a) One person	$859.01	$967
(b) Two persons	$1161.01	$1307

(4) The qualified disabled working individual (QDWI) program income standard is up to two hundred percent of FPL. Beginning April 1, 2001, the QDWI program's income standards are:

(a) One person	$1432
(b) Two persons	$1935

(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, 2001, the QI program's income standards are:

	Minimum	Maximum
(a) One person	$967.01	$1253
(b) Two persons	$1307.01	$1694

(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 Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0085, filed 8/30/01, effective 9/30/01; 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 388-484 WAC
TANF/SFA FIVE YEAR TIME LIMIT

WAC

WAC 388-484-0005 There is a five year (sixty-month) time limit for TANF, SFA and GA-S cash assistance. (1) **What is the sixty-month time limit?**

(a) You can receive cash assistance for temporary assistance for needy families (TANF), state family assistance (SFA), and general assistance for pregnant women (GA-S) for a lifetime limit of sixty months. The time limit applies to cash assistance provided by any combination of these programs, and whether or not it was received in consecutive months.

(b) If you receive cash assistance for part of the month, it counts as a whole month against the time limit.

(c) If you have received cash assistance from another state on or after August 1, 1997, and it was paid for with federal TANF funds, those months will count against your time limit.

(d) The time limit does not apply to diversion cash assistance, support services, food assistance or Medicaid.

(2) **When did the sixty-month time limit go into effect?**

The sixty-month time limit applies to cash assistance received on or after August 1, 1997 for TANF and SFA. Although the GA-S program no longer exists, the time limit applies to GA-S cash assistance received from May 1, 1999 through July 31, 1999.

(3) **Does the time limit apply to me?**

The sixty-month time limit applies to you for any month in which you are a parent or other relative as defined in WAC 388-454-0010, or a minor parent emancipated through court order or marriage.

(4) **Do any exceptions to the time limits apply to me?**

The department does not count months of assistance towards the sixty-month time limit if you are:

(a) A nonneedy adult caretaker relative who is not a member of the assistance unit and you are receiving cash assistance on behalf of a child;

(b) An unemancipated pregnant or parenting minor living in a department approved living arrangement as defined by WAC 388-486-0005; or

(c) An American Indian or Native Alaskan adult and you are living in Indian country, as defined under 18 U.S.C. 1151, or an Alaskan Native village and you are receiving TANF, SFA, or GA-S cash assistance during a period when at least fifty percent of the adults living in Indian country or in the village were not employed. See WAC 388-484-0010.

(5) **What happens if a member of my assistance unit has received sixty months of TANF, SFA, and GA-S cash benefits?**

Once any adult or emancipated minor in the assistance unit has received sixty months of cash assistance, the entire assistance unit becomes ineligible for TANF or SFA cash assistance. Some people may be eligible for an extended period of cash assistance based on hardship criteria to be developed by the department.

(6) **What can I do if I disagree with how the department has counted my months of cash assistance?**

(a) If you disagree with how the department has counted your months of cash assistance, you may ask for a hearing within ninety days of receiving notice of the count.

(b) If your cash assistance is terminated after sixty months and you ask for a hearing as provided under chapter 388-02 WAC, your cash assistance will be continued during

the course of your initial administrative appeal. You must repay the cash assistance, however, if the department's decision is found to be correct.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.010, and 42 U.S.C. 608 (a)(7). 01-04-016, § 388-484-0005, filed 1/26/01, effective 2/1/01. 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.]

WAC 388-484-0010 How does the five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance apply to American Indians or Alaskan Natives living in Indian country? (1) If you are American Indian or Alaskan Native, time limits on temporary assistance for needy families (TANF), state family assistance (SFA) and general assistance for pregnant women (from May 1, 1999 to July 31, 1999) do not count under certain circumstances.

If you are an American Indian or Alaskan Native parent or other relative as defined by WAC 388-454-0010, months of cash assistance do not count against the sixty-month lifetime limit if you live in Indian country or an Alaskan Native village where at least fifty percent of Indian adults are not employed.

(2) **Do time limits on cash assistance apply if I am not an American Indian or Alaskan Native but I am the parent or other relative of an American Indian or Alaskan Native child?**

If you are a non-American Indian or non-Alaskan Native parent or other relative, as defined by WAC 388-454-0010, of an American Indian or Alaskan Native child or children living in a qualifying area of Indian country, your months on assistance will count against your lifetime limit. You may, however, receive more than sixty months of assistance under hardship criteria to be developed by the department.

(3) **Where must I live to qualify for the Indian country exemption to time limits?**

To qualify for this exemption to TANF time limits, you must live in "Indian country." The department uses the "Indian country" definition in federal law at 18 U.S.C. 1151. Indian country is defined as reservations, dependent Indian communities, and allotments. Dependent Indian communities must be set aside by the federal government for the use of Indians and be under federal superintendence. Near reservation areas (areas or communities adjacent or contiguous to reservations) are not considered Indian country for purposes of this exemption.

(4) **Can I live on the reservation or Indian country belonging to a tribe other than my own to qualify for this time limit exemption?**

Yes. You do not need to be an American Indian or Alaskan Native of the same tribe as the reservation or other area of Indian country on which you reside.

(5) **How does the department determine if at least fifty percent of adults living in Indian country are not employed?**

The department uses the most current biennial Indian Service Population and Labor Force Estimates Report published by the Bureau of Indian Affairs (BIA), or any successor report, as the default data source to determine if the not employed rates for areas of Indian country are at least fifty percent.

(6) **What if a tribe disagrees with the not employed rate published in the BIA Indian Service Population and Labor Force Estimates Report?**

A tribe may provide alternative data, based on similar periods to the Indian Service Population and Labor Force Estimates Report, to demonstrate that the not employed rate is at least fifty percent.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.010, and 42 U.S.C. 608 (a)(7). 01-04-016, § 388-484-0010, filed 1/26/01, effective 2/1/01.]

Chapter 388-492 WAC
WASHINGTON COMBINED APPLICATION PROJECT

WAC

WAC 388-492-0010 Washington combined application project (WASHCAP) definitions. "Assistance unit" (AU) — A person who gets SSI, meets the definition of living arrangement "A," has no earned income, and states that they buy and cook food on their own.

"Centralized unit" — The unit that handles all WASHCAP cases for the state except for cases that get services from Home and community service office (HCS). The centralized unit or HCS office processes new applications for WASHCAP benefits and handles current WASHCAP cases.

"Pure SSI household" — Every member of the assistance unit is eligible for SSI on their own behalf.

"SSA" — Social Security Administration. A federal agency that issues all SSA and SSI cash benefits.

"SSI" — Supplemental Security Income. The SSA federal cash grant program for aged, blind or disabled clients.

"WASHCAP" — Washington state combined application project. A simplified food assistance program that automatically opens food assistance benefits for certain SSI clients.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0010, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0020 What is WASHCAP? WASHCAP stands for the Washington state combined application project. WASHCAP is a simplified food assistance program for clients that get SSI from SSA and meet some other basic requirements:

(1) If you live in Washington state and get SSI, SSA asks you if you want to get food assistance benefits. If you meet the requirements of WAC 388-492-0030, you will get your food assistance benefits through WASHCAP.

(2) If you are eligible for WASHCAP, SSA electronically sends us the information we need to open your benefits. You do not have to go to your local community services office to apply for food assistance benefits.

(3) If you want food assistance benefits right away, you must apply for regular food assistance benefits at your local community services office.

(4) While you get WASHCAP benefits, you must report all changes to SSA. SSA automatically shares your information with us.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0020, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0030 Who can get WASHCAP? (1) When you apply for food assistance, you can get WASHCAP benefits when you are eighteen years of age or older and:

(a) Get at least one dollar federal SSI benefits from SSA. We do not consider the state supplement as federal SSI benefits;

(b) Live alone or SSA considers you as a single household;

(c) Buy and cook your food separately from others you live with;

(d) Do not have any earned income; and

(e) If you live in an institution, SSA expects you to be there for less than ninety days.

(2) You are not eligible for WASHCAP if:

(a) You live in an institution for ninety days or longer;

(b) SSA expects you to live in an institution for ninety days or longer;

(c) SSA tells us you have earned income for more than three months in a row; or

(d) You are under age twenty-two and you live in the same home as your parents.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0030, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0040 Can I choose whether I get WASHCAP or regular food assistance? You can choose to have regular food assistance benefits instead of WASHCAP when:

(1) Your shelter costs are more than four hundred eighty dollars a month. We count the following items as a shelter cost:

(a) Rent or mortgage;

(b) Taxes;

(c) Homeowner's insurance (for the building only); and

(d) Mandatory homeowner's association or condo fees.

(2) Your out-of pocket medical expenses are more than thirty-five dollars a month; or

(3) You would get more benefits from being in the regular food assistance program.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0040, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0050 How do I apply for WASHCAP benefits? (1) You apply for WASHCAP at SSA when you apply for SSI. If you want food assistance, your SSA worker will ask you to complete a one-page application for WASHCAP when you have your SSI interview.

(2) If you are eligible for WASHCAP benefits, your benefits will start the first of the month after the month you start getting on-going SSI benefits.

(3) If you need food assistance in five days or less, you must apply for expedited service at the local CSO or HCS office. SSA may also take your application.

(4) If you want food assistance before you get SSI, you must apply for regular food assistance at:

(a) SSA;

(b) Your local community services office (CSO); or

(c) Your local home and community services (HCS) office if you get long-term care services.

(5) If you get regular food assistance, you will still get these benefits:

(a) Through the end of your certification period; or

(b) Until you are approved for WASHCAP benefits.

(6) If your regular food assistance ends before you are eligible for WASHCAP, you must reapply for these benefits.

(7) If you get regular food assistance and you become eligible for WASHCAP, we will automatically change your benefits to WASHCAP.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0050, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0060 How do I get my WASHCAP benefits? (1) If you are eligible for WASHCAP, you will get your food assistance benefits through electronic benefits transfer (EBT).

(2) The department issues your EBT food assistance benefits according to WAC 388-412-0025.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0060, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0070 How are my WASHCAP benefits calculated? We calculate your WASHCAP benefits as follows:

(1) We begin with your gross income. (Social Security tells us how much income you have.)

(2) We subtract a standard deduction of one hundred thirty-four dollars to get your countable income.

(3) We figure your shelter cost as follows:

(a) If Social Security tells us you pay two hundred ninety dollars or more a month for shelter, we use three hundred dollars as your shelter cost; or

(b) If Social Security tells us you pay less than two hundred ninety dollars a month for shelter, we use one hundred forty-four dollars as your shelter cost; and

(c) We add the current standard utility allowance under WAC 388-450-0195 to determine your total shelter cost.

(4) We figure your shelter deduction by subtracting one half of your countable income from your shelter cost.

(5) We figure your net WASHCAP income by subtracting your shelter deduction from your countable income.

(6) We figure your WASHCAP benefits (allotment) by:

(a) Multiplying your net WASHCAP income by thirty percent and rounding up to the next whole dollar; and

(b) Subtracting the result from the maximum allotment under WAC 388-478-0060.

(c) If you are eligible for WASHCAP, your assistance unit will get at least ten dollars food benefits each month.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0070, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0080 Where do I report changes? You report all changes to Social Security according to their reporting requirements. Social Security reports changes to your worker.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0080, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0090 How often does my WASHCAP case need to be reviewed? Your certification period is the amount of time your AU is eligible for WASHCAP benefits. We certify WASHCAP for up to twenty-four months.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0090, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0100 How is my eligibility for WASHCAP reviewed? (1) If SSA reviews your SSI eligibility, they will also complete your review for WASHCAP benefits. SSA sends us this information electronically.

(2) If SSA does not review your SSI eligibility, we will mail you a one-page application two months before your WASHCAP benefits end. You must complete and return this application to the WASHCAP unit or your local HCS office.

(3) We do WASHCAP reviews by mail.

(4) If we get your completed one-page application after your WASHCAP benefits end, we will reopen your benefits back to the first of the month if:

(a) We get your application form within thirty days from the end of your certification period; and

(b) You are still eligible for WASHCAP.

(5) If you are no longer eligible for WASHCAP benefits, we will decide if you are eligible for regular food assistance. We may ask you to give us more information or verification if we cannot make a decision with the information we have.

(6) If we get your completed one-page application form more than thirty days after your benefits end, we will open your WASHCAP benefits the first of the next month after you turn in your application and SSA shows you are eligible for WASHCAP in their system.

(7) If you want regular food assistance while you are waiting for WASHCAP benefits, you must apply for these benefits.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0100, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0110 What happens if my WASHCAP benefits end? (1) If your WASHCAP benefits end because you did not have the review required under WAC 388-492-0100, you must finish the required review or apply for food assistance benefits at your local office.

(2) If your WASHCAP benefits end because you are disqualified for food assistance under WAC 388-400-0040, you are not eligible for regular food assistance. If you get medical assistance, we will send your medical assistance case to your local office.

(3) If your WASHCAP benefits end because SSA stopped your SSI benefits:

(a) We will send you an application for regular food assistance and information about what you must verify in order to get benefits.

(b) You will still receive the same medical benefits until we decide what medical programs you are eligible for under WAC 388-418-0025.

(c) When we get your completed application, we will interview you over the phone. If we need more information to decide if you are eligible, we will tell you what we need.

(d) After we decide if you are eligible for regular food assistance, we will send your case to the local office.

(4) If your WASHCAP benefits end for any other reason:

(a) We will send you an application for regular food assistance along with:

(i) The address of your local office; and

(ii) Information about what you must verify in order to get benefits.

(b) If you get medical assistance, we will send your medical assistance case to the local office;

(c) For the office to decide if you are eligible for food assistance, you must:

(i) Finish the application process for food assistance under chapter 388-406 WAC; and

(ii) Have an interview for food assistance under WAC 388-452-0005.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0110, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0120 What happens to my WASHCAP benefits if I am disqualified? (1) If you are disqualified from receiving SSI for any reason, you will not be able to get WASHCAP food benefits. See WAC 388-492-0030, Who can get WASHCAP?

(2) If you are disqualified from receiving food assistance for any reason, you will not get WASHCAP food benefits. See WAC 388-400-0040(9) for persons disqualified.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0120, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0130 What can I do if I disagree with a decision the department made about my WASHCAP benefits? (1) If you disagree with a decision about your benefits, you may ask for a fair hearing.

(2) You can ask for a hearing by contacting the central unit, home community service office or any responsible department or office of administrative hearings employee.

(3) See chapter 388-08 WAC for information on the fair hearing process.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-058, § 388-492-0130, filed 10/16/01, effective 12/1/01.]

Chapter 388-501 WAC
ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

WAC 388-501-0050 Medical and dental general coverage. All medical and dental services, equipment, and supplies provided to medical assistance administration (MAA) clients are subject to review, before or after payment has been made. MAA may deny or recover reimbursement for such services, equipment, and supplies based on these reviews.

(1) **Covered services**

(a) Covered services are:

(i) Medical and dental services, equipment, and supplies that are within the scope of the eligible client's medical assistance program (see chapter 388-529 WAC) and listed as covered in MAA rules; and

(ii) Determined to be medically necessary as defined in WAC 388-500-0005 or dentally necessary as defined in WAC 388-535-0150.

(b) Providers must obtain prior authorization (PA) or expedited prior authorization (EPA) when required by MAA.

(i) See WAC 388-501-0165 for the PA process.

(ii) The EPA process is designed to eliminate the need for written and telephonic requests for prior authorization for selected services and procedure codes. MAA requires a provider to create an authorization number for EPA for selected procedure codes, using the process explained in the billing instructions for the specific service or program.

(iii) See chapter 388-538 WAC for managed care requirements.

(c) Covered services are subject to the limitations specified by MAA. Providers must obtain PA or EPA before providing services that exceed the specified limit (quantity, frequency or duration). This is known as a limitation extension.

(i) See WAC 388-501-0165 for the PA process.

(ii) The EPA process is designed to eliminate the need for written and telephonic requests for prior authorization for selected services and procedure codes. MAA requires a provider to create an authorization number for EPA for selected procedure codes, using the process explained in the billing instructions for the specific service or program.

(iii) See chapter 388-538 WAC for managed care requirements.

(d) MAA does not reimburse for covered services, equipment or supplies:

(i) That are included in a DSHS waivered program; or

(ii) For a MAA client who is Medicare-eligible if:

(A) The services, equipment or supplies are covered under Medicare; and

(B) Medicare has not made a determination on the claim or has not been billed by the provider.

(2) **Noncovered services**

(a) MAA does not cover services, equipment or supplies to which any of the following apply:

(i) The service or equipment is not included as a covered service in the state plan;

(ii) Federal or state laws or regulations prohibit coverage;

(iii) The service or equipment is considered experimental or investigational by the Food and Drug Administration or the Health Care Financing Administration; or

(iv) MAA rules do not list the service or equipment as covered.

(b) MAA reviews all initial requests for noncovered services based on WAC 388-501-0165.

(c) If a noncovered service, equipment or supply is prescribed under the EPSDT program, it will be evaluated as a covered service and reviewed for medical necessity.

[Statutory Authority: RCW 74.08.090. 01-12-070, § 388-501-0050, filed 6/4/01, effective 7/5/01. 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 388-501-0300 Limits on scope of medical program services. (1) The medical assistance administration (MAA) pays only for equipment, supplies, and services that are listed as covered in MAA Washington Administrative Code (WAC), when the items or services are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary as defined in WAC 388-500-0005;

(c) Billed according to the requirements in WAC 388-502-0100, 388-502-0110, and 388-502-0150; and

(d) 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.

(2) Pursuant to WAC 388-501-0165, MAA covers equipment, supplies, or services that are listed as noncovered when the equipment, supplies, or services are medically necessary and:

(a) Requested under the EPSDT program; or

(b) Included in an MAA waivered program.

(3) When a client or a client's representative requests equipment, supplies, or services that are listed as noncovered, MAA evaluates the request under WAC 388-501-0165.

(4) MAA evaluates requests for covered equipment, supplies, or services that are subject to limitations or other restrictions, and approves such equipment, supplies, or services beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165.

(5) MAA evaluates a request for a service that is in a covered category, but is determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165 which relate to medical necessity.

(6) Clients are responsible for payment as described under WAC 388-502-0160, for services that are not covered under the client's medical care program.

[Statutory Authority: RCW 74.08.090. 01-12-072, § 388-501-0300, filed 6/4/01, effective 7/5/01. 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

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) Osteopathic physicians;
(xvii) Podiatric physicians;
(xviii) Pharmacists
(xix) Physicians;
(xx) Physical therapists;
(xxi) Psychiatrists;
(xxii) Psychologists;
(xxiii) Registered nurse delegators;
(xxiv) Registered nurse first assistants;
(xxv) Respiratory therapists;
(xxvi) Speech/language pathologists;
(xvii) Radiologists; and
(xviii) Radiology technicians (technical only);

(b) Agencies, centers and facilities:

(i) Adult day health centers;
(ii) Ambulance 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) division 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, and 74.09.530. 01-07-076, § 388-502-0010, filed 3/20/01, effective 4/20/01; 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) Accept the payment from the department as payment in full;

(f) Follow the requirements in WAC 388-502-0160 and 388-538-095 about billing clients;

(g) Fully disclose ownership and control information requested by the department;

(h) 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

(i) 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, and 74.09.530. 01-07-076, § 388-502-0020, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0020, filed 7/17/00, effective 8/17/00.]

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 the provider 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 for verifying 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 medical assistance managed care and the client and provider comply with the requirements in WAC 388-538-095;

(b) The client is not enrolled in medical assistance managed care, and the client and provider sign an agreement regarding payment for the service. The agreement 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) A statement listing the specific service to be provided;

(ii) A statement that the service is not covered by MAA;

(iii) A statement that 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 (see WAC 388-501-0200);

(d) The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by MAA;

(e) The provider has documentation that the client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a MAA medical program. This 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 cli-

ent's file for department review upon request. In this case, the provider may bill the client without fulfilling the requirements in subsection (3)(b) of this section regarding the agreement to pay. However, if the patient later becomes eligible for MAA coverage of a provided service, the provider must comply with subsection (4) of this section for that service; 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 covered service that has already been provided because the client:

(a) Applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), 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) Receives a delayed certification as defined in WAC 388-500-0005, 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; or

(c) Receives a retroactive certification as defined in WAC 388-500-0005, 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 after refunding the payment, the provider may 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. 01-21-023, § 388-502-0160, filed 10/8/01, effective 11/8/01; 01-05-100, § 388-502-0160, filed 2/20/01, effective 3/23/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 00-14-069, § 388-502-0160, filed 7/5/00, effective 8/5/00.]

Chapter 388-505 WAC
FAMILY MEDICAL

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-505-0595 Trusts. [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.] Repealed by 01-06-043, filed 3/5/01, effective 5/1/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500.

WAC 388-505-0210 Children's medical eligibility.

(1) A child under the age of one is eligible for categorically needy (CN) medical assistance as defined in chapter 388-500 WAC 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) Children under the age of nineteen are eligible for the children's health insurance program (CHIP), as described in chapter 388-542 WAC, 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 percent of the 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 meet:

(a) Citizenship or immigrant status, state residence, and social security number requirements as described in subsection (2)(a), (b), and (c) of this section;

(b) Income levels described in WAC 388-478-0075 when income is counted according to WAC 388-408-0055 (1)(c); and

(c) 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 cash assistance for August 1996, and except for the August 1996 passage of amendments to federal disability definitions, would be eligible for SSI cash assistance.

(7) Children under the age of nineteen are eligible for Medically Needy (MN) medical assistance as defined in chapter 388-500 WAC 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 above the income levels described in WAC 388-478-0075 (1)(c).

(8) Children described in subsection (4)(a) and (b) whose countable income exceeds the standard in WAC 388-478-0075 (1)(c) are eligible for state-funded MN scope of care.

(9) A child is eligible for SSI-related MN when the child:

(a) Meets the blind and/or disability criteria of the federal SSI program or the condition in subsection (6)(b); and

(b) Has countable income above the level described in WAC 388-478-0070(1).

(10) Noncitizen 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.

(11) There are no resource limits for children under:

(a) CN or MN coverage;

(b) State-funded CN or MN scope of care; or

(c) The children's health programs.

(12) Children may also be eligible for:

(a) Family medical as described in WAC 388-505-0220; or

(b) Medical extensions as described in WAC 388-523-0100.

(13) Except for a client described in subsection (5)(c)(i) and (ii), 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, 74.04.050, [74.04.]055, and [74.04.]057. 01-11-110, § 388-505-0210, filed 5/21/01, effective 6/21/01. 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 assistance when they are:

(a) Receiving temporary assistance for needy families (TANF) cash benefits;

(b) Receiving cash diversion assistance described in chapter 388-222 WAC;

(c) Eligible for TANF cash benefits but choose not to receive; or

(d) Not eligible for or receiving TANF cash assistance, but meet the eligibility criteria for aid to families with dependent children (AFDC) in effect on July 16, 1996 except that:

(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 WAC 388-470-0050 and 388-470-0026 for recipients.

(2) A person is eligible for CN family medical coverage when the person is not eligible for or receiving cash benefits solely because the person:

(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;

(b) Failed to meet the school attendance requirement in chapter 388-400 WAC;

(c) Is an unmarried minor parent who is not in a department-approved living situation;

(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;

(e) Is a fleeing felon or fleeing to avoid prosecution for a felony charge, or a probation and parole violator;

(f) Was convicted of a drug related felony;

(g) Was convicted of receiving benefits unlawfully;

(h) Was convicted of misrepresenting residence to obtain assistance in two or more states;

(i) Has gross earnings exceeding the TANF gross income level; or

(j) Is not cooperating with WorkFirst requirements.

(3) A person is eligible for state-funded CN scope of care family medical when the person:

(a) Is eligible for or receiving SFA cash benefits;

(b) Is receiving SFA cash diversion assistance described in chapter 388-222 WAC;

(c) Is not eligible for or receiving SFA solely due to factors described in subsection (2)(a) through (j) of this section; or

(d) Meets the criteria of (1)(d) of this section.

(4) An adult must cooperate with the division of child support in the identification, use, and collection of medical support from responsible third parties, unless the person meets the medical exemption criteria described in WAC 388-505-0540 or the medical good cause criteria described in chapter 388-422 WAC.

(5) When the only eligible child in an SFA cash assistance unit is over nineteen years of age the assistance unit is not eligible for a family medical program, but individual members shall be redetermined for eligibility for other medical programs.

(6) Except for a client described in WAC 388-505-0210 (5)(c)(i) and (ii), a person who is 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, 74.04.050, [74.04.]055, and [74.04.]057. 01-11-110, § 388-505-0220, filed 5/21/01, effective 6/21/01; 98-16-044, § 388-505-0220, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0740 and 388-522-2210.]

WAC 388-505-0595 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-512 WAC
SSI-RELATED GRANDFATHERED RECIPIENTS

WAC

388-512-1215 Repealed.
388-512-1220 Repealed.
388-512-1225 Repealed.
388-512-1230 Repealed.
388-512-1235 Repealed.
388-512-1240 Repealed.
388-512-1245 Repealed.
388-512-1250 Repealed.
388-512-1255 Repealed.
388-512-1260 Repealed.
388-512-1265 Repealed.
388-512-1275 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-512-1215 General eligibility. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1220 Eligibility—Blindness. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1225 Permanently and totally disabled. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1230 Refusal to accept medical treatment. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1235 Review for disability or blindness. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1240 Computation of available income. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1245 Monthly maintenance standard—Own home. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1250 Monthly maintenance standard—Person in institution. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1255 Available income and nonexempt resources. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1260 Exempt resources. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1265 Nonexempt resources. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1275 Continuing certification. [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.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

WAC 388-512-1215 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1220 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1225 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1230 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1235 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1240 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1245 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1250 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1255 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1260 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1265 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-512-1275 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-513 WAC
CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC

WAC 388-513-1350 Defining the maximum amount of resources allowed and determining resources availability 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 still 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 applies 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) For LTC services the department determines a client's nonexcluded resources as follows:

(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) The department determines available resources of a legally married client, when both spouses are institutionalized, by following WAC 388-506-0620 (5) and (6). For legally married clients when only one spouse meets institutional status, the following rules apply. If the client's current period of institutional status began:

(a) Before October 1, 1989, 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.

(b) On or after October 1, 1989, the department adds together the total amount of nonexcluded resources held in the name of:

(i) Either spouse; or

(ii) Both spouses.

(6) If subsection (5)(b) 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-seven thousand dollars effective January 1, 2001.

(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 388-02 WAC or by consent order, 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 subsection (9)(a), (b), or (c) applies.

(9) A redetermination of the couple's 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)(b) 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 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396R-5). 01-18-055, § 388-513-1350, filed 8/30/01, effective 9/30/01. 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, § 388-513-1350, 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 388-513-1380 Determining a client's participation in the cost of care for long-term care (LTC) services. This rule 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 which 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) Excess resources are reduced in an amount equal to incurred medical expenses (for definition see WAC 388-519-0110(10)) 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;

(b) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan; and

(c) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program, the amount described in WAC 388-513-1315(3); or

(ii) For LTC services provided under the medically needy (MN) program, the amount described in WAC 388-513-1395 (2)(a) or (b).

(5) 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 a VA 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 incurred during the time period covered by the PNA, whether paid or unpaid.

(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.

(6) The department allocates nonexcluded income after deducting amounts described in subsection (5) 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 maintenance needs allowance for the community spouse not to exceed, effective January 1, 2001, two thousand one hundred seventy-five dollars, unless a greater amount is allocated as described in subsection (8) of this section. The monthly maintenance 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 fifty-two dollars; and

(B) Excess shelter expenses as specified under subsection (7) 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 fifty-two 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.

(iii) Child support received from noncustodial 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 services staff documents initial need for the income exemption and reviews the client's circumstances after ninety days.

(7) For the purposes of this section, "excess shelter expenses" means the actual expenses under subsection (7)(b) less the standard shelter allocation under subsection (7)(a). For the purposes of this rule:

(a) The standard shelter allocation is four hundred thirty-six dollars, effective April 1, 2001; 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.

(8) The amount allocated to the community spouse may be greater than the amount in subsection (6)(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.

(9) A client who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396R-5). 01-18-055, § 388-513-1380, filed 8/30/01, effective 9/30/01. 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.]

Chapter 388-517 WAC
MEDICARE-RELATED MEDICAL ELIGIBILITY

WAC

WAC 388-517-0400 Medicare coinsurance payment—Extended care patient. The department will pay for a long-term care client's Medicare coinsurance if the:

(1) Client is eligible for extended care Medicare benefits;

(2) Client is eligible for Medicaid, qualified Medicare beneficiary (QMB) program, or the special low-income Medicare beneficiary (SLMB) program; and

(3) Medicare coinsurance costs less than the Medicaid nursing facility rate.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055. 01-06-033, § 388-517-0400, filed 3/2/01, effective 4/2/01.]

Chapter 388-530 WAC
PHARMACY SERVICES

WAC

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.

"Four brand name prescriptions per calendar month limit" means the maximum number of paid prescription claims for brand name drugs that MAA allows for each client in a calendar month without a complete review of the client's drug profile.

"Generic drug" means a nonproprietary drug that is required to meet the same bioequivalency tests as the original brand name 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.

"Preferred drug" means MAA's drug(s) of choice within a selected therapeutic class.

"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.

"TCS" See **"therapeutic consultation service."**

"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.

"Therapeutic class" means a group of drugs used for the treatment, remediation, or cure of a specific disorder or disease.

"Therapeutic consultation service (TCS)" means the prescriber and an MAA-designated clinical pharmacist jointly review prescribing activity when drug claims for a medical assistance client exceed program limitations.

"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. 01-24-066, § 388-530-1050, filed 11/30/01, effective 1/2/02; 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 388-530-1260 Therapeutic consultation service. (1) The medical assistance administration (MAA) provides a therapeutic consultation service (TCS) to aid appropriate utilization of prescription drugs, improve quality of care and health care outcomes for medical assistance clients, and promote cost effectiveness.

(2) A TCS occurs when a drug claim:

(a) Exceeds the four brand name prescriptions per calendar month limit; or

(b) Is for a nonpreferred drug within selected therapeutic classes.

(3) Through TCS, MAA:

(a) Provides a complete drug profile review for each client whose claims exceed four brand name prescriptions in a calendar month. MAA excludes the following from the four brand name prescriptions per calendar month limit:

(i) Generic drugs; and

(ii) The following drugs:

(A) Antidepressants;

(B) Antipsychotics;

(C) Chemotherapy;

(D) Contraceptives;

(E) HIV;

(F) Immunosuppressants; and

(G) Hypoglycemia rescue agents.

(b) Publishes a list of preferred drugs within selected therapeutic classes. MAA chooses a drug or drugs from a selected therapeutic class for placement on the preferred list when:

(i) The drugs in the class are essentially equal in terms of safety and efficacy; and

(ii) The selected drug or drugs may be the least costly in the therapeutic class.

(4) When a pharmacy provider submits a claim that exceeds TCS limitations for a client, MAA notifies the pharmacy provider that a TCS is required.

(5) The TCS process includes all of the following:

(a) Pharmacy provider requirements:

(i) The pharmacy provider notifies the prescriber that the prescriber or prescriber designee must call the TCS toll-free telephone number to begin a TCS; and

(ii) If the TCS cannot take place due to the prescriber's or prescriber designee's unavailability, the pharmacy provider has the option to dispense an emergency supply of the requested drug 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.

(b) Prescriber requirements:

(i) When the pharmacy provider contacts the client's prescriber as described in subsection (5)(a)(i) of this section, the prescriber or prescriber designee contacts the MAA designee (MAA-designated clinical pharmacist) to begin a TCS;

(ii) After the prescriber or prescriber designee and the MAA designee review the client's drug profile and discuss clinically sound options and cost effective alternative drug(s), the prescriber does one of the following:

(A) Changes the prescription to an alternate drug or preferred drug and contacts the client's pharmacy with the new prescription;

(B) Provides the MAA designee with medical justification for the requested drug and the MAA designee authorizes the drug under the provisions of medical necessity as defined in WAC 388-500-0005; or

(C) Does not agree to prescribe an alternate drug or preferred drug and does not provide medical justification for the requested drug, then:

(I) The MAA designee authorizes only a one-month supply of the requested drug with no refills and sends the initiating prescriber a copy of the client's drug profile and a therapy authorization turnaround form;

(II) The prescriber signs the therapy authorization turnaround form and returns it to the MAA designee; and

(III) Upon receipt of the therapy authorization turnaround form, the MAA designee authorizes six additional months of the requested drug.

(c) MAA designee responsibilities:

(i) Notifies the following by facsimile, electronic mail, or telephone call, the results of the TCS:

(A) Prescriber;

(B) Pharmacy provider; and

(C) MAA for notification to the client. When the TCS indicates a need for a change, limitation, or denial of the requested drug, MAA notifies the client according to WAC 388-501-0165(7).

(ii) Notifies MAA clinical program staff when concerns for client safety are identified during the TCS. See WAC 388-530-1100(2) for how MAA determines restrictions on drug coverage based on, but not limited to, client safety.

(iii) Contacts other prescribers identified during the TCS when opportunities to further improve the client's healthcare outcome are discovered.

(6) A client who does not agree with a TCS decision has a right to a fair hearing under chapter 388-02 WAC. After receiving a request for a fair hearing, MAA may request additional information from the client, the prescriber, or the pharmacy provider. 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, 74.04.050. 01-24-066, § 388-530-1260, filed 11/30/01, effective 1/2/02.]

Chapter 388-533 WAC
MATERNITY-RELATED SERVICES

WAC

WAC 388-533-1000 First Steps childcare program. The purpose of the First Steps childcare program is to fund childcare for children in order to enable their pregnant or postpregnancy mothers to access prenatal care or other medical assistance administration (MAA)-covered services.

(1) For the purposes of this section, the following terms and definitions apply:

(a) **"Postpregnancy"** or **"postpartum"** means the period of time after the pregnancy ends (includes live birth, still birth, miscarriage or pregnancy termination), through the end of the month that includes the sixtieth day from the end of the pregnancy; and

(b) **"Background check central unit (BCCU)"** means the centralized unit established by the department of social and health services (DSHS) that performs background checks as directed by the Washington state legislature.

(2) First Steps childcare is available for the children of either a managed care or fee-for-service client. Subject to the

restrictions and limitations listed in this section, a client is eligible to receive First Steps childcare for her children if she:

(a) Meets one of the following criteria:

(i) Is pregnant; or

(ii) Is within the postpregnancy period.

(b) Is currently eligible under one of the following programs:

(i) Categorically needy program (CNP);

(ii) CNP - emergency medical only;

(iii) Children's health insurance program (CHIP); or

(iv) Children's health.

(c) Requires one or more of the covered services listed in subsection (4) and (5) of this section;

(d) Demonstrates a need for childcare; and

(e) Shows that no other childcare resources are available.

(3) The following persons are eligible to authorize First Steps childcare, subject to the restrictions and limitations in this chapter and other published WAC:

(a) Maternity support services (MSS) professional/paraprofessional agency staff members. See WAC 388-533-0300 (3) and (7);

(b) Maternity case management (MCM) providers. See WAC 388-533-0350;

(c) Community services office (CSO) social workers or designated staff members; and

(d) Other MAA-designated professional/paraprofessional persons.

(4) First Steps childcare may be authorized for a client's children during the client's pregnancy or postpregnancy period when the client pursues any of the following covered services for herself or her newborn children:

(a) Childbirth education classes;

(b) Delivery/birth (during the mother's hospitalization);

(c) Dental care;

(d) Hospital procedures;

(e) Laboratory tests;

(f) Maternity case management (MCM) visits;

(g) Maternity support services (MSS) visits, including nursing, social work, nutrition, and community health worker visits; and

(h) Medical visits.

(5) First Steps childcare authorized for a client's children for the following special needs requires approval by the MAA First Steps childcare coordinator or designee prior to providing the childcare (see subsection (6) of this section for the prior approval process):

(a) Bedrest for the pregnant client; or

(b) The newborn(s) is in a neonatal intensive care unit (NICU) and the parent(s) is visiting the NICU.

(6) The prior approval process for a request for First Steps childcare for either of the reasons stated in subsection (5) of this section is as follows:

(a) The authorizer completes appropriate sections of the DSHS 14-316(X) form and submits the form to the MAA First Steps childcare coordinator or designee.

(i) If the reason for the request is for bedrest for the pregnant client, the authorizer documents in the client's file that the prenatal caregiver has verified that bedrest is necessary; or

(ii) If the reason for the request is to enable a parent(s) to visit the newborn(s) in a NICU, the authorizer documents in the client's file that hospital staff has verified the parent(s) is visiting the newborn(s) regularly.

(b) The MAA First Steps childcare coordinator or designee:

(i) Approves the special needs request and signs and dates the form in the appropriate section and returns the form to the authorizer; or

(ii) Informs the authorizer in writing if the request is denied and payment will not be made.

(7) MAA reimburses for authorized First Steps childcare when provided by any of the following, subject to the limitations and restrictions listed:

(a) A licensed childcare home, center, facility, or foster home; and

(b) A friend, neighbor, or relative, other than those listed in subsection (8) of this section, who is unlicensed and:

(i) Has qualified based on a background check conducted prior to providing the childcare (see subsection (9) of this section for information on the background check process);

(ii) Is eighteen years of age or older; and

(iii) Has a valid social security number; or

(iv) Is authorized to work in the United States.

(8) The following individuals are not eligible to provide First Steps childcare:

(a) The spouse of the client;

(b) The partner of the client;

(c) The father of the baby, babies, or unborn(s);

(d) An unlicensed childcare provider:

(i) Whose background check is pending; or

(ii) Who was disqualified due to the background check; and

(e) Any person under age eighteen.

(9) Each unlicensed individual childcare provider who a client designates to be a First Steps childcare provider is subject to a background check under RCW 43.20A.710 and 74.15.030. First Steps childcare will not be authorized by the MSS or MCM agency or CSO, or reimbursed by MAA, until MAA's background check has been completed on the unlicensed childcare provider. Each unlicensed First Steps childcare provider is subject to a new background check every two years from the date of the first background check.

(a) MAA's background check process includes all of the following:

(i) The unlicensed childcare provider completes and signs the First Steps childcare background check form and returns it to the MSS or MCM agency or CSO, or sends it directly to the department's background check central unit (BCCU). The childcare provider's signature on the First Steps childcare background check form authorizes the department's BCCU to perform the background check.

(ii) BCCU performs a background check on the individual.

(iii) BCCU provides the appropriate MSS or MCM agency or CSO with the results of the background check.

(iv) For cases needing further review, BCCU notifies MAA and MAA:

(A) Follows the criteria described in this subsection to determine if the individual is approved or disqualified to provide First Steps childcare; and

(B) Notifies the MSS or MCM agency or CSO, in writing, of the decision.

(v) The MSS or MCM agency or CSO notifies the client, in writing, of the results of the designated childcare provider's background check.

(b) The department conducts the background check and may include a review of:

(i) Records of criminal convictions and pending criminal charges as listed by the Washington state patrol (WSP);

(ii) Department findings of abuse, neglect, and/or exploitation to children of vulnerable adults; and

(iii) Disciplinary board final decisions.

(c) The department's background check 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.

(d) For the purpose of conducting criminal history portions of background checks as required by chapters 43.20A and 74.15 RCW, the department:

(i) Considers only a person's convictions and pending charges; and

(ii) Does not solicit or use as the sole basis for disqualification, information about:

(A) Arrests not resulting in charges; and

(B) Dismissed charges.

(e) The department maintains a listing of offenses which, because of their seriousness, automatically disqualifies prospective childcare providers from being authorized to provide First Steps childcare to children of eligible clients. See chapter 388-06 WAC for categories of offenses or, if jurisdiction is outside of the state of Washington, their equivalents.

(f) If a criminal history check reveals a designated First Steps childcare provider has been charged with or convicted of an offense, or is found to have abused, neglected or exploited children of vulnerable adults, MAA takes the following actions:

(i) If the check reveals charges are pending against the subject for any of the offenses listed in chapter 388-06 WAC, or their equivalents in other jurisdictions, MAA withholds approval to provide First Steps childcare until dismissal or acquittal occurs. Pending charges for other offenses may be grounds for withholding approval to provide childcare;

(ii) If the check reveals the subject has been convicted of any the offenses listed in chapter 388-06 WAC, or their equivalents in other jurisdictions, MAA informs the MSS or MSM agency or CSO that the individual is not approved to provide First Steps childcare;

(iii) If the check reveals the subject has been convicted of an offense not listed in a category in chapter 388-06 WAC, MAA considers such information in determining the character, suitability, and competence of the prospective caretaker as required by chapter 74.15 RCW. MAA will not use the conviction as the sole basis for not approving the person to provide First Steps childcare unless the conviction is directly related to the authorization being sought. MAA does consider the following factors:

(A) The seriousness and circumstances of the illegal act;

(B) The number of crimes for which the person was convicted;

(C) The amount of time passed since the illegal act was committed;

(D) The age of the person at the time of conviction;

(E) The behavior of the person since the illegal act was committed;

(F) Recommendations of persons closely associated with the person; and

(G) The vulnerability of the persons under care.

(g) MAA keeps confidential any nonconviction background information provided by BCCU. (Conviction history is not confidential.)

(h) The department may provide disqualified individuals with background check findings about themselves at the individual's written request.

(10) A client who does not agree with a department decision regarding First Steps childcare program services has a right to a fair hearing under chapter 388-02 WAC. After receiving a request for a fair hearing, MAA may request additional information from the client 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.

(11) To be reimbursed, authorized First Steps childcare providers must submit claims for payment to MAA within ninety calendar days of the first date the childcare is provided. The childcare provider also must provide a W-9 form. The client receives the billing form and W-9 form from the authorizer listed in subsection (3) of this section, and gives the forms to the designated childcare provider.

(a) First Steps childcare billing form DSHS 14-316(X):

(i) Sections IV and V must be completed by the childcare provider and signed and dated (sections I, II, and if applicable, III, are completed by the authorizer).

(ii) The childcare provider mails the original completed form to MAA, or gives it to the client and the client gives the form to the authorizer, who submits it to MAA.

(b) W-9: The childcare provider completes and mails the original W-9 form to MAA, or gives the completed original to the client and the client gives it to the authorizer, who submits it to MAA. (An original W-9 is completed only once for MAA files unless the information changes.)

(12) MAA sets reimbursement for First Steps childcare services at a maximum dollar amount per hour from legislatively appropriated funds. Reimbursement is subject to any exceptions, restrictions, or other limitations listed in this section and other published WAC. MAA pays the childcare provider directly for First Steps childcare services when the client and the client's designated First Steps childcare provider meet all the criteria in this section.

(13) MAA reimburses MSS agencies for the time spent authorizing childcare through the First Steps childcare program if the client is not receiving MCM services. MAA reim-

burses once per client, per pregnancy/postpregnancy period, when childcare is authorized.

[Statutory Authority: RCW 74.08.090, 74.09.800. 01-15-008, § 388-533-1000, filed 7/6/01, effective 8/6/01.]

Chapter 388-535 WAC
DENTAL-RELATED SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-535-1250 Orthodontic coverage for DSHS children. [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.] Repealed by 02-01-050, filed 12/11/01, effective 1/11/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225.

WAC 388-535-1230 Crowns. (1) Subject to the limitations in WAC 388-535-1100, MAA covers the following crowns without prior authorization:

(a) Stainless steel, and

(b) Nonlaboratory resin for primary anterior teeth.

(2) MAA does not cover laboratory-processed crowns for posterior teeth.

(3) MAA requires prior authorization for the following crowns, which are limited to single restorations for permanent **anterior** (upper and lower) teeth:

(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).

(4) Criteria for covered crowns as described in subsections (1) and (3) of this section:

(a) Crowns may be authorized when the crown is **dentally necessary**.

(b) Coverage is based upon a supportable five year prognosis that the client will retain the tooth if the tooth is crowned. The provider must submit the following client 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.

(5) The laboratory processed crowns described in subsection (3) are covered:

(a) Only when a lesser service will not suffice because of extensive coronal destruction, and treatment is beyond intracoronal restoration;

(b) Only once per permanent tooth in a five year period;

(c) 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.

(6) MAA reimburses only for covered crowns as described in subsections (1) and (3) of this section. The reimbursement is full payment; all of the following are included in the reimbursement and must not be billed separately:

(a) Tooth and soft tissue preparation;

(b) Amalgam or acrylic build-ups;

(c) Temporary restoration;

(d) Cement bases;

(e) Insulating bases;

(f) Impressions;

(g) Seating; and

(h) Local anesthesia.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520. 01-07-077, § 388-535-1230, filed 3/20/01, effective 4/20/01. 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, § 388-535-1230, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1250 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-535A WAC
ORTHODONTIC SERVICES

WAC

WAC 388-535A-0010 Definitions for orthodontic services. The following definitions 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.

"Appliance placement" means the application of orthodontic attachments to the teeth for the purpose of correcting dentofacial abnormalities.

"Cleft" means an opening or fissure involving the dentition and supporting structures especially one occurring in utero. These can be:

(1) Cleft lip;

(2) Cleft palate (involving the roof of the mouth); or

(3) Facial clefts (e.g., macrostomia).

"Comprehensive full orthodontic treatment" means utilizing fixed orthodontic appliances for treatment of the permanent dentition leading to the improvement of a patient's severe handicapping craniofacial dysfunction and/or dentofacial deformity, including anatomical and functional relationships.

"Craniofacial anomalies" means abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures.

"Craniofacial team" means a department of health- and medical assistance administration-recognized cleft palate/maxillofacial team or an American Cleft Palate Association-certified craniofacial team. These teams are responsible for management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provide integrated case management, to promote parent-professional partnership, and make appropriate referrals to implement and coordinate treatment plans.

"Dental dysplasia" means an abnormality in the development of the teeth.

"EPSDT" means the department's early and periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in chapter 388-534 WAC.

"Hemifacial microsomia" means a developmental condition involving the first and second brachial arch. This creates an abnormality of the upper and lower jaw, ear, and associated structures (half or part of the face appears smaller sized).

"Interceptive orthodontic treatment" means procedures to lessen the severity or future effects of a malformation and to affect or eliminate the cause. It is an extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate.

"Limited transitional orthodontic treatment" means orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed only at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

"Malocclusion" means the abnormal contact between the upper and lower teeth that interferes with the highest efficiency during the movements of the jaw that are essential to chewing.

"Maxillofacial" means relating to the jaws and face.

"Occlusion" means the relation of the upper and lower teeth when in functional contact during jaw movement.

"Orthodontics" means 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.

"Orthodontist" means a dentist who specializes in orthodontics, who is a graduate of a postgraduate program in orthodontics that is accredited by the American Dental Association, and who meets the licensure requirements of the department of health.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0010, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0020 Eligibility for orthodontic services. (1) Subject to the limits of this chapter, the **medical assistance administration (MAA)** covers **medically necessary** orthodontic treatment for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate for children only, as follows:

(a) Clients in the **categorically needy** program (CN) receive orthodontic services through age twenty;

(b) Clients in the **children's health program** receive orthodontic services through age eighteen; and

(c) Clients in the **EPSDT** program receive orthodontic services through age twenty.

(2) MAA does not cover orthodontic services for adults.

(3) Eligible clients in department-designated border areas may receive the same orthodontic services as if provided in-state.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0020, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0030 Providers of orthodontic services. With prior approval from MAA, except as indicated under WAC 388-535A-0050, the following providers may furnish and be reimbursed for covered **comprehensive full orthodontic treatment, interceptive orthodontic treatment** (see WAC 388-535A-0060(7)), or **limited orthodontic treatment** (see WAC 388-535A-0060(8)), furnished to MAA clients:

(1) Dentists who specialize in orthodontics;

(2) Pediatric dentists who provide MAA-approved orthodontic services;

(3) General dentists who provide MAA-approved orthodontic services; and

(4) Oral surgeons who provide MAA-approved orthodontic services.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0030, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0040 Orthodontic coverage. (1) MAA covers medically necessary orthodontic treatment for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate when the client meets the eligibility requirements in WAC 388-535A-0020 and the medical conditions in this section. The client must have one of the following:

(a) Cleft (lip or palate), or craniofacial anomaly when the client is treated by and receives follow-up care by a department-recognized 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 dental dysplasia;

(D) Arthrogryposis; or

(E) Marfan syndrome.

(iii) Other medical conditions with significant facial growth impact (e.g., juvenile rheumatoid arthritis (JRA)); or

(iv) Post traumatic, post radiation, or post burn jaw deformity.

(b) Other severe handicapping malocclusions, including one or more of the following:

(i) Deep impinging overbite when lower incisors are destroying the soft tissues of the palate;

(ii) Crossbite of individual anterior teeth when destruction of the soft tissue is present;

(iii) Severe traumatic malocclusion (e.g., loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology);

(iv) Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties; or

(v) Medical conditions as indicated on the Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score that result in a score of twenty-five or higher. MAA reviews all requests for treatment for conditions that result in a score of less then twenty-five, based on medical necessity on a case-by-case basis.

(2) MAA may cover requests for orthodontic treatment for dental malocclusions, other than those listed in subsection (1) of this section when MAA determines that the treatment is medically necessary.

(3) MAA reviews requests for orthodontic treatment for children who are eligible for services under the EPSDT program according to the provisions of WAC 388-534-0100.

(4) MAA covers orthodontic appliance removal for a client whose appliance was placed by a provider not participating with MAA, or whose payment MAA did not cover.

(5) MAA does not cover lost or broken orthodontic appliances.

(6) MAA covers panoramic radiographs (x-rays) once in a three-year period.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0040, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0050 Authorization, prior authorization, and expedited prior authorization for orthodontic services. (1) When MAA authorizes a service, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for the covered service at the time the service is provided.

(2) MAA does not require prior authorization for orthodontic treatment of a client with cleft lip, cleft palate, or craniofacial anomaly when the client is:

(a) Eligible under WAC 388-535A-0020; and

(b) Being treated by a department-recognized cleft palate or craniofacial team.

(3) MAA requires prior authorization for orthodontic treatment of:

(a) Severe handicapping malocclusions;

(b) Dental malocclusions that result in severe dental functional impairment;

(c) Those cases that result in a score less than thirty on the Washington Modified HLD Index Scale; and

(d) Services provided per WAC 388-535A-0030.

(4) MAA allows orthodontists to use expedited prior authorization (EPA) for those cases that score thirty or more on the Washington Modified HLD Index Scale. The EPA process is designed to eliminate the need for telephone prior authorization for selected procedures. The orthodontist must create an authorization number using the process explained in MAA's orthodontic billing instructions. When MAA finds that a provider is using EPA inappropriately, MAA may:

(a) Require the provider to obtain prior authorization from MAA before providing services to any client; or

(b) Take one or more of the actions in WAC 388-502-0230(3).

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0050, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0060 Reimbursement for orthodontic services. (1) MAA considers that a provider who furnishes covered orthodontic services to an eligible client has accepted MAA's rates and fees.

(2) Payment for orthodontic services is based on MAA's schedule of maximum allowances; fees listed in the fee schedule are the maximum allowable fees.

(3) MAA uses state-assigned procedure codes to identify covered orthodontic services.

(4) MAA does not cover out-of-state orthodontic treatment.

(5) Orthodontic providers who are in department-designated border areas must:

(a) Meet the licensure requirements of their state; and

(b) Meet the same criteria for payment as in-state providers, including the requirements to contract with MAA.

(6) MAA reimburses for interceptive orthodontic treatment for cleft palate or craniofacial anomaly per WAC 388-535A-0050.

(7) With the exception of the conditions listed in subsection (6) of this section, MAA reimburses for interceptive orthodontic treatment once per client's lifetime for clients with severe handicapping malocclusions.

(8) MAA reimburses for limited transitional orthodontic treatment for a maximum of one year from original appliance placement. Follow up treatment is allowed in three-month increments, beginning three months after the initial placement.

(9) MAA reimburses for comprehensive full orthodontic treatment up to a maximum of two years from original appliance placement. Six follow up treatments are allowed in three-month increments, beginning six months after the initial placement.

(10) If the client's eligibility for orthodontic treatment under WAC 388-535A-0020 ends before the conclusion of the orthodontic treatment, payment for any remaining treatment is the individual's responsibility; MAA does not reimburse for these services.

(11) The client is responsible for payment of any orthodontic service or treatment received during any period of ineligibility, even if the treatment was started when the client was eligible; MAA does not reimburse for these services.

(12) The client is responsible for paying for services when the client has not disclosed coverage to the provider,

per WAC 388-502-0160 and 388-501-0200; MAA does not reimburse in these situations.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0060, filed 12/11/01, effective 1/11/02.]

Chapter 388-538 WAC
MANAGED CARE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-538-066 Children's health insurance program (CHIP) enrollees. [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.] Repealed by 02-01-075, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396.

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.

"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.

"Assign" or **"assignment"** means that MAA selects a managed care organization (MCO) or primary care case management (PCCM) provider to serve a client who lives in a mandatory enrollment area and who has failed to select an MCO or PCCM provider.

"Basic health (BH)" means the health care program authorized by title 70.47 RCW and administered by the health care authority (HCA). MAA considers basic health to be third-party coverage, however, this does not include basic health plus (BH+).

"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). This program also is referred to as the state children's health insurance program (SCHIP).

"Children with special health care needs" means children identified by the department of social and health services (DSHS) as having special health care needs. This includes:

(1) Children designated as having special health care needs by the department of health (DOH) and served under the Title V program;

(2) Children who meet disability criteria of Title 16 of the Social Security Act (SSA); and

(3) Children who are in foster care or who are served under subsidized adoption.

"Client" means an individual eligible for any medical program who is not enrolled with a managed care organization (MCO) 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 managed care, either with a managed care organization (MCO) or with a primary care case management (PCCM) provider, 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 [managed] care organization (MCO) 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, not currently enrolled in managed care, makes a preenrollment request to remain in

the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-080.

"Health care service" or **"service"** means a service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.

"Healthy options contract or HO contract" means the agreement between the department of social and health services (DSHS) and a managed care organization (MCO) to provide prepaid contracted services to enrollees.

"Healthy options program or HO program" means the medical assistance administration's (MAA) prepaid managed care health program for Medicaid-eligible clients and CHIP clients.

"Managed care" means a comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider.

"Managed care organization" or **"MCO"** means a health maintenance organization or health care service contractor that contracts with the department of social and health services (DSHS) under a comprehensive risk contract to provide prepaid health care services to eligible medical assistance administration (MAA) clients under MAA's managed care programs.

"Nonparticipating provider" means a person or entity that does not have a written agreement with a managed care organization (MCO) but that provides MCO-contracted health care services to managed care enrollees with the authorization of the MCO. The MCO is solely responsible for payment for MCO-contracted health care services that are authorized by the MCO and provided by nonparticipating providers.

"Participating provider" means a person or entity with a written agreement with a managed care organization (MCO) to provide health care services to managed care enrollees. A participating provider must look solely to the MCO for payment for such services.

"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, an 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.

"Prior authorization (PA)" means a process by which enrollees or providers must request and receive MAA approval for certain medical services, equipment, drugs, and 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. See WAC 388-501-0165.

"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 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-050, filed 12/14/01, effective 1/14/02. 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.]

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 388-538-060 Managed care and choice. (1) A client is required to enroll in managed care when that client meets all of the following conditions:

(a) Is eligible for one of the medical programs for which clients must enroll in managed care;

(b) Resides in an area, determined by the medical assistance administration (MAA), where clients must enroll in managed care;

(c) Is not exempt from managed care 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 managed care 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) Enrollment with a managed care organization (MCO) available in their area;

(b) Enrollment with an Indian or tribal primary care case management (PCCM) provider available in their area; or

(c) MAA's fee-for-service system.

(3) A client may enroll with an MCO or PCCM provider by calling MAA's toll-free enrollment line or by sending a completed enrollment form to MAA.

(a) Except as provided in subsection (2) of this section for clients who are AI/AN and in subsection (5) of this section for cross-county enrollment, a client required to enroll in managed care must enroll with an MCO or PCCM provider available in the area where the client lives.

(b) All family members must either enroll with the same MCO or enroll with PCCM providers.

(c) Enrollees may request an MCO or PCCM provider change at any time.

(d) When a client requests enrollment with an MCO 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 an MCO or PCCM provider as follows:

(a) If the client has family members enrolled with an MCO, the client is enrolled with that MCO;

(b) If the client does not have family members enrolled with an MCO, and the client was enrolled in the last six

months with an MCO or PCCM provider, the client is re-enrolled with the same MCO or PCCM provider;

(c) If a client does not choose an MCO or a PCCM provider, but indicates a preference for a provider to serve as the client's primary case provider (PCP), MAA attempts to contact the client to complete the required choice. If MAA is not able to contact the client in a timely manner, MAA documents the attempted contacts and, using the best information available, assigns the client as follows. If the client's preferred PCP is:

(i) Available with one MCO, MAA assigns the client in the MCO where the client's PCP provider is available. The MCO is responsible for PCP choice and assignment;

(ii) Available only as a PCCM provider, MAA assigns the client to the preferred provider as the client's PCCM provider;

(iii) Available with multiple MCOs or through an MCO and as a PCCM provider, MAA assigns the client to an MCO as described in (d) of this subsection;

(iv) Not available through any MCO or as a PCCM provider, MAA assigns the client to an MCO or PCCM provider as described in (d) of this subsection.

(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 an MCO or PCCM provider, MAA assigns the client to a tribal PCCM provider if that client lives in a zip code served by a tribal PCCM provider. If there is no tribal PCCM provider in the client's area, the client continues to be served by MAA's fee-for-service system. A client assigned under this subsection may request to end enrollment at any time.

(ii) If a non-AI/AN client does not choose an MCO or PCCM provider, MAA assigns the client to an MCO or PCCM provider available in the area where the client lives. The MCO is responsible for PCP choice and assignment. An MCO must meet the healthy options (HO) contract's access standards unless the MCO has been granted an exemption by MAA. The HO contract standards are as follows:

(A) There must be two PCPs within ten miles for ninety percent of HO enrollees in urban areas and one PCP within twenty-five miles for ninety percent of HO enrollees in rural areas;

(B) There must be two obstetrical providers within ten miles for ninety percent of HO enrollees in urban areas and one obstetrical provider within twenty-five miles for ninety percent of HO enrollees in rural areas;

(C) There must be one hospital within twenty-five miles for ninety percent of HO enrollees in the contractor's service area;

(D) There must be one pharmacy within ten miles for ninety percent of HO enrolles in urban areas and one pharmacy within twenty-five miles for ninety percent of HO enrollees in rural areas.

(iii) MAA sends a written notice to each household of one or more clients who are assigned to an MCO or PCCM provider. The notice includes the name of the MCO or PCCM provider to which each client has been assigned, the effective date of enrollment, the date by which the client must respond in order to change MAA's assignment, and either the toll-free telephone number of:

(A) The MCO for enrollees assigned to an MCO; or

(B) MAA for enrollees assigned to a PCCM provider.

(iv) An assigned client has at least thirty calendar days to contact MAA to change the MCO or PCCM provider assignment 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) An MCO enrollee's selection of the enrollee's PCP or the enrollee's assignment to a PCP occurs as follows:

(a) MCO enrollees may choose:

(i) A PCP or clinic that is in the enrollee's MCO and accepting new enrollees; or

(ii) Different PCPs or clinics participating with the same MCO for different family members.

(b) The MCO assigns a PCP or clinic that meets the access standards set forth in subsection (4)(d)(ii) of this section if the enrollee does not choose a PCP or clinic;

(c) MCO enrollees may change PCPs or clinics in an MCO at least once a year for any reason, and at any time for good cause; or

(d) In accordance with this subsection, MCO enrollees may file an appeal with the MCO and/or a fair hearing request with the department of social and health services (DSHS) and may change plans if the MCO denies an enrollee's request to change PCPs or clinics.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-060, filed 12/14/01, effective 1/14/02. 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 (BH) enrollees. (1) Certain children and pregnant women who have applied for, or are enrolled in, managed care through basic health (BH) (chapter 70.47 RCW) are eligible for Medicaid under pediatric and maternity expansion provisions of the Social Security Act. The medical assistance administration (MAA) determines Medicaid eligibility for children and pregnant women who enroll through BH.

(2) The administrative rules and regulations that apply to managed care enrollees also apply to Medicaid-eligible clients enrolled through BH, except as follows:

(a) The process for enrolling in managed care described in WAC 388-538-060(3) does not apply since enrollment is through the health care authority, the state agency that administers BH;

(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 BH-contracted MCO.

(c) If a Medicaid eligible client applying for BH does not choose an MCO within ninety days, the client is transferred from BH to the department of social and health services (DSHS) for assignment to managed care.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-065, filed 12/14/01, effective 1/14/02. 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-538-067 Managed care provided through managed care organizations (MCOs). (1) Managed care organizations (MCOs) may contract with the department of social and health services (DSHS) to provide prepaid health care services to eligible medical assistance administration (MAA) clients under the healthy options (HO) managed care program. The MCOs must meet the qualifications in this section to be eligible to contract with DSHS. The MCO must:

(a) Have a certificate of registration from the office of the insurance commissioner (OIC) as either a health maintenance organization (HMO) or a health care services contractor (HCSC).

(b) Accept the terms and conditions of DSHS' HO contract;

(c) Be able to meet the network and quality standards established by DSHS; and

(d) Accept the prepaid rates published by DSHS.

(2) DSHS reserves the right not to contract with any otherwise qualified MCO.

[Statutory Authority: RCW 74.09.080, RCW 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-067, filed 12/14/01, effective 1/14/02.]

WAC 388-538-068 Managed care provided through primary care case management (PCCM). (1) A provider may contract with DSHS as a primary care case management (PCCM) provider to provide health care services to eligible medical assistance administration (MAA) clients under MAA's managed care program. The PCCM provider or the individual providers in a PCCM group or clinic must:

(a) Have a core provider agreement with DSHS;

(b) Hold a current license to practice as a physician, certified nurse midwife, or advanced registered nurse practitioner in the state of Washington;

(c) Accept the terms and conditions of DSHS' PCCM contract;

(d) Be able to meet the quality standards established by DSHS; and

(e) Accept PCCM rates published by DSHS.

(2) DSHS reserves the right not to contract for PCCM with an otherwise qualified provider.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-068, filed 12/14/01, effective 1/14/02.]

WAC 388-538-070 Managed care payment. (1) The medical assistance administration (MAA) pays managed care organizations (MCOs) monthly capitated premiums that:

(a) Have been determined using generally accepted actuarial methods based on analyses of historical healthy options (HO) contractual rates and MCO experience in providing health care for the populations eligible for HO; and

(b) Are paid based on legislative allocations for the HO program.

(2) MAA pays primary care case management (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 MCO's responsibility under the HO contract, even if the MCO has not paid for the service for any reason. The MCO is solely responsible for payment of MCO-contracted health care services:

(a) Provided by an MCO-contracted provider; or

(b) That are authorized by the MCO and provided by nonparticipating providers.

(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 MCOs through the FQHC or RHC. MCOs may contract with FQHCs and RHCs to provide services under HO. FQHCs and RHCs receive an enhancement rate from MAA on a per member, per month basis in addition to the negotiated payments they receive from the MCOs for services provided to MCO enrollees.

(a) MAA pays the enhancement rate only for the categories of service provided by the FQHC or RHC under the HO contact [contract]. 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 (FFS) 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) - (FFS 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, by the 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 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-070, filed 12/14/01, effective 1/14/02. 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 Managed care exemptions. (1) The medical assistance administration (MAA) exempts a client from mandatory enrollment in managed care if MAA becomes aware of the following conditions. The client:

(a) Is receiving foster care placement services from the division of children and family services (DCFS); or

(b) Has Medicare, basic health (BH), CHAMPUS/TRICARE, or other accessible third-party health care coverage that would require exemption from enrollment with:

(i) A managed care organization (MCO) in accordance with MAA's healthy options (HO) contract requirements for MCO enrollment; or

(ii) A primary care case management provider (PCCM) in accordance with MAA's PCCM contract requirements for PCCM enrollment.

(2) Only a client or a client's representative (RCW 7.70.065) may request an exemption from managed care enrollment for reasons other than those stated in subsection (1) of this section. 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.

(3) MAA grants a client's request for an exemption from mandatory enrollment in managed care if any of the following apply:

(a) The client has a documented and verifiable medical need to continue a client/provider relationship due to an established course of care with a physician, physician assistant or advanced registered nurse practitioner. MAA accepts the established provider's signed statement that the client has:

(i) A medical need that requires a continuation of the established care relationship; and

(ii) The client's established provider is not available through any managed care organization (MCO) or as a primary care case management (PCCM) provider.

(b) Prior to enrollment, the client scheduled a surgery with a provider not available to the client through managed care and the surgery is scheduled within the first thirty days of enrollment; or

(c) The client is American Indian/Alaska Native (AI/AN) as specified in WAC 388-538-060(2) and requests exemption; or

(d) The client has been identified by MAA as having special needs that meet MAA's definition of children with special health care needs and requests exemption; or

(e) 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 managed care; or

(f) On a case-by-case basis, the client presents evidence that managed care 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 speaks limited English or is 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 available through managed care;

(iii) The client shows that travel to a managed care PCP is unreasonable when compared to travel to a nonmanaged care primary care provider (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 managed care PCP who is accepting enrollees, and the client's PCP is closer and not in an available plan;

(B) The travel time is over forty-five minutes one-way to the nearest managed care PCP who is accepting enrollees, and the travel time to the client's PCP, who is not available in an MCO or as a PCCM provider, is less;

(C) Other transportation difficulties make it unreasonable to get primary medical services under HO; or

(iv) Other evidence is presented that an exemption is appropriate based on the client's circumstances, as evaluated by MAA.

(4) 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 the client's fair hearing rights.

(5) The client is not enrolled as provided in subsection (2) 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 managed care. 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 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-080, filed 12/14/01, effective 1/14/02. 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) Managed care enrollees are eligible for the scope of medical care as described in WAC 388-529-0100 for categorically needy clients.

(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005.

(b) The managed care organization (MCO) covers the services included in the healthy options (HO) contract for MCO enrollees. In addition, MCOs may, at their discretion, cover services not required under the HO contract.

(c) The medical assistance administration (MAA) covers the categorically needy services not included in the HO contract for MCO enrollees.

(d) MAA covers services on a fee-for-service basis for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services needed by the enrollee or refer the enrollee to other providers who are contracted with MAA for covered services. The PCCM provider is responsible for instructing the enrollee regarding how to obtain the services that are referred by the PCCM provider. The services that require PCCM provider referral are described in the PCCM contract. MAA informs enrollees about the enrollee's program coverage, limitations to covered services, and how to obtain covered services.

(e) MCO enrollees may obtain certain services from either a MCO provider or from a medical assistance provider with a DSHS core provider agreement without needing to obtain a referral from the PCP or MCO. These services are described in the HO contract, and are communicated to enrollees by MAA and MCOs as described in (f) of this subsection.

(f) 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 MCOs. In addition, MAA requires MCOs to provide new enrollees with written information about covered services.

(2) For services covered by MAA through PCCM contracts for managed care:

(a) MAA medically necessary covers services included in the categorically needy scope of care and rendered by providers with a current department of social and health services (DSHS) core provider agreement to provide the requested service;

(b) MAA may require the PCCM provider to obtain authorization from MAA for coverage of nonemergency services;

(c) The PCCM provider determines which services are medically necessary;

(d) An enrollee may request a fair hearing for review of PCCM provider or MAA coverage decisions; and

(e) Services referred by the PCCM provider require an authorization number in order to receive payment from MAA.

(3) For services covered by MAA through contracts with MCOs:

(a) MAA requires the MCO to subcontract with a sufficient providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;

(b) MAA requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;

(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), or the provider to obtain authorization from the MCO, according to the requirements of the HO contract;

(d) MCOs 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 an MCO coverage decisions using the MCO's appeal process, as described in WAC 388-538-0110. An enrollee may also request a hearing for review of an MCO 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 MCO. Any covered services ordered and/or prescribed by the women's health care provider must meet the MCO's service authorization requirements for the specific service.

(4) Unless the MCO chooses to cover these services, or an appeal or a fair hearing decision reverses an MCO or MAA 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 MCO enrollees:

(i) Services received from a participating specialist that require prior authorization from the MCO, but were not authorized by the MCO; and

(ii) Services received from a nonparticipating provider that require prior authorization from the MCO that were not authorized by the MCO. All nonemergency services covered under the HO contract and received from nonparticipating providers require prior authorization from the MCO.

(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 MCO;

(iii) An explanation of why the service is not covered by the MCO 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 MCO, but the enrollee chooses to pay for the service from a provider not participating with the MCO;

(B) The MCO has not authorized emergency department services for nonemergency medical conditions and the enrollee chooses to pay for the emergency department's services rather than wait to receive services at no cost in a participating provider's office; or

(C) The MCO or PCCM 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 MCO 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 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-095, filed 12/14/01, effective 1/14/02. 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 the medical assistance administration's (MAA's) fee-for-service system.

(a) The managed care organization (MCO) covers emergency services for MCO enrollees.

(b) MAA covers emergency services for primary care case management (PCCM) enrollees.

(2) Emergency services for emergency medical conditions do not require prior authorization by the MCO, primary care provider (PCP), PCCM provider, or MAA.

(3) Emergency services received by an MCO enrollee for nonemergency medical conditions must be authorized by the plan for enrollee's MCO.

(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 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-100, filed 12/14/01, effective 1/14/02. 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 an MAA, MCO, PCCM, PCP or provider decision, action, or inaction. An enrollee may do this through the following process:

(a) For managed care organization (MCO) enrolles [enrollees], the MCO's complaint and appeal processes, and through the department's fair hearing process; or

(b) For primary care case management (PCCM) enrollees, the complaint and appeal processes of the medical assistance administration (MAA), and through the department's fair hearing process (chapter 388-02 WAC).

(2) To ensure the rights of MCO enrollees are protected, MAA approves each MCO's complaint and appeal policies and procedures annually or whenever the plan makes a change to the process.

(3) MAA requires MCOs to inform MCO enrollees in writing within fifteen days of enrollment about their rights and how to use the MCO's complaint and appeal processes. MAA requires MCOs to obtain MAA approval of all written information sent to enrollees.

(4) MAA provides PCCM enrollees with information equivalent to that described in subsection (3) of this section.

(5) MCO enrollees may request assistance from the MCO when using the MCO's complaint and appeals processes. PCCM enrollees may request assistance from MAA when using MAA's complaint and appeal process.

(6) An MCO enrollee who submits a complaint under this section is entitled to a written or verbal response from the MCO or from MAA within the timeline in the MAA-approved complaint process.

(7) When an enrollee is not satisfied with how the complaint is resolved by the MCO or by MAA, or if the complaint is not resolved in a timely fashion, the enrollee may submit an appeal to the MCO or to MAA. An enrollee may also appeal an MAA, MCO, primary care provider (PCP), or provider decision, or reconsideration of any action or inaction. An enrollee who appeals an MAA, MCO, 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 an MCO or MAA 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 MAA or the MCO, within the timeline(s) in the appeal process standards, in the enrollee's primary language. The decision does not need to be translated if an enrollee with limited English proficiency prefers correspondence in English, and the deciding authority documents the enrollee's preference. The notice must clearly explain all of the following:

(i) The decision and any action MAA or the MCO intends to take;

(ii) The reason for the decision;

(iii) The specific information that supports MAA's or the MCO'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.

(8) An enrollee may file a fair hearing request without also filing an appeal with MAA or the MCO or exhausting MAA's or the MCO's appeal process.

(9) The MCO's medical director or designee reviews all fair hearings requests, and any related appeals, when the issues involve an MCO's determination of medical necessity.

(10) MAA's medical director or the medical director's designee reviews all fair hearings requests, and any related appeals, when the PCCM enrollee's issues involve an MAA determination of medical necessity.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-110, filed 12/14/01, effective 1/14/02. 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** 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 managed care organization (MCO); or

(b) The enrollee believes the MCO is not authorizing medically necessary care.

(2) A managed care enrollee has a right to a second opinion from a primary or specialty care physician who is participating with the MCO. At the MCO's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the MCO and the enrollee may provide the second opinion.

(3) Primary care case management (PCCM) provider enrollees have a right to a timely referral for a second opinion by another provider who has a core provider agreement with medical assistance administration (MAA).

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-120, filed 12/14/01, effective 1/14/02. 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 managed care. (1) MAA ends an enrollee's enrollment in a managed care organization (MCO) or with a primary care case management (PCCM) provider when the enrollee meets any of the following conditions. The enrollee:

(a) Is no longer eligible for a medical program subject to enrollment; or

(b) Is receiving foster care placement services from the division of children and family services; or

(c) Is or becomes eligible for Medicare, basic health (BH), CHAMPUS/TRICARE, or any other accessible third party health care coverage that would require involuntary disenrollment from:

(i) An MCO in accordance with MAA's healthy options (HO) contract for MCO enrollees; or

(ii) A PCCM provider in accordance with MAA's PCCM contract for PCCM enrollees.

(2) An enrollee or the enrollee's representative as defined in RCW 7.70.065 may request MAA to end enrollment as described in subsections (3) through (10) of this section. A managed care organization (MCO) may request MAA to end enrollment for an enrollee as described in subsection (11) of this section. Only MAA has authority to remove an enrollee from managed care. Pending MAA's final decision, the enrollee remains enrolled unless staying in managed care would adversely affect the enrollee's health status.

(3) MAA grants an enrollee's request to have the enrollee's enrollment ended under the following conditions:

(a) Is American Indian or Alaska Native (AI/AN) and requests disenrollment; or

(b) Is identified by DSHS as a child who meets the definition of "children with special health care needs" and requests disenrollment.

(4) MAA grants an enrollee's requests to be removed from managed care when the client is pregnant or when there is a verified medical need to continue an established course of care. These end enrollments are limited to the following situations: The enrollee:

(a) Has a documented medical need to continue a client/provider relationship due to an established course of care with a physician, physician assistant, or advanced registered nurse practitioner. The standards for documenting a medical need are those in WAC 388-538-080 (3)(a). The established course of care must begin:

(i) While the enrollee was enrolled with managed care but the PCP is no longer available to the enrollee under managed care; or

(ii) Prior to enrollment in managed care and the PCP is not available under any MCO or as a PCCM provider.

(b) Is pregnant and requests to continue her course of prenatal care that was established with an obstetrical provider:

(i) While she was enrolled with the MCO but that provider is no longer available to her in managed care; or

(ii) Prior to enrollment with the current MCO but that provider is not available to her under managed care.

(c) Is scheduled for a surgery with a provider not available to the enrollee in the enrollee's current MCO and the surgery is scheduled to be performed within the first thirty days of enrollment[.]

(5) Except as provided in subsection (4) of this section, MAA does not permit an enrollee to obtain an end enrollment by establishing a course of care with a provider who is not participating with the enrollee's MCO.

(6) MAA ends enrollment on a case-by-case basis when the enrollee presents evidence that the managed care program does not provide medically necessary care that is reasonable available and accessible as offered to the enrollee. MAA considers enrollee requests under this subsection with the same criteria as listed in WAC 388-538-080 (3)(f).

(7) MAA ends enrollment temporarily if an enrollee asks to be taken out of the current MCO in order to stay with the enrollee's established provider, but is willing to enroll in the established provider's MCO for the next enrollment month. MAA reviews the enrollee request according to the criteria in subsections (4) and (6) of this section. MAA's decision under this subsection include all of the following:

(a) The decision is given verbally and in writing;

(b) Verbal and written notices include the reason for the decision and information on hearings so the enrollee may appeal the decision;

(c) If the request to end enrollment is approved, it may be effective back to the beginning of the month the request is made; and

(d) If the request to end enrollment is denied, and the enrollee requests a hearing; the enrollee remains in the MCO or with the PCCM until the hearing decision is made as provided in subsection (2) of this section.

(8) 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.

(9) MAA does not approve an enrollee's request to end enrollment solely to pay for services received but not authorized by the MCO.

(10) The enrollee remains in managed care 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 (7) 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.

(11) MAA may end an enrollee's enrollment in a MCO or with a PCCM provider when the enrollee's MCO or PCCM provider substantiates in writing, to MAA's satisfaction, that:

(a) The enrollee's behavior is inconsistent with the MCO or PCCM provider rules and regulations, such as intentional misconduct; and

(b) After the MCO or PCCM provider 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 MCO or PCCM provider of the MCO or PCCM provider intent to request the enrollee's removal, unless MAA has waived the requirement for the MCO or PCCM provider notice because the enrollee's conduct presents the threat of imminent harm to others. The MCO or PCCM provider notice to the enrollee must include both of the following:

(i) The enrollee's right to use the appeal process as described in WAC 388-538-110 to review the MCO or PCCM provider request to end the enrollee's enrollment; and

(ii) The enrollee's right to use the department fair hearing process.

(12) MAA makes a decision to remove an enrollee from enrollment in managed care within thirty days of receiving the MCO or PCCM provider request to do so. Before making a decision, MAA attempts to contact the enrollee and learn the enrollee's perspective. If MAA approves the MCO or PCCM provider 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 enrollee's fair hearing rights.

(13) MAA does not approve a request to remove an enrollee from managed care 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 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-130, filed 12/14/01,

effective 1/14/02. 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, the medical assistance administration (MAA) does all of the following:

(a) Requires managed care organizations (MCOs) to have a fully operational quality assurance system that meets a comprehensive set of quality improvement program (QIP) standards.

(b) Monitors MCO performance through on-site visits and other audits, and requires corrective action for deficiencies that are found.

(c) Requires MCOs 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 individual MCO performance information and primary care case management (PCCM) program performance information including certain clinical measures and enrollee satisfaction surveys and makes reports of site monitoring visits available upon request.

(2) MAA requires MCOs and PCCM providers 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 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-140, filed 12/14/01, effective 1/14/02. 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

388-539-0500 Coordinated community aids service alternatives (CCASA) program services. [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.] Repealed by 01-23-045, filed 11/15/01, effective 12/16/01. Statutory Authority: RCW 74.08.090.

388-539-0550 Payment—Coordinated community aids service alternatives (CCSA) program. [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.] Repealed by 01-23-045, filed 11/15/01, effective 12/16/01. Statutory Authority: RCW 74.08.090.

WAC 388-539-0500 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-539-0550 Repealed. See Disposition Table at beginning of this chapter.

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, those found in WAC 388-538-050 and in 388-500-0005 Medical definitions, apply to this chapter.

"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). This program also is referred to as the state children's health insurance program (SCHIP).

"Client premium" means a monthly payment a client makes to the department of social and health services (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 term applies to the coverage 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. Extensions of such coverage (e.g., COBRA extensions) also qualify as employer-sponsored dependent coverage as long as there remains a contribution toward the premiums by the employer or union.

"Finance division" means the division of the department of social and health services that sends out billing statements, monitors accounts, and collects the CHIP client premiums.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0050, filed 12/14/01, effective 1/14/02. 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) Children's health insurance program (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 medical assistance administration (MAA) requires CHIP clients, except for clients who are American Indian or Alaska Native (AI/AN), to enroll in managed care according to WAC 388-538-060 (1)(b) through (5)(d). AI/AN clients may choose to receive services under MAA's fee-for-service system.

(3) For eligible CHIP clients who are not enrolled in managed care:

(a) MAA determines which services are medically necessary;

(b) Clients must obtain covered services from providers who have core provider agreements with MAA; and

(c) As a condition of coverage, MAA may require the service provider to obtain authorization from MAA for coverage of nonemergency services.

(4) A CHIP client enrolled in managed care may submit a complaint or appeal as described in WAC 388-538-110.

(5) Any CHIP client may request a fair hearing as described in chapter 388-02 WAC for review of MAA coverage decisions. Clients may elect to participate in a prehearing review as described in WAC 388-526-2610.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0100, filed 12/14/01, effective 1/14/02. 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) If a children's health insurance program (CHIP) client is subject to mandatory enrollment in a managed care organization (MCO) or with a primary care case management (PCCM) provider, the medical assistance administration (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 an MCO or with a PCCM provider. The same enrollment criteria are applied to CHIP clients as to categorically needy Medicaid clients under WAC 388-538-060.

(3) If a CHIP client is not already enrolled in managed care, the client may request an exemption to mandatory enrollment under the process described in WAC 388-538-080. MAA provides fee-for-service coverage while a client's request for exemption from mandatory enrollment in an MCO or with a PCCM provider is being considered and until a final decision is made.

(4) If a CHIP client is already enrolled in an MCO or with a PCCM provider and requests to end the enrollment, the client remains enrolled in the client's MCO or with the PCCM provider pending MAA's final decision. The process for ending enrollment is described in WAC 388-538-130.

(5) If a CHIP client has no MCO or PCCM provider available or is permitted to choose the fee-for-service system under this chapter, the rules that apply to service coverage and payment for the children's health program apply to CHIP coverage (chapters 388-550 through 388-556 WAC).

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0125, filed 12/14/01, effective 1/14/02. 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 the children's health insurance program (CHIP) a client must meet all of the following. The client must:

(a) Not have other creditable coverage (see WAC 388-542-0220(1)); and

(b) Meet the CHIP program requirements and conditions in WAC 388-505-0210(3).

(2) There are no resource standards for a CHIP client. See WAC 388-478-0075(3).

(3) CHIP eligibility certification periods are described in WAC 388-416-0015.

(4) CHIP eligibility is affected by changes in a client's circumstances. See WAC 388-418-0025 (2) and (6).

(5) Ongoing eligibility for CHIP requires the payment of CHIP premiums as described in WAC 388-542-0250. MAA enrolls an otherwise eligible client into the CHIP program in advance of any client premium payment.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0150, filed 12/14/01, effective 1/14/02. 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 enrollment. (1) If the area in which a CHIP client lives has more than one service delivery option available to the client, the client must make a choice concerning how to receive health care services. The choice and enrollment process for CHIP clients is the same as that for categorically needy Medicaid clients described in WAC 388-538-060.

(2) The medical assistance administration (MAA) enrolls CHIP clients in MAA's managed care program (with a managed care organization (MCO) or with a primary care case management (PCCM) provider) prospectively only.

(3) CHIP clients are enrolled in managed care as provided for categorically needy Medicaid clients in WAC 388-538-060.

(4) A client who is required to enroll in managed care may request a change in the client's MCO or PCCM provider on the same bases as in WAC 388-538-060.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0200, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0200, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0220 Ending CHIP client eligibility. (1) If the medical assistance administration (MAA) finds out after eligibility determination that a CHIP client has credit-

able coverage at the time of application, MAA ends the client's eligibility for CHIP effective at the close of the last day of the current month.

(2) MAA ends a client's eligibility for CHIP when the client owes four consecutive months of premiums, based on the due dates listed on the billing from the finance division for the client premium(s).

(3) When MAA ends a client's eligibility according to subsection (2) of this section, a client must meet both of the following conditions to become eligible for CHIP again:

(a) Pay all unforgiven past due premiums (see WAC 388-542-0250(5); and

(b) Serve a waiting period of four consecutive months. The waiting period begins the day after termination of CHIP coverage for nonpayment of premiums as described in this section. The waiting period ends once four full consecutive months of CHIP noncoverage has elapsed. The client does not have CHIP coverage during the waiting period.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0220, filed 12/14/01, effective 1/14/02.]

WAC 388-542-0250 CHIP client costs. (1) The finance division charges ten dollars per covered child, per month, for the CHIP 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 limits a client's out-of-pocket expenses for covered services the client obtains under the CHIP program rules, to the payment of premiums described in subsection (1) if this section.

(4) MAA exempts American Indian/Alaska Native (AI/AN) clients from paying client premiums for coverage under the CHIP program.

(5) MAA forgives client premiums that are more than twelve months overdue.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0250, filed 12/14/01, effective 1/14/02. 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) For contractors serving CHIP clients enrolled in managed care, MAA reimburses contracted managed care organizations (MCOs), primary care case management (PCCM) providers and providers of approved or ancillary care in the same way as described in chapter 388-538 WAC.

(2) For providers of services serving CHIP clients under MAA's fee-for-service system and without the involvement of MCOs or PCCMs, MAA reimburses according to the regulations that apply to categorically needy Medicaid clients under chapters 388-500 through 388-556 WAC.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0275, filed 12/14/01, effective 1/14/02. 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) The medical assistance administration (MAA) requires applicants to serve a full four-consecutive-month waiting period for CHIP coverage if the client or family:

(a) Chooses to end employer sponsored dependent coverage. The waiting period begins the day after the employment-based coverage ends, and ends on the last day of the fourth full month of noncoverage; or

(b) Fails to exercise an optional coverage extension (e.g., COBRA) that meets the following conditions. The waiting period begins on the day there is a documented refusal of the coverage extension when the extended coverage is:

(i) Subsidized in part or in whole by the employer or union;

(ii) Available and accessible to the applicant or family; and

(iii) At a monthly cost to the family meeting the limitation of subsection (2)(b)(iv).

(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 with no post-employment subsidized coverage as described in subsection (1)(b);

(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 caused the loss of coverage for the victim.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0300, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0300, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0500 Managed care rules that apply to CHIP. (1) In addition to the other rules that are incorporated by reference elsewhere in this chapter, the medical assistance administration (MAA) applies the following rules from chapter 388-538 WAC to the CHIP program:

(a) WAC 388-538-060, Managed care and choice, with the exception of subsection (1)(a);

(b) WAC 388-538-070, Managed care payment;

(c) WAC 388-538-080, Managed care exemptions;

(d) WAC 388-538-095, Scope of care for managed care enrollees;

(e) WAC 388-538-100, Managed care emergency services;

(f) WAC 388-538-110.[,] Managed care complaints, appeals and fair hearings;

(g) WAC 388-538-120, Enrollee requests for a second medical opinion;

(h) WAC 388-538-130, Ending enrollment in healthy options; and

(i) WAC 388-538-140, Quality of care.

[Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0500, filed 12/14/01, effective 1/14/02.]

Chapter 388-543 WAC

DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES

WAC

WAC 388-543-1150 Limits and limitation extensions.

The medical assistance administration (MAA) covers non-DME (MSE), DME, and related supplies, prosthetics, orthotics, medical supplies, and related services as described in WAC 388-543-1100(1). MAA Limits the amount, frequency, or duration of certain covered MSE, DME, and related supplies, prosthetics, orthotics, medical supplies, and related services, and reimburses up to the stated limit without requiring prior authorization. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client. In order to exceed the stated limits, the provider must request a limitation extension (LE), which is a form of prior authorization (PA). MAA approves such requests for LE when medical necessary, under the standards for covered services in WAC 388-501-0165. Procedures for LE are found in MAA's billing instructions. The following items and quantities do not require prior authorization; requests to exceed the stated quantities require LE:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - one eight ounce bottle per month;

(b) Alcohol wipes (box of two hundred) - one box per month;

(c) Betadine or pHisoHex solution - one pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - one box per month;

(e) Disinfectant spray - one twelve ounces bottle or can per six month period; or

(f) Periwash (when soap and water are medically contraindicated) - one five ounce bottle of concentrate solution per six-month period.

(2) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - one in a three month period; and

(b) Spring-powered device for lancet - one in a six-month period.

(3) Braces, belts and supportive devices:

(a) Custom vascular supports (CVS) - two pair per six-month period. CVS fitting fee - two per six-month period;

(b) Surgical stockings (below-the-knee, above-the-knee, thigh-high, or full-length) - two pair per six-month period;

(c) Graduated compression stockings for pregnancy support (pantyhose style) - two per twelve-month period;

(d) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - two per twelve-month period;

(e) Ankle, elbow, or wrist brace - two per twelve-month period;

(f) Lumbosacral brace, rib belt, or hernia belt - one per twelve-month period;

(g) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - one per twelve-month period.

(4) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - one per twelve-month period;

(b) Synthetic or lambs wool sheepskin pad - one per twelve-month period;

(c) Heel or elbow protectors - four per twelve-month period.

(5) Ostomy supplies:

(a) Adhesive for ostomy or catheter: cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - ten per month.

(c) Adhesive remover or solvent - three ounces per month.

(d) Adhesive remover wipes, fifty per box - one box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - ten per month.

(g) Continent plug for continent stoma - thirty per month.

(h) Continent device for continent stoma - one per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - ten per month.

(m) Irrigation bag - two every six months.

(n) Irrigation cone and catheter, including brush - two every six months.

(o) Irrigation supply, sleeve - one per month.

(p) Ostomy belt (adjustable) for appliance - two every six months.

(q) Ostomy convex insert - ten per month.

(r) Ostomy ring - ten per month.

(s) Stoma cap - thirty per month.

(t) Ostomy faceplate - ten per month. MAA does not allow the following to be used on a faceplate in combination with drainable pouches (refer to the billing instructions for further details):

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(6) Supplies associated with client-owned transcutaneous electrical nerve stimulators (TENS):

(a) For a four-lead TENS unit - two kits per month. (A kit contains two leads, conductive paste or gel, adhesive, adhesive remover, skin preparation material, batteries, and a battery charger for rechargeable batteries.)

(b) For a two-lead TENS unit - one kit per month.

(c) TENS tape patches (for use with carbon rubber electrodes only) are allowed when they are not used in combination with a kit(s).

(d) A TENS stand alone replacement battery charger is allowed when it is not used in combination with a kit(s).

(7) Urological supplies - diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., adult briefs/child diapers, pull-up training pants, underpads for beds, and liners/shields). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic; and

(v) The product must meet the flammability requirements of both federal law and industry standards.

(b) In addition to the standards in subsection (a) of this section, adult briefs/child diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a backsheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a topsheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For adult briefs, at least four tapes, two on each side.

(B) For child diapers, at least two tapes, one on each side.

(C) The tape adhesive must release from the backsheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up training pants and incontinent pants must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a backsheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads for beds must meet the following specifications. They must:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred-forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(iv) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners/shields (including pads and undergarments) must meet the following specifications. They must:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) MAA covers the products in this subsection only when they are used alone; they cannot be used in combination with each other. MAA approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use (see MAA's billing instructions for how to specify this when billing). The total of all

products used cannot exceed the monthly limitation for the product with the highest limit (see subsections (g), (h), (i), (j), (k), (l), and (m) of this section for product limitations). The following products cannot be used together:

(i) Disposable briefs (incontinent pants)/diapers;

(ii) Disposable pull-up training pants;

(iii) Disposable liners/pads;

(iv) Rented reusable briefs/diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (incontinent pants) (e.g., from a diaper service), or pull-up training pants.

(g) Purchased disposable diapers (any size) are limited to:

(i) Three hundred per month for a child age three and older; and

(ii) Two hundred forty per month for an adult.

(h) Purchased cloth, reusable diapers (any size) are limited to:

(i) Forty-eight per year for a child age three and older; and

(ii) Thirty-six per year for an adult.

(i) Rented cloth, reusable diapers (any size) are limited to:

(i) Three hundred per month for a child age three and older; and

(ii) Two hundred forty per month for an adult.

(j) Disposable briefs (incontinent pants) and pull-up training pants (any size) are limited to:

(i) Three hundred per month for a child age three and older; and

(ii) One hundred fifty per month for an adult.

(k) Reusable briefs (incontinent pants) or pull-up training pants (any size) are limited to:

(i) Purchased - four per year.

(ii) Rented - one hundred fifty per month.

(l) Disposable pant liner/pads are limited to two hundred forty per month.

(m) Underpads for beds are limited to:

(i) Disposable (any size) - one hundred eighty per month.

(ii) Purchased, reusable (large) - forty-two per year.

(iii) Rented, reusable (large) - ninety per month.

(8) Urological supplies - urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - two per month. This cannot be billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. This cannot be billed in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - two per twelve-month period.

(e) Indwelling catheters (any type) - three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - one hundred and twenty per month. These cannot be billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - three per month. These cannot be billed in combination with: other insertion trays without drainage bag and/or indwelling catheter; individual indwelling catheters; and/or individual lubricant packets.

(g) Intermittent urinary catheter - one hundred twenty per month. These cannot be billed in combination with: an insertion tray with or without drainage bag and catheter; or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston) - cannot be billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - thirty per month. These cannot be billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - thirty per month. These cannot be billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric). Allowed as replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - two per month. This cannot be billed in combination with: a latex urinary leg bag; urinary suspensory without leg bag; extension drainage tubing; or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - two per month.

(o) Urinary leg bag, vinyl, with or without tube - two per month. This cannot be billed in combination with: a leg strap; or an insertion tray with drainage bag and without catheter.

(p) Urinary leg bag, latex - one per month. This cannot be billed in combination with an insertion tray with drainage bag and with or without catheter.

(9) Miscellaneous supplies:

(a) Bilirubin light therapy supplies - five days' supply. MAA reimburses only when these are provided with a prior authorized bilirubin light.

(b) Continuous passive motion (CPM) softgoods kit - one, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - one box of twenty.

(d) Eye patch (adhesive wound cover) - one box of twenty.

(e) Lice comb (e.g., LiceOut TM, or LiesMeister TM, or combs of equivalent quality and effectiveness) - one per year.

(f) Nontoxic gel (e.g., LiceOutTM) for use with lice combs - one bottle per twelve month period Syringes and needles ("sharps") disposal container for home use, up to one gallon size - two per month.

(10) Miscellaneous DME:

(a) Bilirubin light or light pad - five days rental per twelve-month period.

(b) Blood glucose monitor (specialized or home) - one in a three-year period.

(c) Continuous passive motion (CPM) machine - up to ten days rental and requires prior authorization.

(d) Diaphragmatic pacing antennae - four per twelve month-period.

(e) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - two per twelve-month period.

(f) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap w/adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - two per twelve-month period.

(11) Prosthetics and Orthotics:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - one every five years.

(b) Preparatory, above knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, molded to model - one per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - one per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - one per twelve-month period.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - one per twelve-month period.

(12) Positioning devices:

(a) Deluxe floor sitter/feeder seat (small, medium, or large), including floor sitter wedge, shoulder harness, and hip strap - one in a three-year period.

(b) High-back activity chair, including adjustable footrest, two pairs of support blocks, and hip strap - one in a three-year period.

(c) Positioning system/supine boards (small or large), including padding, straps adjustable armrests, footboard, and support blocks - one in a five-year period.

(d) Prone stander (child, youth, infant or adult size) - one in a five-year period.

(e) Adjustable standing frame (for child/adult thirty - sixty-eight inches tall), including two padded back support blocks, a chest strap, a pelvic strap, a pair of knee blocks, an abductor, and a pair of foot blocks - one in a five-year period.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-16-141, § 388-543-1150, filed 7/31/01, effective 8/31/01.]

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 reevaluated), 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 WAC 388-543-1150, 388-543-1600, and MAA's billing instructions for further information about specific limitations and requirements for PA and EPA):

(a) Antiseptics and germicides;

(b) Bandages, dressings, and tapes;

(c) Blood monitoring/testing supplies;

(d) Braces, belts, and supportive devices;

(e) Decubitus care products;

(f) Ostomy supplies;

(g) Pregnancy-related testing kits and nursing equipment supplies;

(h) Supplies associated with transcutaneous electrical nerve stimulators (TENS);

(i) Syringes and needles;

(j) Urological supplies (e.g., diapers, urinary retention catheters, pant liners, and doublers); and

(k) Miscellaneous supplies.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-16-141, § 388-543-2800, filed 7/31/01, effective 8/31/01; 01-01-078, § 388-543-2800, filed 12/13/00, effective 1/13/01.]

Chapter 388-545 WAC
THERAPIES

WAC

WAC 388-545-900 Neurodevelopmental centers. (1) This section describes:

(a) Neurodevelopmental centers that may be reimbursed as such by the medical assistance administration (MAA);

(b) Clients who may receive covered services at a neurodevelopmental center; and

(c) Covered services that may be provided at and reimbursed to a neurodevelopmental center.

(2) In order to provide and be reimbursed for the services listed in subsection (4) of this section, MAA requires a neurodevelopmental center provider to do all of the following:

(a) Be contracted with the department of health (DOH) as a neurodevelopmental center;

(b) Provide documentation of the DOH contract to MAA;

(c) Sign a core provider agreement with MAA; and

(d) Receive a neurodevelopmental center provider number from MAA.

(3) Clients who are twenty years of age or younger and who meet the following eligibility criteria may receive covered services from neurodevelopmental centers:

(a) For occupational therapy, refer to WAC 388-545-300(2);

(b) For physical therapy, refer to WAC 388-545-500(2);

(c) For speech therapy and audiology services, refer to WAC 388-545-700(2); and

(d) For early and periodic screening, diagnosis and treatment (EPSDT) screening by physicians, refer to WAC 388-529-0200.

(4) MAA reimburses neurodevelopmental centers for providing the following services to clients who meet the requirements in subsection (3) of this section:

(a) Occupational therapy services as described in WAC 388-545-300;

(b) Physical therapy services as described in WAC 388-545-500;

(c) Speech therapy and audiology services as described in WAC 388-545-700; and

(d) Specific pediatric evaluations and team conferences that are:

(i) Attended by the center's medical director; and

(ii) Identified as payable in MAA's billing instructions.

(5) In order to be reimbursed, neurodevelopmental centers must meet MAA's billing requirements in WAC 388-502-0020, 388-502-0100 and 388-502-0150.

[Statutory Authority: RCW 74.09.080, 74.09.520 and 74.09.530. 01-20-114, § 388-545-900, filed 10/3/01, effective 11/3/01.]

Chapter 388-546 WAC
TRANSPORTATION SERVICES

WAC

WAC 388-546-0001 Definitions. The following definitions and abbreviations, and those found in WAC 388-500-0005, apply to sections WAC 388-546-0150 through 388-546-4000. Defined words and phrases are bolded the first time they are used in the text:

"Advanced life support (ALS)" means that level of care that calls for invasive emergency medical services requiring advanced medical treatment skills.

"Aid vehicle" means a vehicle used to carry aid equipment and individuals trained in first aid or emergency medical procedure.

"Air ambulance" means a rotary blade (helicopter) or fixed-wing aircraft (airplane) designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to treat patients before and during transportation.

"Ambulance" means a ground or air vehicle designed, licensed per RCW 18.73.140 and used to provide transportation to the ill and injured; and to provide personnel, facilities, and equipment to treat patients before and during transportation.

"Base rate" means the medical assistance administration's (MAA) minimum reimbursement amount per covered trip, which includes allowances for emergency medical personnel and their services, the costs of standing orders, reusable supplies and equipment, hardware, stretchers, some disposable supplies, normal waiting time, and the normal overhead costs of doing business. The base rate excludes mileage and MAA specified disposable supplies that can be billed separately.

"Basic life support (BLS)" means that level of care that justifies ambulance transportation but requires only basic medical treatment skills. It does not include the need for or delivery of invasive medical services.

"Broker" (see "transportation broker").

"Brokered transportation" means nonemergent transportation arranged by a broker, under contract with MAA, to or from covered medical services for an eligible client (also, see "transportation broker").

"Border area hospitals" (see WAC 388-501-0175).

"Emergency medical service" means medical treatment and care that may be rendered at the scene of any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.

"Emergency medical transportation" means ambulance transportation during which a client receives needed emergency medical services en route to an appropriate medical facility.

"Fixed wing aircraft" means an airplane.

"Ground ambulance" means a ground vehicle designed and primarily used to provide transportation to the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation.

"Invasive procedure" means a medical intervention that intrudes on the client's person or breaks the skin barrier.

"Liftoff fee" means either of the two base rates MAA pays to air ambulance providers for transporting a client. MAA establishes one liftoff fee for rotary aircraft and one liftoff fee for fixed wing aircraft.

"Medical control" means the medical authority upon whom an ambulance provider relies to coordinate prehospital emergency services, triage and trauma center assignment/destination for the person being transported. The medical control is designated in the trauma care plan by the approved medical program director of the region in which the service is provided.

"Nonemergent ambulance transportation" means the use of a ground ambulance to carry a client who may be confined to a stretcher but typically does not require the provision of emergency medical services en route. Nonemergent ambulance transportation is usually scheduled or prearranged. See also "prone or supine transportation."

"Prone or supine transportation" means transporting a client confined to a stretcher, with or without emergency medical services being provided en route.

"Rotary blade aircraft" means a helicopter.

"Scheduled transportation" means prearranged transportation for an eligible client, typically in a vehicle other than an ambulance, with no emergency medical services being required or provided en route to and from a covered medical service.

"Standing order" means an order remaining in effect indefinitely until canceled or modified by an approved medical program director (regional trauma system) or the ambulance provider's medical control.

"Transportation broker" means a person or organization contracted by MAA to arrange, coordinate and manage the provision of necessary but nonemergent transportation services for eligible clients to and from covered medical services.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0001, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0100 The MAA transportation program. The **medical assistance administration** (MAA) covers **medically necessary** transportation to and from the **provider** of MAA covered services that is closest and most appropriate to meet the client's medical need. See WAC 388-546-0150 through 388-546-1000 for **ambulance** transportation and WAC 388-546-5000 through 388-546-5600 for brokered/nonemergency transportation. See WAC 388-546-0150 for client eligibility for ambulance transportation. See WAC 388-546-5100 for client eligibility for brokered/nonemergency transportation.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0100, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0150 Client eligibility for ground and air ambulance transportation. (1) MAA covers medically necessary ambulance transportation to MAA covered services for medical assistance clients, including clients enrolled in MAA's managed care program(s) (e.g., Healthy Options). The exception is that MAA does not cover ambulance services for clients eligible for "family planning only."

(2) MAA does not cover out-of-state ambulance services for clients who are eligible for:

(a) The medically indigent program; or

(b) The general assistance - unemployable program.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0150, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0200 Scope of coverage for ground and air ambulance. (1) All ambulance transportation to and from medical services covered under the client's medical assistance program must be:

(a) Medically necessary based on the client's condition at the time of the ambulance trip;

(b) Appropriate to the client's actual medical need;

(c) Documented in the provider's client record as to medical necessity; and

(d) To one of the following destinations:

(i) The closest appropriate MAA contracted medical provider of MAA covered services; or

(ii) The designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual.

(2) MAA limits coverage to that medically necessary ambulance transportation required because the client cannot be safely or legally transported any other way. If a client can safely travel by car, van, taxi, or other means, the ambulance trip is not medically necessary and the ambulance service is not covered by MAA. See WAC 388-546-0250 (1) and (2) for MAA's process for determining medical necessity.

(3) If **Medicare** or another **third party** is the client's primary health insurer and that primary party denies coverage of an ambulance trip due to a lack of medical necessity, MAA requires the provider to report:

(a) That third party determination on the billing to MAA; and

(b) A justification for the trip showing that the trip meets the medical necessity criteria of MAA.

(4) MAA covers the following ambulance transportation for its eligible clients:

(a) **Emergency medical transportation** by **air ambulance** when justified under the conditions of this chapter; and

(b) Medical transportation by **ground ambulance** when the client:

(i) Has an emergency medical need for the transportation;

(ii) Needs medical attention to be available during the trip; or

(iii) Must be transported by stretcher or gurney.

(5) MAA covers (through the healthy options managed care plan) medically necessary ambulance transportation for clients enrolled in the plan. This coverage is included in the prepaid plan premium (see WAC 388-546-0400(2)).

(6) MAA covers medically necessary ambulance transportation for clients enrolled in MAA's primary care case management (PCCM) program. Ambulance services that are **emergency medical services** or that are approved by the PCCM in accordance with MAA requirements are reimbursed by MAA according to MAA's published billing instructions.

(7) MAA covers ambulance trips transporting patients from one hospital to another when the transferring or discharging hospital has inadequate facilities to provide the necessary medical services required. MAA covers air ambulance transportation for hospital transfers only if transportation by ground ambulance would endanger the client's life or health.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0200, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0250 Ambulance services that MAA does not cover. (1) MAA evaluates a request for any service that is listed as noncovered in this section under the provisions of WAC 388-501-0165.

(2) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restrictions, MAA evacuates, on a case-by-case basis, requests to exceed the specified limits or restrictions.

MAA approves such requests when medically necessary, in accordance with WAC 388-501-0165.

(3) MAA does not cover ambulance services when the transportation is:

(a) Not medically necessary based on the client's condition at the time of service (see exception at WAC 388-546-1000);

(b) Refused by the client;

(c) For a client who is deceased at the time the ambulance arrives on-scene;

(d) For a client who dies after the ambulance arrives on-scene but prior to transport and the ambulance crew did not provide significant medical services on-scene (see WAC 388-546-0500(2));

(e) Requested for the convenience of the client or the client's family;

(f) More expensive than arranging to bring the necessary medical service to the client's location;

(g) To transfer a client from a medical facility to the client's home (see exception at WAC 388-546-1000);

(h) Requested solely because a client has no other means of transportation;

(i) Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or

(j) Not to the nearest appropriate medical facility (e.g., the client's destination is an urgent care clinic or freestanding outpatient facility rather than a hospital emergency room) (see exception at WAC 388-546-1000).

(4) MAA does not cover ambulance services for hospital to hospital transportation if the transportation is requested:

(a) To accommodate a physician's or other health care provider preference for facilities;

(b) To move the client closer to family or home (e.g., for personal convenience); or

(c) To meet insurance requirements or hospital/insurance agreements.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0250, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0300 General requirements for air and ground ambulance providers. (1) Air and ground ambulances must be licensed, operated, and equipped according to federal, state, and local statutes, ordinances and regulations.

(2) Air and ground ambulances must be staffed and operated by appropriately trained and certified personnel. Personnel who provide any **invasive procedure**/emergency medical services for a client during an ambulance trip must be properly authorized and trained per RCW 18.73.150 and 18.73.170.

(3) MAA requires providers of ambulance services to show medical justification on billing documents for transportation and related services/supplies billed to MAA. Documentation in the provider's client record must include adequate descriptions of the severity and complexity of the client's condition (including the circumstances that made the conditions acute and emergent) at the time of the transportation. MAA may review the client record to ensure MAA's criteria are met.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0300, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0400 General limitations to payment for ground and air ambulance services. (1) MAA reimburses providers of covered ambulance transportation services on the basis of usual and customary charges or the rates established by MAA, whichever is lower.

(2) MAA does not reimburse providers directly for ambulance services provided to a client who is enrolled in an MAA Healthy Options managed care plan. Payment in such cases is the responsibility of the prepaid managed care plan.

(3) MAA includes certain covered ambulance services in its payments to inpatient hospitals. MAA does not reimburse ambulance providers for ambulance transportation services if the client remains as an inpatient in a hospital and the transportation is for temporary transfer to another facility for diagnostic or treatment services (e.g., MRI scanning, kidney dialysis). Transportation of an inpatient for such services is included in MAA's payment to the hospital. It is the responsibility of the hospital where the client is an inpatient to reimburse ambulance providers for these transports.

(4) MAA reimburses for the actual mileage incurred for covered trips by paying from the client's point of origin to the point of destination. MAA does not reimburse mileage for any distances traveled to the pick-up point or any other distances traveled when the client is not on board the ambulance.

(5) MAA does not reimburse for ambulance services if:

(a) The client is not transported to an appropriate treatment facility; or

(b) The client dies before the ambulance trip begins (see the single exception for ground ambulance providers at WAC 388-546-0500(2)).

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0400, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0450 Ground ambulance levels of service and other reimbursement. (1) MAA reimburses at two levels of service for ground ambulance emergency transportation: **Basic life support** (BLS) and **advanced life support** (ALS):

(a) A BLS emergency ambulance trip is one in which the client requires and receives basic medical services on-scene and/or en route from the scene of the acute and emergent illness or injury to a hospital or other appropriate treatment facility. Examples of basic medical services are: Controlling bleeding, splinting fracture(s), treating for shock, and cardiopulmonary resuscitation (CPR).

(b) An ALS trip is one in which the client requires and receives more complex services on-scene and/or en route from the scene of the acute and emergent illness or injury to a hospital. Examples of more complex medical services are: the initiation of intravenous therapy, airway intubation, or heart defibrillation. To qualify for reimbursement at the ALS level, certified paramedics or other ALS-qualified personnel on-board must provide the advanced medical services in a properly equipped vehicle.

(2) MAA reimburses for ambulance services (BLS or ALS) based on the client's actual medical condition and the

level of medical services needed and provided during the trip. Local ordinances or **standing orders** that require all ambulance trips be ALS equipped do not qualify a trip for MAA reimbursement at the ALS level of service.

(3) MAA reimburses separately for: Oxygen and oxygen administration; and/or intravenous supplies and IV administration. All other reusable supplies, disposable supplies, required equipment and up to thirty minutes of waiting time are included in MAA's **base rate**. MAA includes in the base rate equipment and/or supplies that are not specifically listed as separately payable in the medical transportation billing instructions. MAA does not reimburse for separately chargeable items that are provided to the client based on standing orders.

(4) The provider must document each trip to reflect the level of care needed by the patient, the training and qualifications of the personnel on board and the types of medical interventions provided by the personnel on-board. A ground ambulance trip is classified and paid at a BLS level, even if certified paramedics or ALS-qualified personnel are on board the ambulance, if no ALS-type interventions are needed and provided en route.

(5) MAA reimburses ground ambulance providers one mileage reimbursement rate, regardless of the level of service. Ground ambulance mileage is reimbursed when the client is transported to and from medical services within the local community only, unless necessary medical care is not available locally. The provider must fully document the circumstances that make medical care outside of the client's local community necessary.

(6) MAA reimburses for an extra attendant, when the ground ambulance provider submits justification to MAA for an extra attendant along with the claim for trip reimbursement, and that extra attendant is on-board for the trip because of one or more of the following:

(a) The client weighs three hundred pounds or more;

(b) The client is violent or difficult to control;

(c) The client is being transported for Involuntary Treatment Act (ITA) purposes and the client must be restrained; or

(d) More than one client is being transported, and each requires medical attention and/or close monitoring.

(7) The first thirty minutes of waiting time is included in MAA's base rate. MAA reimburses ground ambulance providers for additional waiting time if the time:

(a) Is extensive;

(b) Constitutes unusual circumstances; and

(c) Is documented in the provider's records and on the billing form. Documentation must include the reason for the wait, the total length of time spent waiting and the amount of waiting time being billed to MAA.

(8) MAA does not reimburse providers for waiting time if:

(a) The waiting time is to provide a return trip pickup; or

(b) The waiting time is to provide a second trip for the same client for the same date of service.

(9) MAA reimburses ambulance providers for ferry tolls incurred when transporting MAA clients. The ferry toll(s) must be thoroughly documented on the claim form. MAA reimburses:

(a) One standard reimbursement rate for all Puget Sound ferry trips (each way); and

(b) Actual cost, based on invoice, for all San Juan Island ferry trips.

(10) MAA reimburses ambulance providers for bridge tolls based on actual cost. To be reimbursed, the provider must submit the receipt(s) for the bridge toll(s) incurred during the trip.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0450, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0500 Special circumstances and payment limits for ground ambulance services. (1) When more than one client is transported in the same ground ambulance at the same time, the provider must bill MAA:

(a) At a reduced base rate for the additional client, and

(b) No mileage charge for the additional client.

(2) MAA reimburses a provider at the appropriate base rate (no mileage and no separate supplies) if there is no transportation provided because the client died on scene. MAA allows reimbursement only if the ambulance crew provides necessary and substantial medical care to the client on-scene and prior to the client's death.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0500, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0600 Procedure code modifiers. Ground ambulance providers must use procedure code modifiers published by MAA when billing MAA for ground ambulance trips. The same modifiers that describe the ambulance trip's place of origin and the client's destination must be used for all services related to the same trip.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0600, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0700 Specific payment limitations for air ambulance services. (1) MAA reimburses for air ambulance services only when all of the following apply:

(a) The necessary medical treatment is not available locally or the client's pick up point is not accessible by ground ambulance;

(b) The vehicle and crew meet the provider requirements in WAC 388-546-0300 and 388-546-0800;

(c) The client's destination is an acute care hospital; and

(d) The client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance.

(2) MAA reimburses one **liftoff fee** per client, per trip.

(3) MAA reimburses mileage for air ambulance services based on air miles and not on highway mileage charts.

(4) MAA reimburses a lift-off fee for each client when two or more clients are transported on a single air ambulance trip. In such a case, the provider must divide equally the total air mileage by the number of clients transported and bill MAA for the mileage portion attributable to each eligible client.

(5) If a client's transportation requires use of more than one ambulance to complete the trip to the hospital or other approved facility, MAA limits its reimbursement as follows:

(a) If more than one air ambulance is used, MAA reimburses one lift-off fee per client and the total of air miles. Mileage reimbursement will be based on the mode of air transport used for the greater distance traveled.

(b) If both air and ground ambulances must be used, MAA reimburses one lift-off fee and total air miles to the air ambulance provider, and the applicable base rate and ground mileage to each ground ambulance provider involved in the trip. The one exception to this rule is when the ground ambulance fee(s) is included in the negotiated trip payment as provided in WAC 388-546-0800 (4)(b).

(6) MAA does not reimburse separately for individual services or an extra attendant for air ambulance transportation. MAA's lift-off fee and mileage reimbursement includes all personnel, services, supplies, and equipment related to the trip.

(7) MAA does not reimburse private organizations for volunteer medical air ambulance transportation services, unless the transportation services and fees are prior authorized by MAA. If authorized, MAA's reimbursement is based on the actual cost to provide the service or at MAA's established rates, whichever is lower. MAA does not reimburse separately for items or services that MAA includes in the established rate(s).

(8) If MAA determines, upon review, that an air ambulance trip was not:

(a) Medically necessary, MAA may deny or recoup its payment and/or limit reimbursement based on MAA's established rate for a ground ambulance trip (if that would result in a lower cost to MAA); or

(b) To the nearest available and appropriate hospital, MAA may deny or recoup its payment and impose a maximum reimbursement for the trip based on the nearer facility.

(9) Providers must have prior authorization from MAA for any nonemergency air transportation whether by air ambulance or other mode of air transportation.

(10) MAA uses commercial airline companies (i.e., limits air ambulance services) whenever the client's medical condition permits the client to be transported by nonmedical and/or scheduled carriers.

(11) MAA does not reimburse for air ambulance services if there is no transportation provided.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0700, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0800 Payment for ground and air ambulance services outside the state of Washington. MAA reimburses emergency transportation provided to MAA's eligible clients who are out-of-state at the time of service (see WAC 388-546-0150(2) for exceptions).

(1) MAA requires any out-of-state ground or air ambulance provider who provides covered services to an MAA client to:

(a) Meet the licensing requirements of the ambulance provider's home state (United States of America and its territories only); and

(b) Sign an MAA core provider agreement.

(2) MAA does not reimburse for an interstate trip if the client is eligible for in-state services, only.

(3) MAA reimburses out-of-state providers at the lower of:

(a) The provider's billed amount; or

(b) The rate established by MAA.

(4) MAA requires any out-of-state ground ambulance provider who is transporting MAA clients within the state of Washington to comply with RCW 18.73.180 regarding stretcher transportation.

(5) Air ambulance providers who provide emergency transportation that takes a client out-of-state or that brings a client in state from an out-of-state location must obtain MAA's prior authorization.

(6) MAA reimburses air ambulance providers the agreed upon rate for each medically necessary interstate air ambulance trip.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0800, filed 1/16/01, effective 2/16/01.]

WAC 388-546-1000 Nonemergency ground ambulance transportation. (1) MAA reimburses for nonemergency ground ambulance transportation at the BLS ambulance level of service under the following conditions:

(a) The client needs to have basic ambulance level medical attention available during transportation; or

(b) The client must be transported by stretcher or gurney (in the **prone or supine** position) for medical or safety reasons.

(2) MAA requires ambulance providers to thoroughly document the circumstances requiring nonemergency ground ambulance transportation.

(3) Ground ambulance providers may choose to enter into contracts with MAA's **transportation brokers** to provide nonemergency transportation at a negotiated payment rate. Any such subcontracted rate may not exceed the costs MAA would incur under subsection (1) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-1000, filed 1/16/01, effective 2/16/01.]

WAC 388-546-5000 Nonemergency transportation program definitions. The following terms apply to WAC 388-546-5000, 388-546-5100, 388-546-5200, 388-546-5300, 388-546-5400, and 388-546-5500:

"Broker" means an organization or entity contracted with the department of social and health services (DSHS)/**medical assistance administration (MAA)** to arrange nonemergency transportation services for MAA's clients.

"Drop-off point" means the place authorized by the transportation broker for the client's trip to end.

"Escort" means a person authorized by the broker to be transported with a client to a medical service. An escort may be authorized depending on the client's age, mental state or capacity, safety requirements, mobility requirements, communication or translation requirements, or cultural issues.

"Guardian" means a person who is legally responsible for a client and who may be required to be present when a client is receiving medical services.

"Local provider of type" means the medical provider within the client's local community who fulfills the require-

ments of the medical appointment. The provider may vary by medical specialty, the provider's acceptance of MAA's clients, and whether managed care, primary care case management or third party participation is involved.

"Noncompliance" means a client:

(1) Engages in violent, seriously disruptive, or illegal conduct;

(2) Poses a direct threat to the health and/or safety of self or others; or

(3) Fails to be present at the pick-up point of the trip.

"Pick-up point" means the place authorized by MAA's transportation broker for the client's trip to begin.

"Return trip" means the return of the client to the client's home, or another authorized return point, from the location where a covered medical service has occurred.

"Service mode" means the method of transportation the transportation broker selects to use for an MAA client.

"Stretcher trip" means a transportation service that requires a client to be transported in a prone or supine position. This may be by stretcher, board or gurney (reclined and with feet elevated). Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

"Trip" means transportation one-way from the **pick-up point** to the **drop-off point** by an authorized transportation provider.

"Urgent care" means an unplanned appointment for a covered medical service with verification from an attending physician or facility that the client must be seen that day.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5000, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5100 Nonemergency transportation program scope of coverage. (1) MAA covers transportation that is necessary for its clients to receive **medically necessary** MAA covered services. See WAC 388-546-0100 through 388-546-1000 for Ambulance transportation that covers emergency ambulance transportation and limited nonemergency ground ambulance transportation as medical services.

(2) Licensed ambulance providers, who contract with MAA's transportation brokers, may be reimbursed for nonemergency transportation services under WAC 388-546-5200 as administrative services.

(3) MAA covers nonemergency transportation under WAC 388-546-5000 through 388-546-5500 as an administrative service as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170 (a)(2). As a result, clients may not select the transportation provider(s) or the mode of transportation (**service mode**).

(4) Prior authorization by MAA is required for all out-of-state nonemergency transportation. Border areas as defined by WAC 388-501-0175 are considered in-state under this section and subsequent sections.

(5) MAA requires all nonemergency transportation to and from covered services to meet the following:

(a) The covered service must be medically necessary as defined in WAC 388-500-0005;

(b) It must be the lowest cost available service mode that is both appropriate and accessible to the client's medical condition and personal capabilities; and

(c) Be limited to the **local provider of type** as follows:

(i) Clients receiving services provided under MAA's fee-for-service program may be transported only to the local provider of type. MAA's transportation **broker** is responsible for considering and authorizing exceptions.

(ii) Clients enrolled in MAA's managed care (healthy options) program may be transported to any **provider** supported by the client's managed care plan. Clients may be enrolled in a managed care plan but are obtaining a specific service not covered under the plan. The requirements in subsection (5)(c)(i) apply to these fee-for-service services.

(6) MAA does not cover nonemergency transportation services if the covered medical services are within three-quarters of a mile walking distance from the client's residence. Exceptions to this rule may be granted by MAA's transportation broker based on the client's documented medical condition or personal capabilities, or based on safety or physical accessibility concerns, as described in WAC 388-546-5400(1).

(7) A client must use personal or informal transportation alternatives if they are available and appropriate to the client's needs.

(8) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed-route public transportation system unless the need for more specialized transportation is present and documented. Examples of such a need are the client's use of a portable ventilator, a walker or a quad cane.

(9) MAA does not cover any nonemergency transportation service that is not addressed in WAC 388-546-1000 or in 388-546-5000 through 388-546-5500. See WAC 388-501-0160 for information about obtaining approval for noncovered transportation services, known as exception to rule (ETR).

(10) If a medical service is approved by ETR, both the broker and MAA must separately prior approve transportation to that service.

(11) MAA may exempt members of federally recognized Indian tribes from the brokered transportation program. Where MAA approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC 388-546-5000 through 388-546-5400, tribal members obtain their transportation services as provided by the tribe or tribal agency.

(12) A client who is denied service under this chapter may request a fair hearing per chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5100, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5200 Nonemergency transportation program broker and provider requirements. (1) MAA requires that all nonambulance transportation providers serving MAA clients be under subcontract with the department's contracted transportation broker. MAA's transportation brokers may subcontract with ambulance providers for nonemer-

gency trips in licensed ground ambulance vehicles as administrative services. See WAC 388-546-5100(2).

(2) MAA requires all contracted and subcontracted transportation providers under this chapter to be licensed, equipped, and operated in accordance with applicable federal, state, and local laws.

(3) MAA's transportation brokers determine the level of transportation service needed by the client and the mode of transportation to be used for each authorized **trip**.

(4) MAA's transportation brokers must comply with the terms specified in their contracts.

(5) MAA's transportation brokers may require up to forty-eight hours advance notice of a requested trip (see WAC 388-546-5300(2)) with the exception of hospital requests or **urgent care** trips. MAA allows its transportation brokers to accommodate requests that provide less than forty-eight hours advance notice, within the limits of the resources available to a broker at the time of the request.

(6) If MAA's transportation broker is not open for business and unavailable to give advance approval for a hospital discharge or urgent care request as described in subsection (5), the sub-contracted transportation provider must either:

(a) Provide the transportation in accordance with the broker's instructions and request an after-the-fact authorization from the transportation broker within seventy-two hours of the transport; or

(b) Deny the transportation, if the requirements of this section cannot be met.

(7) If the sub-contracted transportation provider provides transportation as described in subsection (6), the broker may agree to grant retroactive authorization as provided in WAC 388-546-5300(3). Such retroactive authorization must be:

(a) Documented as to the reasons retroactive authorization is needed; and

(b) Agreed to by the broker within seventy-two hours after the transportation to a medical appointment.

(8) MAA, through its transportation brokers, does not pay for transportation under the following conditions:

(a) Clients are not eligible for transportation services when medical services are within reasonable walking distance (normally three-quarters of a mile actual traveling distance), taking into account the client's documented medical condition and personal capabilities (see WAC 388-546-5100(6));

(b) Clients must use personal or informal transportation alternatives if they are available and appropriate to the clients' needs (see WAC 388-546-5100(7));

(c) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed route public transportation under the terms of WAC 388-546-5100(8);

(d) MAA or MAA's transportation broker may deny transportation services requested if the request is not necessary, suitable, or appropriate to the client's medical condition (see WAC 388-546-5100 (1) and (5)(a));

(e) The medical services requiring transportation must be services that are covered by the client's medical program (see WAC 488-546-5100(1)); or

(f) The transportation selected by the broker for the client must be the lowest cost available alternative that is both appropriate and accessible to the client's medical condition and personal capabilities.

(9) The transportation broker mails a written notice of denial to each client who is denied coverage of transportation within three business days of the denial.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5200, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5300 Nonemergency transportation program client requirements. (1) Clients must be compliant with MAA's transportation brokers, the brokers' subcontracted transportation providers, and MAA's medical services providers. A client who is in **noncompliance** may have limited transportation service mode options available. The broker mails the client a written notice of limited transportation service mode options within three business days of the broker's decision that transportation service mode options are limited.

(2) Clients must request, arrange and obtain authorization for transportation forty-eight hours in advance of a medical appointment. Exceptions to the forty-eight-hour advance arrangements are described in subsection (3) of this section and in WAC 388-546-5200 (5) and (6).

(3) If MAA's contracted broker is not open for business at the time nonemergency transportation is needed, the client must follow the transportation broker's instructions to obtain transportation service.

(4) MAA will cover a clients transportation to medically necessary covered services with local providers of type. Transportation services will be covered to nonlocal providers of type in the following circumstances:

(a) The client is enrolled in a healthy options managed health care plan and the client's primary care provider (PCP) or a PCP referred provider is not the closest available provider;

(b) The client's service is covered by a **third party** payer and the payer requires or refers the client to a specific provider;

(c) A charitable or other voluntary program (e.g., Shriners) is paying for the client's medical service;

(d) The medical service required by the client is not available within the local healthcare service area;

(e) The total cost to MAA is lower when the services are obtained outside of the local healthcare service area; or

(f) The out-of-area service is required to provide continuity of care for the client's ongoing care as:

(i) Documented by the client's primary care provider; and

(ii) Agreed to by MAA's contracted transportation broker.

(5) MAA may require transportation brokers to refer any of the exception categories listed in subsection (4) to MAA's medical director or the medical director's designee for review and/or prior authorization of the medical service.

(6) If local medical services are not available to a client because of **noncompliance** with MAA's transportation brokers, the brokers' subcontracted transportation providers, or MAA's medical services providers, MAA does not cover

nonemergency transportation to out-of-area medical services for the client. MAA's contracted broker mails a written notice to the client within three business days of the broker's determination that the client's documented noncompliance results in a denial to out-of-area transportation services.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5300, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5400 Nonemergency transportation program general reimbursement limitations. (1) To be reimbursed, MAA requires that a trip be a minimum of three-quarters of a mile from pick-up point to drop off point (see WAC 388-546-5100(6)). MAA's transportation broker may grant exceptions to the minimum distance requirement for any of the following conditions:

(a) When there is medical justification for a shorter trip;

(b) When the trip involves an area that MAA's contracted broker considers to be unsafe for the client, other riders, or the driver; or

(c) When the trip involves an area that the broker determines is not physically accessible to the client.

(2) MAA reimburses for **return trips** from covered medical services if the return trips are directly related to the original trips. MAA, through its transportation broker, may deny coverage of a return trip if any delays in the return trip are for reasons not directly related to the original trip.

(3) MAA does not reimburse any costs related to intermediate stops that are not directly related to the original approved trip.

(4) MAA's transportation broker may authorize intermediate stops that are directly related to the original approved trip if the broker determines that the intermediate stop is likely to limit or eliminate the need for supplemental covered trips. MAA considers the following reasons to be related to the original trip:

(a) Transportation to and from an immediate subsequent medical referral; or

(b) Transportation to a pharmacy to obtain one or more prescriptions when the pharmacy is within a reasonable distance of the original medical appointment route.

(5) MAA may pay the costs of meals and lodging for clients who must be transported to out-of-area medical services. MAA's transportation brokers make the determination that meals and lodging are necessary based on client need and the reasonableness of costs (as measured against state per diem rates).

(6) MAA may pay transportation costs, including meals and lodging, for authorized **escorts**. MAA's transportation brokers make the determination that the costs of escorts are necessary based on client need and reasonableness of costs (as measured against state per diem rates).

(7) MAA does not provide escorts or pay the wages of escorts. MAA does not pay for the transportation of an escort when the client is not present unless the broker documents exceptional circumstances causing the broker to determine that the service is necessary to ensure that the client has access to medically necessary care.

(8) MAA may reimburse for the transportation of a **guardian** with or without the presence of the client if the broker documents its determination that such a service is necessary to ensure that the client has access to medically necessary care.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5400, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5500 Modifications of privately owned vehicles. (1) MAA may cover and reimburse the purchase of vehicle driving controls, a vehicle wheelchair lift conversion, or the purchase or repair of a vehicle wheelchair lift, when:

(a) The requested item is necessary for the client's transportation to medically necessary MAA-covered services; and

(b) The client owns a vehicle that MAA determines is suitable for modification; and

(c) Medical transportation provided under WAC 388-546-5000 through 388-546-5400 cannot meet the client's need for transportation to and from medically necessary covered services at a lower total cost to the department (including anticipated costs); and

(d) Prior approval from MAA is obtained.

(2) Any vehicle driving controls, vehicle wheelchair lift conversion or vehicle wheelchair lift purchased by MAA under this section becomes the property of the client on whose behalf the purchase is made. MAA assumes no continuing liability associated with the ownership or use of the device.

(3) MAA limits the purchase of vehicle driving control(s), vehicle wheelchair lift conversion or vehicle wheelchair lift to one purchase per client. If a device purchased under this section becomes inoperable due to wear or breakage and the cost of repair is more than the cost of replacement, MAA will consider an additional purchase under this section as long as the criteria in subsection (1) of this section are met.

(4) MAA must remain the payer of last resort under this section.

(5) MAA does not cover the purchase of any new or used vehicle under this section or under this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5500, filed 3/2/01, effective 4/2/01.]

Chapter 388-550 WAC
HOSPITAL SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-550-2700 Substance abuse detoxification 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, § 388-550-2700, filed 12/18/97, effective 1/18/98.] Repealed by 01-16-142, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652.

WAC 388-550-1050 Hospital services definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this chapter.

"Accommodation costs" means the expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made. These expenses include, but are not limited to, room and board, 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 for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional in order to maintain their health status (see WAC 248-27-015).

"Acute physical medicine and rehabilitation (Acute PM&R)" means a twenty-four hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation.

"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 alcoholism 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(s)" means secondary procedure(s) that are 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 medical condition before study, which is initially responsible for the client's admission to the hospital, as defined by the ICD-9-CM diagnostic code.

"Advance directive" means a document, such as a living will executed by a client. The advanced directive tells the client's health care providers and others the client's decisions regarding the client's medical care, particularly whether the client or client's representative wishes to accept or refuse extraordinary measures to prolong the client's 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.

"Alcoholism 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 DRG assignments.

"Allowed charges" means the maximum amount for any procedure that the department allows as the basis for payment computation.

"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 provided by a hospital to a patient during the patient's hospital stay. These services include, but are not limited to, laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services.

"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 MAA 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" - See **"prior authorization"** and **"expedited prior authorization (EPA)."**

"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" means the charge submitted to the department by the provider.

"Blended rate" means a mathematically weighted average rate.

"Border area hospital" means a hospital located outside Washington state and located in one of the border areas listed in WAC 388-501-0175.

"Bundled services" mean interventions which are integral to the major procedure and are not reimbursable separately.

"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 when the rate for that service is not included in MAA's published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping hospital staff members on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services which are 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.

Capital costs due solely to changes in ownership of the provider's capital assets are excluded.

"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 (CMI)" means the arithmetical index that measures the average relative weight of a case treated in a hospital during a defined period.

"Charity care" means necessary hospital health care rendered to indigent persons, 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.

"Client" means a person who receives or is eligible to receive services through department of social and health services (DSHS) programs.

"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 MAA's hospital selective contracting 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.

"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 a hospital's average cost of treating Medicaid clients. 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 **"hospital conversion factor"** and **"negotiated conversion factor."**

"County hospital" means a hospital established under the provisions of chapter 36.62 RCW.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Customary charge payment limit" means the limit placed on aggregate 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 covered 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.

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

"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 numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, 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 (ICD-9), 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" - See **"hospital dispute conference."**

"Distinct unit" means a Medicare-certified distinct area for psychiatric or rehabilitation services within an acute care hospital or a department-designated unit in a children's hospital.

"Division of alcohol and substance abuse (DASA)" is the division within DSHS responsible for providing alcohol and drug-related services to help clients recover from alcoholism and drug addiction.

"DRG" - See **"diagnosis-related group."**

"DRG-exempt services" means services which are paid for through other methodologies than those using cost-based conversion factors (CBCF) or negotiated conversion factors (NCF).

"DRG payment" means the payment made by the department for a client's inpatient hospital stay. This payment 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.

"DSHS" means the department of social and health services.

"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 is capable of providing emergency services including trauma care.

"Emergency services" means medical services required by and provided to a patient after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity 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. For hospital reimbursement purposes, inpatient maternity services are treated as emergency services.

"Equivalency factor (EF)" 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—DRG payment method" means a hospital that for a certain patient category is reimbursed for services to MAA clients through methodologies other than those using cost-based or negotiated conversion factors.

"Exempt hospital—Hospital selective contracting program" means a hospital that is either not located in a selective contracting area or is exempted by the department from the selective contracting program.

"Expedited prior authorization (EPA)" means the MAA-delegated process of creating an authorization number for selected medical/dental procedures and related supplies and services in which providers use a set of numeric codes to indicate which MAA-acceptable indications, conditions, diagnoses, and/or MAA-defined criteria are applicable to a particular request for service.

"Expedited prior authorization (EPA) number" means an authorization number created by the provider that certifies that MAA-published criteria for the medical/dental procedures and related supplies and services have been met.

"Experimental" means a term to describe a procedure, or course of treatment, which lacks 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.

"Facility triage fee" means the amount MAA will pay a hospital for a medical evaluation or medical screening examination, performed in the hospital's emergency department, for 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 the department uses to reimburse providers for covered medical services provided to medical assistance clients when these services are not covered under MAA's *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 daily amount used to determine payment 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 group of health care providers involved in the care of a client.

"High-cost outlier" means a claim paid under the DRG method that did not meet the definition of "administrative day," and has extraordinarily high costs when compared to other claims in the same DRG, in which the allowed charges, before January 1, 2001, exceed three times the applicable DRG payment and exceed twenty-eight thousand dollars. For dates of service January 1, 2001 and after, to qualify as a high-cost outlier, the allowed charges must exceed three times the applicable DRG payment and exceed thirty-three thousand dollars.

"Hospice" means a medically-directed, interdisciplinary program of palliative services for terminally ill clients and the clients' families. Hospice is provided under arrangement with a Title XVIII Washington state-licensed and Title XVIII-certified Washington state hospice.

"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 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" means costs incurred in or associated with a specified base period.

"Hospital conversion factor" means a hospital-specific dollar amount that reflects the average cost for a DRG paid case of treating Medicaid clients in a given hospital. See cost-based conversion factor (CBCF) and negotiated conversion factor (NCF).

"Hospital covered service" means a service that is provided by a hospital, included in the medical assistance program and is within the scope of the eligible client's medical care program.

"Hospital cost report" - See **"cost report."**

"Hospital dispute resolution conference" means a meeting for deliberation during a provider administrative appeal.

(1) The first dispute resolution conference is usually a meeting between medical assistance administration and hospital staff, to discuss a department action or audit finding(s). The purpose of the meeting is to clarify interpretation of regulations and policies relied on by the department or hospital, provide an opportunity for submission and explanation of additional supporting documentation or information, and/or to verify accuracy of calculations and application of appropriate methodology for findings or administrative actions being appealed. Issues appealed by the provider will be addressed in writing by the department.

(2) At the second level of dispute resolution:

(a) For hospital rates issues, the dispute resolution conference is an informal administrative hearing conducted by an MAA administrator for the purpose of resolving contractor/provider rate disagreements with the department's action at the first level of appeal. The dispute resolution conference in this regard is not a formal adjudicative process held in accordance with the Administrative Procedure Act.

(b) For hospital audit issues, the audit dispute resolution hearing will be held by the office of administrative hearings in accordance with WAC 388-560-1000. This hearing is a formal proceeding and is governed by chapter 34.05 RCW.

"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 (same as peer group 1);

(2) Group B - urban hospitals without medical education programs (same as peer group 2);

(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.

"Hospital selective contracting program" or **"selective contracting"** means a negotiated bidding program for hospitals within specified geographic areas to provide inpatient hospital services to medical assistance clients.

"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.

"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 patient's diagnosis;

(2) Offered the patient an opportunity to ask questions about the procedure and to request information in writing;

(3) Given the patient a copy of the consent form;

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. 441.257; and

(5) Given the patient oral information about all of the following:

(a) The patient's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.

"Inpatient hospital admission" means admission as an inpatient to a hospital for a stay longer than twenty-four hours, or for a stay twenty-four hours or less with cases including:

(1) The death of a client;

(2) Obstetrical delivery;

(3) Initial care of a newborn; or

(4) Transfer to another acute care facility.

To qualify for inpatient reimbursement, even when the stay is longer than twenty-four hours, the medical care record must evidence the need for inpatient care.

"Inpatient services" means all services provided directly or indirectly by the hospital to a patient subsequent to admission and prior to discharge, and includes, but is not limited to, the following services: Bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and services provided by the hospital within twenty-four hours of the patient's admission as an inpatient.

"Inpatient stay" - See **"inpatient hospital admission."**

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alpha numerical designations (coding).

"Length of stay (LOS)" means the number of days of inpatient hospitalization. See also **"PAS length of stay (LOS)."**

"Length of stay extension request" means a request from a hospital provider for the department, or in the case of psychiatric admission, the appropriate regional support network (RSN), 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 before January 1, 2001, are less than ten percent of the applicable DRG payment or less than four hundred dollars. For dates of service on and after January 1, 2001, to qualify as a low-cost outlier, the allowed charges must be less than ten percent of the applicable DRG payment or less than four hundred and fifty dollars.

"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 ser-

vices. 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" is the state and federally funded aid program that covers the categorically needy (CNP) and medically needy (MNP) programs.

"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 administration (MAA)" is the administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI children's health insurance program (CHIP), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

"Medical assistance program" means both Medicaid and medical care services programs.

"Medical care services" means the limited scope of care financed by state funds and provided to general assistance-unemployable (GAU) and ADATSA clients.

"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 patient 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 person who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the person 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 to four 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 **"hospital conversion factor"** and **"cost-based conversion factor."**

"Nonallowed service or charge" means a service or charge that is not recognized for payment by the department, and cannot be billed to the 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 hospital selective contracting program.

"Noncovered service or charge" means a service or charge that is not reimbursed by the department.

"Nonemergent hospital admission" means any inpatient hospitalization of a patient who does not have an emergent condition, as defined in WAC 388-500-0005, Emergency services.

"Nonparticipating hospital" means a noncontract hospital. See **"noncontract hospital."**

"Operating costs" means all expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

"OPPS" - See **"outpatient prospective payment system."**

"OPPS adjustment" means the legislative mandated reduction in the outpatient adjustment factor made to account for the delay of OPPS implementation.

"OPPS outpatient adjustment factor" means the outpatient adjustment factor reduced by the OPPS and adjustment factor as a result of legislative mandate.

"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.

"Out-of-state hospital" means any hospital located outside the state of Washington and 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 patient 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 prospective payment system (OPPS)" means a classification system that groups outpatient visits according to the clinical characteristics, and typical resource use and costs associated with their diagnoses and the procedures performed.

"Outpatient short stay" means an acute hospital stay of twenty-four hours or less, with the exception of cases involving:

(1) The death of a client;

(2) Obstetrical delivery;

(3) Initial care of a new born; or

(4) Transfer to another acute care facility.

When the department determines that the need for inpatient care is not evidenced in the medical record, even in stays longer than twenty-four hours, the department considers and reimburses the stay as an outpatient short stay.

"Outpatient stay" - See **"outpatient short stay."**

"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 an inpatient 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)."**

"Patient consent" means the informed consent of the patient and/or the patient's legal guardian, as evidenced by the patient's or guardians's signature on a consent form, for the procedure(s) to be performed upon or for the treatment to be provided to the patient.

"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 room charge, per client, billed by the facility for room and board services that are covered by the department. This is sometimes referred to as "room rate."

"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 until the end of the month which includes the sixtieth day following the end of the pregnancy.

"Principal diagnosis" means the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

"Principal procedure" means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

"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.

"Private room rate" means the rate customarily charged by a hospital for a one-bed room.

"Professional activity study (PAS)" means the compilation of inpatient hospital data by diagnosis and age, conducted by the Commission of Professional and Hospital Activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region.*

"Professional component" means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a reimbursement that recognizes the physician's cognitive skill.

"Prognosis" means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.

"Prolonged service" means direct face-to-face patient services provided by a physician, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services.

"Prospective payment system (PPS)" means a system that sets payment rates for a predetermined 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 predetermined period.

"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;

(3) Support a weak or deformed portion of the body.

"Psychiatric hospitals" means Medicare-certified distinct part psychiatric units, Medicare-certified psychiatric hospitals, and state-designated pediatric distinct part psychiatric units in acute care hospitals. State-owned psychiatric hospitals are excluded.

"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 a method 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.

"RCC" - See **"ratio of costs-to-charges."**

"Rebasing" means the process of recalculating the hospital cost-based conversion factors or RCC using historical data.

"Recalibration" means the process of recalculating DRG relative weights using historical 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 that meet the following criteria during the Hospital Selective Contracting (HSC) waiver application period:

(1) Are located within Washington state;

(2) Are more than ten miles from the nearest hospital in the HSC competitive area; and

(3) Have fewer than seventy-five beds; and

(4) Have fewer than five hundred Medicaid admissions within the previous waiver 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-assigned three-digit coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" means the services a hospital facility provides a patient during the patient's hospital stay. These services include, but are not limited to, a routine or special care hospital room and related furnishings, routine supplies, dietary and nursing services, and the use of certain hospital equipment and facilities.

"Rural health clinic" means a clinic that is located in areas designed by the Bureau of Census as rural and by the Secretary of the Department of Health, Education and Welfare (DHEW) as medically underserved.

"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 negotiated bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by Medicaid patients.

"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."**

"Seven-day readmission" means the situation in which a patient who was admitted as an inpatient and discharged

from the hospital has returned to inpatient status to the same or a different hospital within seven days as a result of one or more of the following:

(1) A new spell of illness;

(2) Complication(s) from the first admission;

(3) A therapeutic admission following a diagnostic admission;

(4) A planned readmission following discharge; or

(5) A premature hospital discharge.

"Short stay" - See **"outpatient short stay."**

"Special care unit" means a department of health (DOH) or 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 patients or diseases.

"Spenddown" means the process of assigning excess income for the medically needy program, or excess income and/or resources for the medically indigent program, to the client's cost of medical care. The client must incur medical expenses equal to the excess income (spenddown) before medical care can be authorized.

"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 Medicaid services, including 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 provided to a patient which is less intensive 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 day" means a day in which an inpatient is receiving skilled nursing services in a hospital designated swing bed at the hospital's census hour. The hospital swing bed must be certified by the health care financing administration (HCPA) 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 or distinct unit to another.

"Transferring hospital" means the hospital or distinct unit that transfers 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. See chapter 246-976 WAC.

"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, nonhospital-based acute PM&R (Level B) nursing facilities, hospital-based skilled nursing facilities, home health, and hospice agencies in billing third party payers for services provided to patients.

"Unbundled services" means services which are excluded from the DRG payment to a hospital.

"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 has no health insurance coverage or has insufficient health insurance or other resources to cover the cost of provided inpatient and/or outpatient services.

"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 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-1050, filed 7/31/01, effective 8/31/01. 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) The medical assistance administration (MAA) covers the admission of a medical assistance client to a hospital only when the client's attending physician orders admission and when the admission and treatment provided meet the requirements of this chapter. For nonemergent hospital admissions, "attending physician" means the client's primary care provider, or the primary provider of care to the client at the time of hospitalization. For emergent admissions, "attending physician"

means the staff member who has hospital admitting privileges and evaluates the client's medical condition upon the client's arrival at the hospital.

(2) Medical record documentation of hospital services must meet the requirements in WAC 388-502-0020(1), Records and reports—Medical record system.

(3) In areas where the choice of hospitals is limited by managed care or selective contracting, the department is not responsible for payment under fee-for-service for hospital care and/or services:

(a) Provided to clients enrolled in an MAA managed care plan, unless the services are excluded from the health carrier's capitation contract with MAA and are covered under the medical assistance program; or

(b) Received by a Medicaid-eligible client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WAC 388-550-4600 and 388-550-4700 apply.

(4) The department provides chemical-dependent pregnant Medicaid-eligible clients up to twenty-six days of inpatient hospital care for hospital-based detoxification, medical stabilization, and drug treatment when:

(a) An alcoholism, drug addiction and treatment support act ADATSA 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.

(5) The department covers detoxification of acute alcohol or other drug intoxication only in a hospital having a detoxification provider agreement with MAA to perform these services.

(6) The department covers 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 provides or directly supervises such services.

(7) The department pays hospitals for services provided in special care units when the provisions in WAC 388-550-2900(13) are met.

(8) All services are subject to review and approval as stated in WAC 388-501-0050.

(9) For inpatient voluntary or involuntary psychiatric admissions, see WAC 388-550-2600 and chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-1100, filed 7/31/01, effective 8/31/01. 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 388-550-2700 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-550-2800 Inpatient payment methods and limits. (1) The department reimburses hospitals for inpatient hospital services using the rate setting methods identified in the department's approved state plan that includes:

Method	Used for
DRG negotiated conversion factor	Hospitals participating in the Medicaid hospital selective contracting program under waiver from the federal government
DRG cost-based conversion factor	Hospitals not participating in or exempt from the Medicaid hospital selective contracting program
Ratio of costs-to-charges (RCC)	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) The department's annual aggregate Medicaid payments to each hospital for inpatient hospital services provided to Medicaid clients will not exceed the hospital's usual and customary charges to the general public for the services (42 CFR § 447.271). The department recoups annual aggregate Medicaid payments that are in excess of the usual and customary charges.

(3) The department's annual aggregate payments for inpatient hospital services, including state-operated hospitals, will not exceed the estimated amounts that the department would have paid using Medicare payment principles.

(4) When hospital ownership changes, the department's payment to the hospital will 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 medical assistance administration:

(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) The department requires hospitals to follow generally accepted accounting principles unless federally or state regulated.

(8) Participating hospitals must permit the department to conduct periodic audits of their financial and statistical records.

(9) Payments for trauma services may be enhanced per WAC 246-976-935.

(10) The department reimburses hospitals for claims involving clients with third-party liability insurance:

(a) At the lesser of either the DRG:

(i) Billed amount minus the third-party payment amount; or

(ii) Allowed amount minus the third-party payment amount; or

(b) The RCC allowed payment minus the third-party payment amount.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-2800, filed 7/31/01, effective 8/31/01. 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) To receive reimbursement for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the department; and

(b) Be an in-state or border area hospital that meets the definition in RCW 70.41.020 and is certified under Title XVIII of the federal Social Security Act; or

(c) Be an out-of-state hospital that meets the conditions in WAC 388-550-6700.

(2) The department does not pay a hospital for inpatient care and/or services when the managed care plan is contracted to cover those services.

(3) The department does not pay a hospital for care or services provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(4) The department does not pay hospitals for ancillary services in addition to the DRG payment.

(5) When the hospital is paid by the RCC method, the department and the client are not financially responsible for payment of the additional days of hospitalization when:

(a) The additional days exceed the seventy-fifth percentile of the professional activities study (PAS) length of stay (LOS) limitations; and

(b) The hospital has not requested and/or received approval from the department as specified in WAC 388-550-1700; or for psychiatric inpatient stays, the appropriate regional support network (RSN).

(6) LOS extensions are not required for claims reimbursed by the DRG method.

(7) The department is not financially responsible for payment of elective or nonemergent inpatient services that are included in the department's selective contracting program and for those that a client receives in a nonparticipating hospital in a selective contracting area (SCA) unless the provider meets the department's authorization requirement in WAC 388-550-1700(12). The client may only be held responsible for payment of such services in accordance with WAC 388-502-0160. See WAC 388-550-4600 for selective contracting program requirements.

(8) The department considers hospital stays of twenty-four hours or less outpatient short stays, and does not pay such stays under the DRG or ratio of costs-to-charges (RCC) methods unless one of the following situations apply:

(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) When the department determines that the need for inpatient care is not evidenced in the medical record, even in stays longer than twenty-four hours, the department considers and reimburses the stay as an outpatient short stay.

(10) When the stay does not meet the definition of an inpatient hospital admission, the department limits reimbursement to the first twenty-four hours of allowed services, and uses the outpatient payment method.

(11) The department considers all services provided by the hospital within twenty-four hours of admission for a scheduled or elective surgery to be included in the hospital's inpatient payment. These services must not be charged to the client. Clients may only be held financially responsible for services in accordance with WAC 388-502-0160.

(12) The department does not count toward the threshold for hospital outlier status:

(a) Any charges for extra days of inpatient stay prior to a scheduled or elective surgery; and

(b) The associated services provided during those extra days.

(13) Accommodation charges: The department reimburses charges related to accommodation costs by multiplying the hospital's appropriate room rate charge by the hospital's RCC rate.

(a) Effective January 1, 2001, the department no longer requires a hospital to provide a room rate change form to indicate its usual and customary accommodation charge. Charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. §447.271.

(b) The department does not pay hospitals for private room accommodations. The department pays a semi-private room rate and requires the hospital to bill using a semi-private room revenue code when the hospital has:

(i) Only private rooms; or

(ii) Both private and semi-private rooms and provides an MAA client accommodations in a private room.

(14) The department determines its actual payment for a hospital admission by deducting from the basic hospital reimbursement the client responsibility amount (referred to as spend-down) and any third party liability amount.

(15) The department reduces reimbursement rates to hospitals for services provided to clients eligible under the state-only medically indigent (MI) and medical care services (MCS) programs according to the hospital specific equivalency factor and/or ratable, as provided in WAC 388-550-4800.

(16) The department 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.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-2900, filed 7/31/01, effective 8/31/01. 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 388-550-3300 Hospital peer groups and cost caps. (1) For rate-setting purposes the department groups hospitals into peer groups and establishes cost caps for each peer group. The department sets hospital reimbursement rates at levels that recognize the costs of reasonable, efficient, and effective providers.

(2) The four medical assistance administration (MAA) hospital 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) MAA uses a cost cap at the seventieth percentile for a peer group.

(a) MAA caps 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) MAA exempts peer group A hospitals from the cost cap because they are paid under the ratio of costs-to-charges methodology for Medicaid claims.

(c) MAA exempts peer group D hospitals from the cost cap because they are specialty hospitals without a common peer group on which to base comparisons.

(4) MAA calculates a peer group's cost cap based on the hospitals' base period costs after subtracting:

(a) Indirect medical education costs, in accordance with 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) MAA uses 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. After the peer group cost cap is calculated, MAA adds 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) In its rate setting process for peer groups A and B, MAA recognizes changes in peer group status and considers DOH's approval or recommendation. In cases where corrections or changes in individual hospital's base-year cost or peer group assignment occur after peer group cost caps are calculated, MAA updates the peer group cost caps involved only if the change in the individual hospital's base-year costs or peer group assignment will 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 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3300, filed 7/31/01, effective 8/31/01. 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, § 388-550-3300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. The department applies the following payment rules when a client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit:

(1) The department does not reimburse a hospital for a nonemergent case when the hospital transfers the client to another hospital.

(2) The department pays a hospital that transfers emergent cases to another hospital, the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment; or

(b) A per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. The department determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average length of stay.

(3) The department uses:

(a) The hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and

(b) MAA's length of stay data to determine the number of medically necessary days for a client's hospital stay.

(4) The department:

(a) Pays the hospital that ultimately discharges the client to any residence other than a hospital (e.g., home, nursing facility, etc.) the full DRG payment; and

(b) Applies the outlier payment methodology if a transfer case qualifies as a high- or low-cost outlier.

(5) The department does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back.

(a) The department's maximum payment to the discharging hospital is the full DRG payment.

(b) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (2) of this section.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3600, filed 7/31/01, effective 8/31/01. 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, § 388-550-3600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3700 DRG high-cost and low-cost outliers. (1) A claim qualifies as a diagnosis-related group (DRG) high-cost outlier when:

(a) The admission date for the claim is before January 1, 2001, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of twenty-eight thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(b) The admission date for the case is January 1, 2001, or after, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of thirty-three thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(2) If the claim qualifies as a DRG high-cost outlier, the high cost outlier threshold is the amount in subsection (1)(a)(i) or (ii), whichever is greater, for an admission date

before January 1, 2001; or subsection (1)(b)(i) or (ii), whichever is greater, for an admission date January 1, 2001 or after.

(3) The department determines payment for claims qualifying as DRG high-cost outliers as follows:

(a) Payment for all qualifying claims, except for claims in psychiatric DRGs 424-432 and in-state childrens hospitals, are paid seventy-five percent of the allowed charges above the outlier threshold, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(b) In-state children's hospitals are paid eighty-five percent of the allowed charges above the outlier threshold, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(c) Psychiatric DRG high-cost outliers for DRGs 424-432 are paid one hundred percent of the allowed charges above the outlier threshold, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

Examples for DRG high cost outlier claim qualification and payment calculation (admission dates are January 1, 2001, or after).

DRG Allowed Charges	Applicable DRG Payment	Three times App. DRG Payment	DRG Allowed Charges > $33,000?	DRG Allowed Charges > Three times App. DRG Payment?	DRG High-Cost Outlier Payment	Hospital's Individual RCC Rate
$17,000	$ 5, 000	$15,000	No	Yes	N/A	64%
*33,500	5,000	15,000	Yes	Yes	**$5,240	64%
10,740	35,377	106,131	No	No	N/A	64%

Payment calculation example for DRG allowed charges of:	Nonpsych DRGs/Nonin-state children's hospital (RCC is 64%)
*$33,500	DRG allowed charges
- $33,000 $ 500	The greater amount of 3x app. DRG pymt ($15,000) or $33,000
x 48%	75% of allowed charges x hospital RCC rate (nonpsych DRGs/nonin-state children's) (75% x 64% = 48%)
$ 240	Outlier portion
+ $ 5,000	Applicable DRG payment
**$ 5,240	Outlier payment

(4) A claim qualifies as a DRG low-cost outlier if:

(a) The admission date for the claim is before January 1, 2001, and the and allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred dollars.

(b) The admission date for the claim is January 1, 2001, or after, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred fifty dollars.

(5) If the claim qualifies as a DRG low-cost outlier:

(a) For an admission date before January 1, 2001, the low-cost outlier amount is the amount in subsection (4)(a)(i) or (ii), whichever is greater; or

(b) For an admission date on January 1, 2001, or after, the low-cost outlier amount is the amount in subsection (4)(b)(i) or (ii), whichever is greater.

(6) The department's payment for a claim that qualifies as a DRG low-cost outlier is the allowed charges for the claim multiplied by the hospital's RCC rate.

(7) The department does not pay administrative days until the case exceeds the DRG high-cost outlier threshold for that claim.

(8) The department makes day outlier payments to hospitals in accordance with section 1923 (a)(2)(C) of the Social Security Act, for clients who have exceptionally long stays. A hospital is eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share hospital (DSH) and the client served is under age 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 allowed charges for the hospitalization are less than the DRG high-cost outlier threshold as defined in subsection (1) of this section; and

(d) The client's length of stay exceeds the day outlier threshold for the applicable DRG payment amount. The day outlier threshold is defined as the number of days in an average length of stay for a discharge (for an applicable DRG payment), plus twenty days.

(9) The department bases the day outlier payment on the number of days that exceed the day outlier threshold, multiplied by the administrative day rate.

(10) The department's total payment for day outlier claims is the applicable DRG payment plus the day outlier or administrative days payment.

(11) The department pays day outliers only for claims that do not reach a DRG 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 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3700, filed 7/31/01, effective 8/31/01. 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 medical assistance administration (MAA) rebases the Medicaid payment system periodically using each hospital's cost report for its fiscal year that ends during the calendar year designated by MAA to be used for each update.

(2) MAA recalibrates DRG relative weights periodically, as described in WAC 388-550-3100, but no less frequently than each time rebasing is conducted. The department makes recalibrated relative weights effective on the rate implementation date, which can change with each rebasing.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3800, filed 7/31/01, effective 8/31/01. 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, § 388-550-3800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4300 Hospitals and units exempt from the DRG payment method. (1) Except when otherwise specified, inpatient services provided by hospitals and units that are exempt from the diagnosis-related group (DRG) payment method are reimbursed by the RCC payment method described in WAC 388-550-4500.

(2) Subject to the restrictions and limitations listed in this section, the department exempts the following hospitals and units from the DRG payment method for inpatient services provided to Medicaid-eligible clients:

(a) Peer group A hospitals, as defined in WAC 388-550-3300(2). Exception: Inpatient services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(i) General assistance programs;

(ii) Medically indigent program (MIP); and

(iii) Other state-only administered programs.

(b) Rehabilitation units when the services are provided in medical assistance administration (MAA)-approved acute physical medicine and rehabilitation (acute PM&R) hospitals and designated distinct rehabilitation units in acute care hospitals.

MAA uses the same criteria as the Medicare program to identify exempt rehabilitation hospitals and designated distinct rehabilitation units. Exception: Inpatient rehabilitation services provided to clients eligible under the following programs are covered and reimbursed through the DRG payment method:

(i) General assistance programs;

(ii) Medically indigent program (MIP); and

(iii) Other state-only administered programs.

(c) Out-of-state hospitals excluding hospitals located in designated border areas as described in WAC 388-501-0175. Inpatient services provided to clients eligible under the following programs are not covered or reimbursed by the department:

(i) General assistance programs;

(ii) Medically indigent program (MIP); and

(iii) Other state-only administered programs.

(d) Military hospitals when no other specific arrangements have been made with the department. Military hospitals may individually elect or arrange for one of the following payment methods in lieu of the RCC payment method:

(i) A negotiated per diem rate; or

(ii) DRG.

(e) Nonstate-owned specifically identified psychiatric hospitals and designated hospitals with Medicare certified distinct psychiatric units. The department uses the same criteria as the Medicare program to identify exempt psychiatric hospitals and distinct psychiatric units of hospitals.

(i) Inpatient psychiatric services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(A) General assistance programs;

(B) Medically indigent program (MIP); and

(C) Other state-only administered programs.

(ii) If the department determines that the psychiatric services provided to clients eligible under the programs listed in subsection (2)(e)(i) of this section qualify for a special exemption, the services may be reimbursed by using the ratio of costs-to-charges (RCC) payment method.

(iii) Regional support networks (RSNs) that arrange to reimburse nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals directly, may use the department's payment methods or contract with the hospitals to reimburse using different methods. Claims not paid directly through an RSN are paid through the department's MMIS payment system.

(3) The department limits inpatient hospital stays that are exempt from the DRG payment method and identified in subsection (2) of this section 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 the stay is:

(a) Approved for a specific number of days by the department, or for psychiatric inpatient stays, the regional support network (RSN);

(b) For chemical dependency treatment which is subject to WAC 388-550-1100; or

(c) For detoxification of acute alcohol or other drug intoxication.

(4) If subsection (3)(c) of this section applies to eligible clients, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three-and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4300, filed 7/31/01, effective 8/31/01. 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, § 388-550-4300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4400 Services—Exempt from DRG payment. (1) Except when otherwise specified, inpatient services exempt from the diagnosis-related group (DRG) payment method are reimbursed by the RCC payment method described in WAC 388-550-4500.

(2) Subject to the restrictions and limitations in this section, the department exempts the following services for Medicaid clients from the DRG payment method:

(a) Neonatal services for DRGs 602-619, 621-628, 630, 635, and 637-641.

(b) Acquired immunodeficiency syndrome (AIDS)-related inpatient services for those cases with a reported diagnosis of AIDS-related complex and other human immunodeficiency virus infections. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs, medically indigent program, and any other state-only administered program.

(c) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the department to perform these services. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs, medically indigent program, and any other state-only administered program.

(d) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically-dependent pregnant women (CUP program) by a certified hospital. These are Medicaid program services and are not funded by the department through the general assistance programs, medically indigent program, or any other state-only administered program.

(e) Acute physical medicine and rehabilitation services provided in MAA-approved rehabilitation hospitals and hospital distinct units, and services for physical medicine and rehabilitation patients. Rehabilitation services provided to clients under the general assistance programs, medically indigent program, and any other state-only administered program are also reimbursed through the RCC payment method.

(f) Psychiatric services provided in nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals.

(g) Chronic pain management treatment provided in department-approved pain treatment facilities.

(h) Administrative day services. The department reimburses administrative days based on the statewide average Medicaid nursing facility per diem rate, which is adjusted annually each November 1. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. Hospitals must request an administrative day designation on a case-by-case basis.

(i) Inpatient services recorded on a claim that is grouped by MAA to a DRG for which MAA has not published an all patient DRG relative weight, except that claims grouped to DRGs 469 and 470 will be denied payment. This policy also applies to covered services paid through the general assistance programs, medically indigent program, and any other state-only administered program.

(j) Organ transplants that involve the heart, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, or simultaneous kidney/pancreas. These services are also exempt from the DRG payment method when funded by MAA through the general assistance programs, medically indigent program, and any other state-only administered program.

(3) Inpatient services provided through a managed care plan contract are reimbursed by the managed care plan.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4400, filed 7/31/01, effective 8/31/01. 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, § 388-550-4400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4500 Payment method—Inpatient RCC and administrative day rate and outpatient rate. (1) The inpatient ratio of costs-to-charges (RCC) payment is the hospital's allowable charges on a claim multiplied by the hospital's inpatient RCC rate. The department limits this RCC payment to the hospital's allowable usual and customary charges.

(a) The medical assistance administration (MAA) calculates a hospital's 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 a hospital's inpatient RCC rate 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) The department limits a hospital's RCC payment to one hundred percent of its allowable charges.

(3) The department establishes the basic inpatient hospital RCC payment by multiplying the hospital's assigned RCC rate by the allowed charges for medically necessary services. MAA deducts client responsibility (spend-down) and third-party liability (TPL) from the basic payment to determine the actual payment due.

(4) The department uses the RCC payment method to reimburse:

(a) DRG-exempt hospitals as provided in WAC 388-550-4300; and

(b) Any hospital for DRG-exempt services described in WAC 388-550-4400.

(5) In-state and border area hospitals that lack sufficient HCFA 2552 Medicare cost report data to establish a hospital specific RCC are reimbursed using the weighted average in-state:

(a) RCC rate for inpatient services as provided in WAC 388-550-4300 and 388-550-4400; and

(b) Outpatient rate as provided in WAC 388-550-6000.

(6) Out-of-state hospitals are also reimbursed for the respective services using the weighted average in-state:

(a) RCC rate for inpatient services as provided in WAC 388-550-4300 and 388-550-4400; and

(b) Outpatient rate for outpatient hospital services as provided in WAC 388-550-6000.

(7) MAA identifies all in-state hospitals that have hospital specific RCC rates, and calculates the weighted average in-state RCC rate annually on August 1, by dividing the total allowable operating costs of these hospitals by the total respective patient revenues.

(8) The department 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 placement outside the hospital 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 provided during administrative days are not reimbursed.

(c) The department identifies administrative days for a DRG exempt case during the length of stay review process after the client's discharge from the hospital.

(d) The department pays the hospital at the administrative day rate starting the date of hospital admission if the admission is solely for a stay until an appropriate sub-acute placement can be made.

(9) MAA calculates the weighted average in-state outpatient rate annually on August 1, by multiplying the weighted average in-state RCC rate by the outpatient adjustment factor.

(10) For hospitals that have their own hospital specific inpatient RCC rate, MAA calculates the hospital's specific outpatient rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor.

(11) The outpatient adjustment factor:

(a) Must not exceed 1.0; and

(b) Is updated annually on November 1. This update causes an additional update of the outpatient rate for each hospital on November 1 annually.

(12) MAA establishes the basic hospital outpatient payment as provided in WAC 388-550-6000. MAA deducts client responsibility (spend-down) and third-party liability (TPL) from the basic payment to determine the actual payment due.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4500, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 USC 1395x(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 388-550-4800 Hospital payment method—State-only programs. (1) The medical assistance administration (MAA):

(a) Calculates payments to hospitals for covered services provided to eligible clients under the state-only MI and medical care services programs using one of the following payment methods:

(i) Diagnosis-related group (DRG); or

(ii) Ratio of costs-to-charges (RCC) methodologies; and

(b) Calculates the respective state-only program RCC rate and cost based conversion factor (CBCF) by reducing:

(i) The hospital's Title XIX inpatient RCC rate by the hospital's ratable; and

(ii) The hospital's Title XIX DRG CBCF.

(2) To calculate ratables, MAA:

(a) Adds a hospital's Medicare and Medicaid revenues, to the value of the hospital's charity care and bad debts. MAA deducts the hospital's low-income disproportionate share hospital (LIDSH) revenue from this total to arrive at the hospital's community care dollars; then

(b) Subtracts 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 CBCF is multiplied by (1 minus the ratable), and that result is multiplied by the equivalency factor (EF) to calculate the state-only CBCF. The hospital's Title XIX RCC rate is multiplied by (1 minus the ratable) to calculate the state-only program RCC.

(e) The payments for services under the state-only MI and medical care services programs are mathematically represented as follows:

State-only program RCC = Title XIX RCC x (1 minus the ratable) x EF

State-only program CBCF = Title XIX Conversion Factor x (1 minus the ratable) x EF

(3) MAA updates each hospital's ratable annually on August 1.

(4) MAA:

(a) Uses the EF to hold the DRG reimbursement rates for the state-only programs at their current level prior to any rebasing. MAA applies the EF only to the Title XIX DRG CBCFs, not to the Title XIX RCCS. The EF does not apply when the DRG rate change is due to the application of an inflation factor.

(b) Calculates a hospital's equivalency factor as follows:

EF = (Current state-only program CBCF divided by (Title XIX CBCF) multiplied by (1 minus the ratable))

(5) When a client eligible for the MI program or medical care services program has a trauma that qualifies under the trauma program, the hospital is reimbursed the full Medicaid reimbursement 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 74.08.090. and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4800, filed 7/31/01, effective 8/31/01. 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.]

Chapter 388-551 WAC
ALTERNATIVES TO HOSPITAL SERVICES

WAC

WAC 388-551-3000 Private duty nursing services for clients seventeen years of age and younger. This section applies to private duty nursing services for eligible clients on fee-for-service programs. Managed care clients receive pri-

vate duty nursing services through their plans (see chapter 388-538 WAC).

(1) **"Private duty nursing"** means four hours or more of continuous skilled nursing services provided in the home to eligible clients with complex medical needs that cannot be managed within the scope of intermittent home health services. Skilled nursing service is the management and administration of the treatment and care of the client, and may include, but is not limited to:

(a) Assessments (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity, hydration, level of consciousness, constant observation for comfort and pain management);

(b) Administration of treatment related to technological dependence (e.g., ventilator, tracheotomy, bilevel positive airway pressure, intravenous (IV) administration of medications and fluids, feeding pumps, nasal stints, central lines);

(c) Monitoring and maintaining parameters/machinery (e.g., oximetry, blood pressure, lab draws, end tidal CO_2s, ventilator settings, humidification systems, fluid balance, etc.); and

(d) Interventions (e.g., medications, suctioning, IV's, hyperalimentation, enteral feeds, ostomy care, and tracheostomy care).

(2) To be eligible for private duty nursing services, a client must meet all the following:

(a) Be seventeen years of age or younger (see chapter 388-71 WAC for information about private duty nursing services for clients eighteen years of age and older);

(b) Be eligible for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-529-0100 and 388-529-0200 for client eligibility);

(c) Need continuous skilled nursing care that can be provided safely outside an institution; and

(d) Have prior authorization from the department.

(3) The department contracts only with home health agencies licensed by Washington state to provide private duty nursing services and pays a rate established by the department according to current funding levels.

(4) A provider must coordinate with a division of developmental disabilities case manager and request prior authorization by submitting a complete referral to the department, which includes all of the following:

(a) The client's age, medical history, diagnosis, and current prescribed treatment plan, as developed by the individual's physician;

(b) Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities;

(c) An emergency medical plan which includes notification of electric, gas and telephone companies as well as local fire department;

(d) Psycho-social history/summary which provides the following information:

(i) Family constellation and current situation;

(ii) Available personal support systems;

(iii) Presence of other stresses within and upon the family; and

(iv) Projected number of nursing hours needed in the home, after discussion with the family or guardian.

(e) A written request from the client or the client's legally authorized representative for home care.

(5) The department approves requests for private duty nursing services for eligible clients on a case-by-case basis when:

(a) The information submitted by the provider is complete;

(b) The care provided will be based in the client's home;

(c) Private duty nursing will be provided in the most cost-effective setting;

(d) An adult family member, guardian, or other designated adult has been trained and is capable of providing the skilled nursing care;

(e) A registered or licensed practical nurse will provide the care under the direction of a physician; and

(f) Based on the referral submitted by the provider, the department determines:

(i) The services are medically necessary for the client because of a complex medical need that requires continuous skilled nursing care which can be provided safely in the client's home;

(ii) The client requires more nursing care than is available through the home health services program; and

(iii) The home care plan is safe for the client.

(6) Upon approval, the department will authorize private duty nursing services up to a maximum of sixteen hours per day except as provided in subsection (7) of this section, restricted to the least costly equally effective amount of care.

(7) The department may authorize additional hours:

(a) For a maximum of thirty days if any of the following apply:

(i) The family or guardian is being trained in care and procedures;

(ii) There is an acute episode that would otherwise require hospitalization, and the treating physician determines that noninstitutionalized care is still safe for the client;

(iii) The family or guardian caregiver is ill or temporarily unable to provide care;

(iv) There is a family emergency; or

(v) The department determines it is medically necessary.

(b) If the department determines it is medically necessary according to the process explained in WAC 388-501-0165, Determination process for coverage of medical equipment and medical or dental services.

(8) The department adjusts the number of authorized hours when the client's condition or situation changes.

(9) Any hours of nursing care in excess of those authorized by the department are the responsibility of the client, family or guardian.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 01-05-040, § 388-551-3000, filed 2/14/01, effective 3/17/01.]

Chapter 388-561 WAC

TRUSTS, ANNUITIES, AND LIFE ESTATES—EFFECT ON MEDICAL PROGRAMS

WAC

WAC 388-561-0001 Definitions. **"Annuitant"** means a person or entity that receives the income from an annuity.

"Annuity" means a policy, certificate or contract that is an agreement between two parties in which one party pays a lump sum to the other, and the other party agrees to guarantee payment of a set amount of money over a set amount of time. The annuity may be purchased at one time or over a set period of time and may be bought individually or with a group. It may be revocable or irrevocable. The party guaranteeing payment can be an:

(1) Individual; or

(2) Insurer or similar body licensed and approved to do business in the jurisdiction in which the annuity is established.

"Beneficiary" means an individual(s) designated in the trust who benefits from the trust. The beneficiary can also be called the grantee. The beneficiary and the grantor may be the same person.

"Designated for medical expenses" means the trustee may use the trust to pay the medical expenses of the beneficiary. The amount of the trust that is designated for medical expenses is considered an available resource to the beneficiary. Payments are a third party resource.

"Disbursement" or **"distribution"** means any payment from the principal or proceeds of a trust, annuity, or life estate to the beneficiary or to someone on their behalf.

"Discretion of the trustee" means the trustee may decide what portion (up to the entire amount) of the principal of the trust will be made available to the beneficiary.

"Exculpatory clause" means there is some language in the trust that legally limits the authority of the trustee to distribute funds from a trust if the distribution would jeopardize eligibility for government programs including Medicaid.

"Grantor" means an individual who uses his assets or funds to create a trust. The grantor may also be the beneficiary.

"Income beneficiary" means the person receiving the payments may only get the proceeds of the trust. The principal is not available for disbursements. If this term is used, the principal of the trust is an unavailable resource.

"Irrevocable" means the legal instrument cannot be changed or terminated in any way by anyone.

"Life estate" means an ownership interest in a property only during the lifetime of the person(s) owning the life estate. In some cases, the ownership interest lasts only until the occurrence of some specific event, such as remarriage of the life estate owner. A life estate owner may not have the legal title or deed to the property, but may have rights to possession, use, income and/or selling their life estate interest in the property.

"Principal" means the assets that make up the entity. The principal includes income earned on the principal that has not been distributed. The principal is also called the corpus.

"Proceeds" means the income earned on the principal. It is usually interest, dividends, or rent. When the proceeds are not distributed, they become part of the principal.

"Pooled trust" means a trust meeting all of the following conditions:

(1) It contains funds of more than one disabled individual, combined for investment and management purposes;

(2) It is for the sole benefit of disabled individuals (as determined by SSA criteria);

(3) It was created by the disabled individuals, their parents, grandparents, legal guardians, or by a court;

(4) It is managed by a nonprofit association with a separate account maintained for each beneficiary; and

(5) It contains a provision that upon the death of the individual, for any funds not retained by the trust, the state will receive all amounts remaining in the individual's separate account up to the total amount of Medicaid paid on behalf of that individual.

"Revocable" means the legal instrument can be changed or terminated by the grantor, or by petitioning the court. A legal instrument that is called irrevocable, but that can be terminated if some action is taken, is revocable for the purposes of this section.

"Special needs trust" means a trust meeting all of the following conditions:

(1) It is for the sole benefit of a disabled individual (as determined by SSA criteria) under sixty-five years old;

(2) It was created by the individual's parent, grandparent, legal guardian, or by a court; and

(3) It contains a provision that upon the death of the individual, the state will receive the amounts remaining in the trust up to the total amount of Medicaid paid on behalf of the individual.

"Testamentary trust" means a trust created by a will from the estate of a deceased person. The trust is paid out according to the will.

"Trust" means property (such as a home, cash, stocks, or other assets) is transferred to a trustee for the benefit of the grantor or another party. The department includes in this definition any other legal instrument similar to a trust. For annuities, refer to WAC 388-561-0200.

"Trustee" means an individual, bank, insurance company or any other entity that manages and administers the trust for the beneficiary.

"Undue hardship" means the client would be unable to meet shelter, food, clothing, and health care needs if the department applied the transfer of assets penalty.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0001, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0100 Trusts. (1) The department determines how trusts affect eligibility for medical programs.

(2) The department disregards trusts established, on or before April 6, 1986, for the sole benefit of a client who lives in an intermediate care facility for the mentally retarded (ICMR).

(3) For trusts established on or before August 10, 1993 the department counts the following:

(a) If the trust was established by the client, client's spouse, or the legal guardian, the maximum amount of money (payments) allowed to be distributed under the terms of the trust is considered available income to the client if all of the following conditions apply:

(i) The client could be the beneficiary of all or part of the payments from the trust;

(ii) The distribution of payments is determined by one or more of the trustees; and

(iii) The trustees are allowed discretion in distributing payments to the client.

(b) If an irrevocable trust doesn't meet the conditions under subsection (3)(a) then it is considered either:

(i) An **unavailable** resource, if the client established the trust for a beneficiary other than the client or the client's spouse; or

(ii) An **available** resource in the amount of the trust's assets that:

(A) The client could access; or

(B) The trustee distributes as actual payments to the client and the department applies the transfer of assets rules of WAC 388-513-1365.

(c) If a revocable trust doesn't meet the description under subsection (3)(a):

(i) The full amount of the trust is an available resource of the client if the trust was established by:

(A) The client;

(B) The client's spouse, and the client lived with the spouse; or

(C) A person other than the client or the client's spouse only to the extent the client had access to the assets of the trust.

(ii) Only the amount of money actually paid to the client from the trust is an available resource when the trust was established by:

(A) The client's spouse, and the client did not live with the spouse; or

(B) A person other than the client or the client's spouse; and

(C) Payments were distributed by a trustee of the trust.

(iii) The department considers the funds a resource, not income.

(4) For trusts established on or after August 11, 1993:

(a) The department considers a trust as if it were established by the client when:

(i) The assets of the trust, as defined under WAC 388-470-0005, are at least partially from the client;

(ii) The trust is not established by will; and

(iii) The trust was established by:

(A) The client or the client's spouse;

(B) 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

(C) 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.

(b) Only the assets contributed to the trust by the client are available to the client when part of the trust assets were contributed by any other person.

(c) The department does not consider:

(i) The purpose for establishing a trust;

(ii) Whether the trustees have, or exercise, any discretion under the terms of the trust;

(iii) Restrictions on when or whether distributions may be made from the trust; or

(iv) Restrictions on the use of distributions from the trust.

(d) For a revocable trust established as described under subsection (4)(a) of this section:

(i) The full amount of the trust is an available resource of the client;

(ii) Payments from the trust to or for the benefit of the client are income of the client; and

(iii) Any payments from the trust, other than payments described under subsection (4)(d)(ii), are considered a transfer of client assets.

(e) For an irrevocable trust established as described under subsection (4)(a) of this section:

(i) Any part of the trust from which payment can be made to or for the benefit of the client is an available resource. When payment is made from such irrevocable trusts, we will consider the payments as:

(A) Income to the client when payment is to or for the client's benefit; or

(B) The transfer of an asset when payment is made to any person for any purpose other than the client's benefit;

(ii) A trust from which a payment cannot be made to or for the client's benefit is a transfer of assets. For such a trust, the transfer of assets is effective the date:

(A) The trust is established; or

(B) The client is prevented from receiving benefit, if this is after the trust is established.

(iii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(5) Trusts established on or after August 11, 1993 are not considered available resources if they contain the assets of either:

(a) A person sixty-four years of age or younger who is disabled as defined by SSI criteria (as described in WAC 388-503-0510) and the trust:

(i) Is established for the sole benefit of this person by their 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 spent on the client's behalf; or

(b) A person regardless of age, who is disabled as defined by SSI criteria (as described in WAC 388-503-0510), and the trust is managed by a nonprofit association which:

(i) Maintains separate accounts for each trust beneficiary; and

(ii) May pool such separate accounts only for investment and fund management purposes; and

(iii) Stipulates that either:

(A) The state will receive all amounts remaining in the client's separate account upon the death of the client, up to the amount of Medicaid spent on the client's behalf; or

(B) The funds will remain in the trust to benefit other disabled beneficiaries of the trust.

(6) The department considers payments made from trusts in subsection (5) to be unearned income.

(7) The department will only count income from trusts and not the principal, if:

(a) The beneficiary has no control over the trust; and

(b) It was established with funds of someone other than the client, spouse or legally responsible person.

(8) This section does not apply when a client establishes that undue hardship exists.

(9) WAC 388-513-1365 applies when the department determines that a trust or a portion of a trust is a transfer of assets.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0100, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0200 Annuities. (1) The department determines how annuities affect eligibility for medical programs.

(2) A revocable annuity is considered an available resource.

(3) The income from an irrevocable annuity, meeting the requirements of this section, is considered in determining eligibility and the amount of participation in the total cost of care. The annuity itself is not considered a resource or income.

(4) An annuity established on or after May 1, 2001 will be considered an available resource unless it:

(a) Is irrevocable;

(b) Is paid out in equal monthly amounts within the actuarial life expectancy of the annuitant;

(c) Is issued by an individual, insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established; and

(d) Names the department as the beneficiary of the remaining funds up to the total of Medicaid funds spent on the client during the client's lifetime. This subsection only applies if the annuity is in the client's name.

(5) An irrevocable annuity established on or after May 1, 2001 that is not scheduled to be paid out in equal monthly amounts, can still be considered an unavailable resource if:

(a) The full pay out is within the actuarial life expectancy of the client; and

(b) The client:

(i) Changes the scheduled pay out into equal monthly payments within the actuarial life expectancy of the annuitant; or

(ii) Requests that the department calculate and budget the payments as equal monthly payments within the actuarial life expectancy of the annuitant. The income from the annuity remains unearned income to the annuitant.

(6) An irrevocable annuity, established prior to May 1, 2001 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource transferred without adequate consideration at the time it was purchased. A penalty period of ineligibility, determined according to WAC 388-513-1365, may be imposed equal to the amount of the annuity to be paid out in excess of the annuitant's actuarial life expectancy.

(7) An irrevocable annuity, established on or after May 1, 2001 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource transferred without adequate consideration at the time it was purchased. A penalty may be imposed equal to the amount of the annuity to be paid out in excess of the annuitant's actuarial life expectancy. The penalty for a client receiving:

(a) Long-term care benefits will be a period of ineligibility (see WAC 388-513-1365).

(b) Other medical benefits will be ineligibility in the month of application.

(8) An irrevocable annuity is considered unearned income when the annuitant is:

(a) The client;

(b) The spouse of the client;

(c) The blind or disabled child of the client; or

(d) A person designated to use the annuity for the sole benefit of the client, client's spouse, or a blind or disabled child of the client.

(9) An annuity is not considered an available resource when there is a joint owner, co-annuitant or an irrevocable beneficiary who will not agree to allow the annuity to be cashed, UNLESS the joint owner or irrevocable beneficiary is the community spouse. In the case of a community spouse, the cash surrender value of the annuity is considered an available resource and counts toward the maximum community spouse resource allowance.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0200, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0300 Life estates. (1) The department determines how life estates affect eligibility for medical programs.

(2) A life estate is an excluded resource when either of the following conditions apply:

(a) It is property other than the home, which is essential to self-support or part of an approved plan for self-support; or

(b) It cannot be sold due to the refusal of joint life estate owner(s) to sell.

(3) Remaining interests of excluded resources in subsection (2) may be subject to transfer of asset penalties under WAC 388-513-1365.

(4) Only the client's proportionate interest in the life estate is considered when there is more than one owner of the life estate.

(5) A client or a client's spouse, who transfers legal ownership of a property to create a life estate, may be subject to transfer-of-resource penalties under WAC 388-513-1365.

(6) When the property of a life estate is transferred for less than fair market value (FMV), the department treats the transfer in one of two ways:

(a) For noninstitutional medical, the value of the uncompensated portion of the resource is combined with other nonexcluded resources; or

(b) For institutional medical, a period of ineligibility will be established according to WAC 388-513-1365.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0300, filed 3/5/01, effective 5/1/01.]

Chapter 388-815 WAC
DRUG-FREE WORKPLACE PROGRAMS

WAC

388-815-005 through 388-815-250 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-815-005 Purpose. [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, effec-

tive 8/25/96.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-010 Definitions. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-020 Eligible employers. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-030 Certification of employer to L&I. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-100 Employer certification procedures. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-110 Certification maintenance. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-120 Program oversight. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-130 Denial of certification. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-140 Decertification. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-160 Hearings, appeals. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-200 Program requirements—Policy statement. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-205 Program requirements—Notifications. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-210 Program requirements—Substance abuse testing. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-215 Program requirements—How employers get certified through a 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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-220 Program requirements—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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-230 Supervisor training. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-240 Employee education. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

388-815-250 Confidentiality. [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.] Repealed by 01-13-026, filed 6/12/01, effective 7/13/01. Statutory Authority: Chapter 70.96A RCW.

WAC 388-815-005 through 388-815-250 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-820 WAC
COMMUNITY RESIDENTIAL SERVICES AND SUPPORT

(Formerly chapter 275-26 WAC)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-820-005 Purpose. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-015 Exemptions. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-025 Review and evaluation. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-035 Eligibility for residential services and support. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-045 Administration. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-055 Staffing. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-065 Individual service plan. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-075 Health services. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-085 Client records. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-095 Notice of fine and appeal rights. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-105 Physical requirements. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-115 Payment for service. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

388-820-125 Change of ownership. [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.] Repealed by 01-16-016, filed 7/19/01, effective 11/1/01.

WAC 388-820-005 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-010 What is the purpose of this chapter? (1) This chapter establishes standards for the department of social and health services (DSHS) to provide, or contract to provide, individualized community residential services to clients who:

(a) Are eligible to receive services by the division of developmental disabilities (DDD); and

(b) Receive support from certified service providers.

(2) Service providers support eligible clients to enable them to:

(a) Enjoy all rights and privileges under the Constitution and laws of the United States and the state of Washington; and

(b) Participate in community life and have control of their environment to the greatest extent possible.

(3) The authority for this chapter is Title 71A RCW.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-010, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-020 What definitions apply to this chapter? "Agency" means an entity interested in becoming a service provider that offers residential instruction and support services to clients.

"Certification" means the determination by DSHS that an agency or service provider has satisfactorily complied with the requirements outlined in this chapter and in the department contract.

"Client" means a person who:

- Has a developmental disability;
- Is eligible under RCW 71A.10.020; and
- Is authorized by DDD to receive residential services outlined in this chapter. (For eligibility criteria, see chapter 388-825 WAC.)

"Client services" means instruction and support activities that benefit clients, as specified under WAC 388-820-450 through 388-820-510.

"Community alternatives program (CAP)" means a Title XIX Medicaid waiver program that serves a specific number of individuals. This waiver is for particular home- and community-based services not covered under the Medicaid state plan. (See WAC 388-825-170 for more details.)

"Community protection services" (Community Protection Intensive Supported Living Services, or CP-ISLS) means intensive supported living services provided to clients who meet the criteria of "Individual with Community Protection Issues."

"DDD" refers to the division of developmental disabilities at DSHS.

"DSHS" refers to the department of social and health services of Washington state.

"Exceptions" means DSHS' approval of a written request for an exception to a rule in this chapter. (There are no exceptions to RCWs.)

"Group home" means residential services provided in a dwelling that is:

- Owned, leased, or rented by an entity other than the client;
- Licensed by the applicable state authority; and
- Operated by a provider.

(See WAC 388-820-090 for further details.)

"Group training home" means a certified nonprofit residential facility that provides full-time care, treatment, training, and maintenance for clients, as defined under RCW 71A.22.020(2).

"IFP" refers to individual financial plan. (See WAC 388-820-620.)

"IISP" refers to the individual instruction and support plan for clients. (See WAC 388-820-560 through 388-820-580.)

"Individual with community protection issues" means a client identified by DDD as needing one or more of the following criteria:

- The person has been convicted of or charged with a crime of sexual violence as defined in chapter 71.09 RCW, including, but not limited to, rape, statutory rape, rape of a child, and child molestation;
- The person has been convicted of or charged with acts directed towards strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization;

• The person has been convicted of or charged with a sexually violent offense and/or predatory act, and may constitute a future danger;

• The person has not been convicted and/or charged, but has a history of stalking, sexually violent, predatory, and/or opportunistic behavior which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors that may escalate to violence;

• The person has committed one or more violent crimes, such as murder, attempted murder, arson, first degree assault, kidnapping, or use of a weapon to commit a crime.

"Instruction" means goal-oriented teaching that is designed for acquiring and enhancing skills.

"ISP" refers to the individual service plan for clients. (See WAC 388-820-520 through 388-820-550.)

"Nursing assistant" means a person who is registered or certified by department of health under chapter 18.88A RCW. A nursing assistant performs certain nursing care tasks that are delegated by a registered nurse for a specific client in authorized settings. (See chapter 246-841 WAC for more details.)

"Reprisal" means any negative action taken as retaliation against an employee.

"Residential service" means client services offered by certified service providers.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"Service provider" means an agency certified by and contracted with DDD to provide residential services to clients.

"Severity" means the seriousness of an incident. This is determined by the extent to which a client's physical, mental, or psychosocial well-being is or may be compromised or threatened.

"Support" means assistance as requested or needed by a client, based on their abilities, needs, and goals.

"Supported living" means residential services provided to clients living in their own homes, which are owned, rented, or leased by the clients or their legal representatives. (See WAC 388-820-080 for more details.)

"Trust account" means a bank account containing two or more clients' funds where the service provider has the authority to make deposits and withdrawals.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-020, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-030 What are residential services? Residential service is supports provided to eligible clients by service providers to enable clients to live in their community. These may include:

(1) Supported living services;

(2) Group home services; or

(3) Services provided in the group training home.

Residential services must follow the requirements outlined in this chapter.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-030, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-040 Who certifies residential services? Residential services are certified by DDD to support eligible clients.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-040, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-050 Where are residential services provided? Residential services may be offered by service providers in:

(1) The client's own home;

(2) Group homes; or

(3) The group training home.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-050, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-060 Who may receive residential services? Clients who are at least eighteen years old and authorized by DDD may receive residential services.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-060, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-070 What physical and safety requirements exist for residential services? For clients who receive more than forty hours of residential service per month.

(1) When clients receive more than forty hours of residential services per month, the service provider must ensure

that the following physical and safety requirements are met for the client:

(a) A safe and healthy environment;

(b) Accessible telephone equipment;

(c) An evacuation plan developed and practiced with the client;

(d) An entrance and/or exit that does not rely solely upon windows, ladders, folding stairs, or trap doors;

(e) A safe storage area for flammable and combustible materials;

(f) Unblocked exits;

(g) A working smoke detector, with a light-alarm for clients with hearing impairments, located close to sleeping rooms;

(h) A flashlight or a nonelectrical light source in working condition; and

(i) Basic first-aid supplies.

For clients who receive forty hours or less of residential service per month.

(2) When clients receive forty hours or less of residential services per month, at least once every six months, the service provider must ensure the following physical safety requirements are met:

(a) A safe and healthy environment;

(b) An entrance and/or exit that does not rely solely upon windows, ladders, folding stairs, or trap doors;

(c) A safe storage area for flammable and combustible materials;

(d) Unblocked exits; and

(e) A working smoke detector, with a light-alarm for clients with hearing impairments, located close to sleeping rooms.

(3) The following supports are also offered to clients who receive forty hours or less of residential services. These clients may choose not to participate in meeting these requirements. This choice must be documented by the service provider, as per WAC 388-820-100. The supports offered include:

(a) Accessible telephone equipment;

(b) An evacuation plan developed and practiced with the client;

(c) A flashlight or a nonelectrical light source in working condition; and

(d) Basic first-aid supplies.

For all clients:

(4) The service provider must ensure that documentation is kept, showing that physical safety requirements are met. The client may independently document that these requirements are met as long as the client's IISP shows this involvement.

(5) Residential services must be located in a residential neighborhood within reasonable distance of necessary resources, unless a client chooses to live in a remote area. Resources include stores, banks, laundromats, churches, job opportunities, and other public services.

(a) **Exception:** Group homes certified prior to 1983 may not follow this requirement.

(b) **Exception:** Clients who receive community protection services may not follow this requirement.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-070, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-080 What are supported living services? (1) Supported living services are instruction and supports offered by service providers to clients who live in or are establishing their own homes. Homes must be owned, rented, or leased by the clients or their legal representatives.

(2) Clients who receive supported living services are responsible for paying for their daily living expenses, such as rent, utilities, and food, using their personal financial resources.

(3) The level of support is based on each client's instruction and support needs. Support may range from one hour per month to twenty-four hours per day of staff support per client.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-080, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-090 What are group homes? (1) Group homes are residences that are licensed as either a boarding home or an adult family home by aging and adult services administration in DSHS, under chapters 388-78A and 388-76 WAC, respectively.

(2) The service provider must ensure that group homes comply with all applicable licensing regulations.

(3) Group homes provide residential services to two or more clients.

(4) Clients who live in group homes pay costs of room and board from their own financial resources. (See WAC 388-820-120 for additional information.)

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-090, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-100 When must a service provider document a client's refusal to participate in services? (1) A service provider must document a client's refusal to participate in:

(a) Physical and safety requirements, as outlined in WAC 388-820-070(2); and

(b) Health services under WAC 388-820-690.

(2) Documentation must include the following:

(a) A description of events relating to the client's refusal to participate in these services;

(b) A plan to inform the client of the benefits of these services;

(c) A description of the service provider's efforts to give the services to the client; and

(d) Any health or safety concerns that the refusal may pose.

(3) The service provider must review this documentation with the client at least every six months. The client or client's guardian must sign the documentation after reviewing it.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-100, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-110 May a service provider offer services to nonclients in the same household as clients? Service providers must notify DDD of their intent to offer services to nonclients who are in the same household with clients. DDD must approve any of these situations, considering the health, safety, and preference of the clients.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-110, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-120 Who pays for a client's residential services? (1) DSHS must pay for residential services provided to clients under department contract at the contracted rate.

(2) DSHS must require a client to share the cost of services when mandated by federal or state statute or regulation.

(3) The service provider must inform DSHS when the client requires additional supports.

(a) The service provider must submit a written request with justification for additional service hours.

(b) DSHS may approve and provide payment for additional expenses or services.

(c) The service provider must retain a copy of department approval.

(4) For a client who is receiving group home services and support:

(a) The client must pay for cost of care or services from earnings or other financial resources. Clients receiving SSI are responsible only for the cost of room and board.

(b) DSHS may pay for these services only after a client has used his or her own financial resources.

(c) When a client's guardian or legal representative controls the client's income, estate, or trust fund, they must reimburse the service provider as described in WAC 388-820-120.

(5) Clients receiving supported living services must pay for their own housing, utilities, food, clothing, and other personal and incidental expenses from earnings and other financial resources.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-120, filed 10/26/01, effective 1/1/02; 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 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-820-130 When may a service provider receive initial set-up funds from DSHS? (1) DSHS may enter into a contractual agreement to reimburse the service provider for costs incurred to establish services. The costs must be based on a budget negotiated with DSHS.

(2) DSHS may reimburse service providers for client costs of establishing a residence.

(3) For reimbursement, the service provider must submit the billing documents required by DSHS.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-130, filed 10/26/01, effective 1/1/02; 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.]

WAC 388-820-140 What are the different types of certification? There are three different types of certification that DDD approves for residential services:

(1) Initial certification;

(2) Regular certification; and

(3) Provisional certification.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-140, filed 10/26/01, effective 1/1/02.]

WAC 388-820-150 When may DDD grant initial certification to an agency? (1) An interested agency must apply to DDD to be certified.

(2) DDD may grant initial certifications to agencies that meet the requirements outlined in this chapter.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-150, filed 10/26/01, effective 1/1/02.]

WAC 388-820-160 How does an agency apply for initial certification? To apply for initial certification, an agency must go through the following application procedure.

(1) An agency's completed application must be submitted to the regional DDD office for initial certification in that region. The application must include:

(a) A letter of intent;

(b) A mission statement;

(c) A statement of assurance stating that the service provider will not discriminate against a client or employee (see WAC 388-820-280);

(d) Verification of financial stability;

(e) A budget forecast;

(f) A staff-coverage schedule;

(g) A staff in-service training plan;

(h) The agency's policies and procedures;

(i) Relevant experience and qualifications of the agency;

(j) A minimum of two professional references;

(k) A copy of the license if applying for a group home;

(l) The administrator's resume; and

(m) A list of the agency board of directors and affiliations, if applicable.

(2) DSHS must provide the county with a copy of the agency's application.

(3) The county may submit written recommendations about the application to DSHS within thirty calendar days after receiving the application. DSHS reviews the county's recommendations.

(4) An agency must comply within one hundred and eighty days of the certification's effective date with:

(a) Relevant federal, state, and local laws and ordinances; and

(b) Department-established requirements.

(5) DDD notifies the agency in writing that all documentation has been received and approves or denies initial certification.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-160, filed 10/26/01, effective 1/1/02.]

WAC 388-820-170 What happens after an agency receives initial certification? After an agency receives initial certification, DDD decides whether to grant a residential services contract with that agency.

(1) Under initial certification, agencies that receive a contract with DDD become service providers. Once a contract is in place, a service provider is approved for receiving client referrals and serving clients in a particular region for up to one hundred and eighty days. Service providers must have a separate contract for each region where they receive referrals and serve clients.

(2) If DDD does not contract with an agency, initial certification will be valid for up to a year for that agency.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-170, filed 10/26/01, effective 1/1/02.]

WAC 388-820-180 May initial certification be extended for a service provider? If the initial certification expires before DDD conducts a formal review and evaluation of a service provider, DDD may extend the initial certification up to one hundred and eighty days.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-180, filed 10/26/01, effective 1/1/02.]

WAC 388-820-190 How does a service provider receive regular certification? (1) DSHS uses a formal review and evaluation process to determine whether a service provider has complied with certification requirements outlined in this chapter and the department contract.

(2) The county may submit recommendations about a service provider to DSHS.

(3) After determining that a service provider has complied with requirements, DSHS may approve a service provider for regular certification.

(a) This certification allows a service provider to continue to receive referrals and provide instruction and support to clients.

(b) Regular certification may be granted to service providers for up to two years.

(4) Regular certification may be extended for a period up to one hundred and eighty days.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-190, filed 10/26/01, effective 1/1/02.]

WAC 388-820-200 How often are reviews and evaluations done for service providers? (1) DSHS must review and/or evaluate each service provider's services at least every two years.

(2) DSHS may review a client's records and activities at any time to see if the service provider continues to address the clients' needs for instruction and support activities.

(3) DSHS may conduct additional evaluations or audits of any service provider at its discretion.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-200, filed 10/26/01, effective 1/1/02.]

WAC 388-820-210 What occurs during review and evaluation? (1) Service providers are evaluated, using this chapter and the DSHS contract requirements.

(2) To gather information, evaluators use a sample of clients that the service provider supports. Ways to gather information for evaluation must include:

(a) Review of records;

(b) Interview of clients, legal representatives, and others with the client's consent; and

(c) Observation of staff and client interactions.

(3) Information may also be gathered by conducting:

(a) Interviews with other entities contracted with DSHS; and

(b) Interviews with DSHS staff.

(4) The state-contracted evaluators conduct meetings with the service provider and DDD to discuss their preliminary findings and request additional information and clarification.

(5) Evaluators conduct an exit conference to present the evaluation report to the service providers and DSHS. The service provider's administrator or designee must be present at this exit conference.

(a) The evaluation report will include the service provider's operation history.

(b) If the service provider has not complied with certification requirements or with its contract with DSHS, the evaluator will note the findings in the report.

(c) The report must specify the corrective action plan. The corrective action plan and specific time frames are negotiated between the service provider and DSHS.

(d) At the conclusion of the exit conference, the service provider may request a copy of part or all of the draft report from the evaluator.

(e) The service provider may also submit a letter requesting a draft copy of the report to DDD headquarters within fourteen days of the exit conference.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-210, filed 10/26/01, effective 1/1/02.]

WAC 388-820-220 May service providers disagree with evaluation findings? (1) If service providers disagree with evaluation findings, they must submit in writing docu-

mentation supporting their position within fourteen calendar days after:

(a) The exit conference; or

(b) Receipt of the draft of the evaluation report.

(2) After receiving the service provider's documentation, DDD must send written notification of its decision to the service provider within fourteen calendar days.

(3) The service provider's documentation and DDD's decision must become part of the final evaluation report.

(4) DDD must file a report of the evaluation results and send a copy to the service provider. At this time, the evaluation report is considered to be a public document.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-220, filed 10/26/01, effective 1/1/02.]

WAC 388-820-230 May a service provider receive provisional certification? (1) A service provider that does not comply with all requirements of this chapter may receive provisional certification by DSHS.

(2) Provisional certification may not exceed one hundred eighty days.

(3) At the end of provisional certification:

(a) If the service provider has complied with certification requirements, DSHS may approve the service provider for regular certification.

(b) If the service provider has not complied with certification requirements, DSHS must revoke the service provider's certification and terminate the contract.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-230, filed 10/26/01, effective 1/1/02.]

WAC 388-820-240 When may DSHS decertify a service provider? If a service provider does not comply with certification requirements, DSHS may decertify a service provider under chapter 43.20A RCW. Upon decertification, DSHS terminates the contract and stops all payments.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-240, filed 10/26/01, effective 1/1/02.]

WAC 388-820-250 What are administrators of service providers required to do? DSHS requires administrators of service providers to oversee all aspects of services delivered to clients, consistent with the DSHS contract. This includes:

(1) Overseeing all aspects of staff development, such as recruitment and staff training;

(2) Preparing and maintaining policies and procedures related to client services, personnel, and financial records; and

(3) Securely storing client, personnel, and financial records.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-250, filed 10/26/01, effective 1/1/02.]

WAC 388-820-260 Must service providers' administrative documents be approved by DDD? Service providers must have DDD approval for several types of administrative documents.

(1) Service providers must have these written statements approved by DDD:

(a) A mission statement;

(b) Program description and admission criteria;

(c) An organizational chart and description showing all supervisory relationships; and

(d) Definition of staff roles and responsibilities, including the person designated to act in the absence of the administrator.

(2) Service providers must also have these policies and procedures approved by DDD:

(a) Background checks, as required under chapter 388-146 WAC;

(b) Client confidentiality and release of information;

(c) Client rights, which must include information on how to report suspected abuse, neglect, exploitation, and mistreatment;

(d) Client grievance procedures, including a client's right to file a complaint or suggestion without interference;

(e) Protection of client's financial interests, including management of client accounts, if applicable;

(f) Medication management, administration, and assistance;

(g) Plans for responding to missing persons; client emergencies, including access to medical, mental health, and law enforcement resources; and natural or other disasters;

(h) Notification of client's guardian and/or relatives in case of emergency; and

(i) Methods used for soliciting client input and feedback on services and support received.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-260, filed 10/26/01, effective 1/1/02.]

WAC 388-820-270 What are the requirements for personnel policies? (1) Service providers must maintain current written personnel policies and procedures.

(2) Personnel policies and procedures must be available to all employees.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-270, filed 10/26/01, effective 1/1/02.]

WAC 388-820-280 What nondiscrimination requirements must agencies and service providers meet? (1) When employing staff or supporting clients, agencies and service providers must not discriminate against any person on the basis of:

(a) Race;

(b) Color;

(c) Creed;

(d) Religion;

(e) National origin;

(f) Age;

(g) Gender;

(h) Presence of any sensory, mental, or physical disability, including HIV/AIDS conditions;

(i) Use of a trained dog guide or service animal by a person with a disability;

(j) Marital status;

(k) Disabled status or Vietnam Era veteran status;

(l) Sexual orientation; and

(m) Any other reasons prohibited by law.

(2) **Exception:** An employer may deny employment to a person if the decision is based upon a bona fide occupational qualification. (See chapter 49.60 RCW.)

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-280, filed 10/26/01, effective 1/1/02.]

WAC 388-820-290 What staffing requirements must service providers meet? (1) A service provider must have a designated administrator.

(2) Clients must have immediate access to staff, or the means to contact staff, at all times: Twenty-four hours a day, seven days a week.

(3) A service provider must provide adequate staff within contracted funds to administer the program and meet the needs of the clients.

(4) A service provider must have other staff available, as specified by the service provider's contract with DSHS.

(5) Each group home must maintain staffing that complies with:

(a) Boarding home or adult family home licensing requirements under chapter 388-78A or 388-76 WAC, respectively; and

(b) Contract requirements with the division of developmental disabilities.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-290, filed 10/26/01, effective 1/1/02.]

WAC 388-820-300 May clients instruct and support other clients? Clients must not be routinely involved in the unpaid instruction and support of other clients.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-300, filed 10/26/01, effective 1/1/02.]

WAC 388-820-310 Do employees and volunteers need background checks? (1) Employees and volunteers must have a background check cleared by DSHS before working alone, unsupervised with clients. Employee and volunteers waiting for background checks may work with clients only if they are directly observed by staff who have a DSHS background clearance.

(2) An FBI check is required when an employee or volunteer has resided in the state for less than three years. Service providers must follow the requirements under WAC 388-06-0500 through 388-06-0540 for provisional hire of employees awaiting Federal Bureau of Investigation (FBI) background checks.

(3) Clearances must be obtained for each service provider where the staff person works or volunteers.

(4) Clearances must be renewed as specified by DDD.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-310, filed 10/26/01, effective 1/1/02.]

WAC 388-820-320 What are the minimum requirements for staff employed by service providers? Service provider staff must meet the following minimum requirements:

(1) Exhibit job-related competency and the ability to make independent judgments;

(2) Have a high school diploma or GED equivalent, unless the employees were hired before 1983;

(3) Be at least eighteen years of age when employed as a direct care staff, or at least twenty-one years of age when employed as an administrator; and

(4) Treat a client with dignity and consideration, respecting the client's civil and human rights at all times.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-320, filed 10/26/01, effective 1/1/02.]

WAC 388-820-330 What staff training is required? The service provider must give specific training to staff. Within the first six months, staff must receive a minimum of thirty-two total hours of training that meet the following requirements.

(1) Before the employee works alone with clients, the service provider must explain the following to the employee:

(a) The current instruction and support plan for the employee's clients;

(b) Emergency procedures for clients;

(c) The DSHS-approved policy on abuse and neglect; and

(d) Client confidentiality.

(2) Within the first four weeks of employing a staff person, the service provider must provide training that includes:

(a) The service provider's mission statement;

(b) Policies and procedures; and

(c) On-the-job training.

(3) Additional training within the first six months must include:

(a) First aid/CPR;

(b) Bloodborne pathogens with HIV/AIDS information; and

(c) Client services.

(4) Each employee must keep first aid/CPR certification and bloodborne pathogens training current.

(5) The service provider must document orientation and training activities.

(6) Group homes must also meet the training requirements mandated by the licensing requirements specified by DSHS.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-330, filed 10/26/01, effective 1/1/02.]

WAC 388-820-340 How often must performance reviews be conducted for staff of service providers? (1) Written performance reviews for staff of residential service providers must be conducted at least annually and kept on file.

(2) If the service provider is a nonprofit organization, administrators must be evaluated annually by their supervisor or by the organization's governing board.

(3) If the service provider is a for-profit organization, owners are not required to have performance reviews.

(4) If the service provider is a governmental agency, administrators are evaluated by their supervisor.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-340, filed 10/26/01, effective 1/1/02.]

WAC 388-820-350 When must service providers have staff-coverage schedules approved by DDD? (1) DDD must approve staff-coverage schedules for those service providers who have on-duty staff twenty-four hours a day.

(2) The staff-coverage schedules must be approved at the following times:

(a) Before certification review takes place;

(b) When household configuration changes affect funding; and

(c) When additional staffing is requested.

(3) Staff-coverage schedules may be requested by DDD at any time.

(4) Each service provider must retain copies of the approved staff-coverage schedules.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-350, filed 10/26/01, effective 1/1/02.]

WAC 388-820-360 What happens when a service provider's ownership changes? (1) A service provider must inform DSHS in writing sixty days before a change of ownership occurs.

(2) On the effective date of a change of ownership, DSHS must terminate the department's certification and contract with the previous service provider.

(3) DSHS must withhold final payment to the previous service provider until that service provider submits and DSHS accepts all reports and required documents.

(4) DSHS is under no obligation to contract with the new owner entity.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-360, filed 10/26/01, effective 1/1/02.]

WAC 388-820-370 When may a client's service provider change? A client's service provider may change when:

(1) A client stops receiving residential services and supports from a service provider;

(2) A service provider transfers ownership; or

(3) The client chooses a different service provider.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-370, filed 10/26/01, effective 1/1/02.]

WAC 388-820-380 Are clients' records considered confidential? (1) The service provider and staff must consider all client record information privileged and confidential. Copies of client record information are available to:

(a) DSHS, the client, and/or legal representative upon their request to the service provider; and

(b) The county developmental disabilities board with DDD approval, as allowed under RCW 71A.14.070.

(2) Any other transfer or inspection of records must be authorized by a release of information form that:

(a) Specifically gives information about the transfer or inspection; and

(b) Is signed by the client or guardian.

(3) A signed release of information is valid for up to one year.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-380, filed 10/26/01, effective 1/1/02.]

WAC 388-820-390 How long does a service provider need to keep client records? (1) While supporting a client, a service provider must keep a client's records from at least the past four years.

(2) After a client's participation with a service provider ends, the client's records must be kept by the service provider for at least six years.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-390, filed 10/26/01, effective 1/1/02.]

WAC 388-820-400 What information do service providers need to keep in client records? A service provider needs to keep certain information in client records to fulfill DSHS requirements. The client's records must include, but not be limited to, the following:

(1) The client's name, address, and Social Security number.

(2) The name, address, and telephone number of the client's relative, guardian or legal representative.

(3) Copies of legal guardianship papers, if any.

(4) Client health records, including:

(a) The name, address, and telephone number of the client's physician, dentist, mental health service provider, and any other health care service provider;

(b) Health care service providers' instructions about health care needed, including appointment dates and date of next appointment if appropriate;

(c) Written documentation that the health care service providers' instructions have been followed; and

(d) A record of major health events and surgeries when known.

(5) A copy of the client's individual service plan (ISP).

(6) The client's individual instruction and support plan (IISP), including:

(a) Instruction and support activities for each client as a basis for review and evaluation of client's progress;

(b) Semiannual 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 that the client wants included.

(7) Progress notes and incident reports on clients.

(8) The client's financial records for funds managed by the service provider, including:

(a) Receipts, ledgers and records of the client's financial transactions; and

(b) Client's related bankbooks, checkbooks, bank registers, tax records and bank statements.

(9) Burial plans and wills.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-400, filed 10/26/01, effective 1/1/02.]

WAC 388-820-410 Do service providers need to keep client's property records? The service provider must assist clients in maintaining current, written property records when the clients receive forty hours or more a month of services. The record consists of:

(1) A list of items with a value of at least twenty-five dollars that the client owns when moving into the program;

(2) A list of personal possessions with a value of seventy-five dollars or more per item once the client is receiving services;

(3) Description and identifying numbers, if any, of the property;

(4) The date the client purchased the items after moving into the program;

(5) The date and reason for addition or removal from the record; and

(6) The signature of the staff or client making the entry.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-410, filed 10/26/01, effective 1/1/02.]

WAC 388-820-420 Are there requirements for record entries? (1) The service provider must note all record entries in ink.

(2) Entries must be made at the time of or immediately following the occurrence of the event recorded, in legible writing, and dated and signed by the person making the entry.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-420, filed 10/26/01, effective 1/1/02.]

WAC 388-820-430 Who must service providers notify in emergencies? In emergencies, a service provider must:

(1) Notify the client's guardian or legal representative as soon as possible;

(2) Immediately report to DSHS about a serious incident or emergency, as specified in the contract; and

(3) Submit a written incident report to DSHS, as required by law or policy.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-430, filed 10/26/01, effective 1/1/02.]

WAC 388-820-440 What abuse and neglect reporting requirements must service providers meet? (1) Under chapter 74.34 RCW, all administrators, owners, staff and volunteers are mandated to report instances of suspected client abuse, neglect, exploitation, or mistreatment.

(2) Reports must be made to one of two different areas at DSHS:

(a) Service providers giving supported living services must report to adult protective services (APS); and

(b) Service providers giving services through group homes must report to residential care services (RCS).

(3) Reports must be made to law enforcement agencies, when appropriate.

(4) Service providers must have DSHS-approved policies and procedures that specify reporting requirements for client abuse, neglect, exploitation, or mistreatment.

(5) Each administrator, owner, staff person, and volunteer must sign this policy about reporting requirements. The service provider must place the signed policy in the personnel file for staff or volunteers.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-440, filed 10/26/01, effective 1/1/02.]

WAC 388-820-450 What are client services? Clients must receive instruction and support activities in one or more of these client services:

(1) Health and safety;

(2) Personal power and choice;

(3) Competence and self-reliance;

(4) Positive recognition by self and others;

(5) Positive relationships; and

(6) Integration in the physical and social life of the community.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-450, filed 10/26/01, effective 1/1/02.]

WAC 388-820-460 What health and safety support may a service provider offer to a client? Service providers offer health and safety support to assist clients. This may include assisting clients to:

(1) Know when they need health services;

(2) Maintain good health;

(3) Learn about basic nutrition;

(4) Learn about human sexuality;

(5) Use health services, including mental health services;

(6) Manage and/or self-administer their medications;

(7) Deal with illness and injury;

(8) Apply first-aid procedures;

(9) Learn self-protection;

(10) Become aware of fire evacuation plans and burglary protection strategies; and

(11) Know emergency procedures, such as using 911 or a local emergency number.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-460, filed 10/26/01, effective 1/1/02.]

WAC 388-820-470 What support may a service provider offer to a client to increase personal power and choices? Service providers support a client's personal power and choices. This may include assisting clients to:

(1) Secure housing and furnishings that reflect personal preferences, life style, and financial means;

(2) Express personal opinions and make decisions;

(3) Learn and exercise rights and responsibilities;

(4) Improve communication skills;

(5) Participate in a variety of activities of their choice, including new experiences;

(6) Exercise voter rights;

(7) Learn about and participate in self-advocacy and protection services; and

(8) Make career choices.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-470, filed 10/26/01, effective 1/1/02.]

WAC 388-820-480 What support may a service provider offer to increase a client's competence and self-reliance? Service providers increase a client's competence and self-reliance. This may include assisting clients to:

(1) Develop and achieve their goals;

(2) Learn and use daily living skills, such as meal planning and preparation, grocery shopping, doing laundry, using

household appliances, managing money, and using leisure time;

(3) Identify situations where the client needs or desires assistance from others;

(4) Complete or participate in all tasks within their abilities; and

(5) Acquire and use adaptive devices and equipment, as needed.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-480, filed 10/26/01, effective 1/1/02.]

WAC 388-820-490 How may service providers assist clients in gaining positive recognition? Service providers encourage a client's positive recognition. This may include assisting clients to:

(1) Create positive self-esteem and feelings of self-worth;

(2) Choose valued social roles;

(3) Make choices that enhance their positive recognition by community members; and

(4) Present themselves in ways that are typical of other people in their community.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-490, filed 10/26/01, effective 1/1/02.]

WAC 388-820-500 What support may a service provider offer to increase the positive relationships in the client's life? Service providers encourage clients in developing, maintaining, and expanding positive relationships. This may include assisting clients to:

(1) Improve their communication skills;

(2) Experience opportunities to meet and interact with other people;

(3) Initiate, build and sustain relationships;

(4) Involve the client's guardian, chosen family members or representative in planning and making decisions that affect the client;

(5) Resolve disagreements with peers, family, friends, staff, neighbors, and coworkers; and

(6) Cope with the loss of a significant relationship, such as the death of a friend or family member, the end of a relationship, the loss of a job, or a change of staff.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-500, filed 10/26/01, effective 1/1/02.]

WAC 388-820-510 How may a service provider assist clients with becoming integrated into their community? Service providers encourage clients to become integrated into the physical and social life of the community. Service providers may assist clients to:

(1) Use community resources such as grocery store, bank, and social organizations;

(2) Use available transportation;

(3) Access educational and vocational opportunities; and

(4) Participate on boards, committees, or other positions of influence or status.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-510, filed 10/26/01, effective 1/1/02.]

WAC 388-820-520 What is an individual service plan (ISP) for clients? An individual service plan (ISP) is required for each client. The ISP outlines the support needs and interests of the client. The plan identifies the responsibilities of the service provider and other entities in supporting the client. Examples of other entities are: Vocational provider, therapists, nurses, and advocates. (See RCW 71A.18.010.)

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-520, filed 10/26/01, effective 1/1/02.]

WAC 388-820-530 Who is responsible for completing and overseeing a client's ISP? The client's DDD case resource manager is responsible for completing and overseeing a client's individual service plan (ISP).

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-530, filed 10/26/01, effective 1/1/02.]

WAC 388-820-540 Who may participate in creating a client's ISP? (1) The case resource manager must have face-to-face contact with the client in developing the individual service plan (ISP).

(2) The case resource manager must also involve the client's guardian or legal representative and the service provider.

(3) In creating a client's individual service plan (ISP), under RCW 71A.18.010, the client and DDD case resource manager may involve:

(a) Department staff; and

(b) Other interested persons invited by the client.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-540, filed 10/26/01, effective 1/1/02.]

WAC 388-820-550 How often must the ISP be reviewed? (1) The DDD case resource manager must review the ISP with the client at least every twelve months.

(2) In addition, an ISP meeting must be held with the client at least every two years, under RCW 71A.18.010. The meeting must be held in the client's home unless requested otherwise by the client.

(3) A client may request a review of the ISP at any time.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-550, filed 10/26/01, effective 1/1/02.]

WAC 388-820-560 What is an individual instruction and support plan (IISP) for clients? (1) An individual instruction and support plan (IISP) outlines the specific requirements for carrying out the residential services portion outlined in the individual service plan (ISP). The IISP must describe the methods of instruction and/or support needed to reach the client's goal.

(2) The IISP must be based on the goals of the individual service plan (ISP), reflect the client's preferences, and have the client's agreement.

(3) The IISP identifies activities and opportunities that promote one or more of the following client services:

(a) Health and safety;

(b) Personal power and choice;

(c) Positive recognition by self and others;

(d) Integration in the physical and social life of the community;

(e) Positive relationships; and

(f) Competence and self-reliance.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-560, filed 10/26/01, effective 1/1/02.]

WAC 388-820-570 Who may participate in developing the IISP for each client? (1) The service provider must develop with each client a written individual instruction and support plan (IISP).

(2) The client may involve other interested individuals in developing the IISP.

(3) The service provider must facilitate the individual instruction and support plan (IISP) in a manner that:

(a) Is respectful and inclusive of the client;

(b) Is appropriate to the age of the client or is preferred by the client;

(c) Takes place or occurs in community settings; and

(d) Results in opportunities for clients to experience positive change and personal growth.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-570, filed 10/26/01, effective 1/1/02.]

WAC 388-820-580 Who oversees the IISP for each client? (1) The service provider must oversee the progress made on each client's individual instruction and support plan (IISP).

(2) In overseeing each client's IISP, the service provider must:

(a) Consult with other service providers serving the client and other interested persons, as needed, to coordinate the IISP;

(b) Revise the IISP as goals are achieved, or as requested by the client and/or guardian; and

(c) Review and update the plan at least every six months.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-580, filed 10/26/01, effective 1/1/02.]

WAC 388-820-590 May a service provider manage a client's funds? (1) A service provider may manage a client's funds after either:

(a) Obtaining written consent from the client, the client's guardian or legal representative; or

(b) Becoming the designated payee by the source of the client's unearned income.

Note: An example is a client receiving unearned income from the Social Security Administration.

(2) A client's funds are considered to be managed by a service provider when the service provider:

(a) Has signing authority and may disperse a client's funds; and/or

(b) May limit access to client funds by not allowing funds to be expended.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-590, filed 10/26/01, effective 1/1/02.]

WAC 388-820-600 May a service provider hold bankbooks and bankcards for a client? Clients may ask a service provider to hold their bankbooks and bankcards while still having access to their own funds. This must be documented in the client's individual instruction and support plan (IISP).

Note: In this situation, service providers are not necessarily considered managers of the client's funds.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-600, filed 10/26/01, effective 1/1/02.]

WAC 388-820-610 May a service provider combine agency and client funds? A service provider may not combine client funds with any agency funds, such as agency operating funds.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-610, filed 10/26/01, effective 1/1/02.]

WAC 388-820-620 Does the service provider need to develop an individual financial plan (IFP) for clients? (1) A financial management plan is required only for those clients whose funds are managed by the service provider. The client and service provider must develop this individual financial plan (IFP) together.

(2) The IFP must be reviewed at least every twelve months by the service provider and client.

(3) A copy of the IFP must be sent to:

(a) The guardian and/or legal representative; and

(b) The client's DDD case resource manager upon request.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-620, filed 10/26/01, effective 1/1/02.]

WAC 388-820-630 What information must the IFP include? This plan must include all of the following items:

(1) The part of the client's funds and income that will be managed by the service provider;

(2) The part of client funds and income that will be managed by the client or legal representative;

(3) The type of accounts used;

(4) A budget process;

(5) Asset management, such as personal property, burial plan, retirement funds, stock, and vehicles;

(6) Cash management;

(7) Money management instruction and/or support;

(8) An explanation of which purchases require receipts;

(9) Contingency plan for expenditures if a client's resources exceed the CAP limit; and

(10) A signature of the client and the client's guardian, if any.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-630, filed 10/26/01, effective 1/1/02.]

WAC 388-820-640 How does a service provider manage client funds? (1) For client's funds that the service provider manages, the service provider must:

(a) Separately track each client's money even when several clients reside together;

(b) Keep the client's account current by maintaining a running balance;

(c) Reconcile the client's account to the bank statement on a monthly basis;

(d) Make deposits to the client's account within one week of receiving the client's money;

(e) Prevent the client's account from being overdrawn;

(f) Ensure that individual cash funds do not exceed seventy-five dollars per person unless specified differently in the individual's financial plan; and

(g) Retain receipts for purchases of over twenty-five dollars.

(2) When a client's service provider receives a check made out to the client, the service provider assisting the client must either:

(a) Get the client's signature and designation "for deposit only," and deposit the check in the client's account; or

(b) Get the client's "x" mark in the presence of another witness, cosign the check with the designation "for deposit only," and deposit the check in the client's account.

(3) If the check for a client is made out to a payee other than the client, the payee signs the check.

(4) Clients must never sign a blank check.

(5) When clients use checks for purchases, they must sign checks at the time of purchase unless specified differently in their individual financial plan.

(6) The service provider must document the names of any staff who assist a client with financial transactions.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-640, filed 10/26/01, effective 1/1/02.]

WAC 388-820-650 What documentation must service providers keep to protect a client's financial interests? Service providers must keep certain documentation for the part of funds they manage for clients. This protects clients' financial interests.

(1) Documentation for bank and cash accounts must include monthly reconciliation of bank and cash accounts that are verified and initialed by a second party who did not make or assist in the transaction.

(2) Other documentation that a service provider must keep for client **financial** transactions include:

(a) Monthly bank statements and reconciliation;

(b) Checkbook registers and bankbooks;

(c) Deposit receipts;

(d) Receipts for purchases over twenty-five dollars, or as specified in the financial plan;

(e) Any itemized subsidiary ledgers showing deposits, withdrawals, and interest payments to individual clients; and

(f) A control journal for trust accounts.

(3) Other documentation that a service provider must keep for client **cash** transactions include:

(a) A detailed ledger signed by the person who withdrew any of the client's money;

(b) Monthly reconciliation to the cash amount;

(c) Detailed accounting of the money received on behalf of the client, such as cash received from writing checks over the purchase amount, and a list of where the money was spent; and

(d) Receipts for purchases over twenty-five dollars where service provider staff withdrew the money.

(4) Service providers must notify DSHS when the client:

(a) Receives services under a CAP (community alternative program) waiver; and

(b) Has an account that reaches three hundred dollars less than the maximum amount allowed by federal or state law.

Note: CAP-waiver is defined under WAC 388-825-170.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-650, filed 10/26/01, effective 1/1/02.]

WAC 388-820-660 How are a client's funds transferred when they are managed by a service provider? When a service provider manages a client's funds, transferring those funds must follow specific procedures.

(1) When a client transfers from one service provider to another, the previous service provider must transfer client funds within thirty days. To transfer funds, the previous service provider must:

(a) Give the client, the client's guardian, and/or the legal representative a written accounting of all known client funds;

(b) When applicable, give the new service provider a written accounting of all transferred client funds;

(c) Obtain a written receipt from the client, client's guardian and/or legal representative for all transferred funds; and

(d) When applicable, obtain the new service provider's written receipt for the transferred funds.

(2) When a client becomes incapacitated or a client's whereabouts are unknown, the client's service provider must transfer the client's funds within one hundred and eighty days to the client's legal guardian, to DSHS, or to the requesting governmental entity.

(3) When a client dies, the service provider must transfer the client's funds within ninety days to:

(a) The client's guardian;

(b) The legal representative;

(c) The requesting governmental entity; or

(d) DSHS if the client does not have a legal heir.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-660, filed 10/26/01, effective 1/1/02.]

WAC 388-820-670 How does a service provider handle loans to a client? (1) A service provider may loan money to a client from the service provider's funds and collect the debt from the client by installments.

(2) The client's service provider must **not**:

(a) Charge a client interest for money loaned; or

(b) Borrow funds from the client.

(3) A service provider must retain a signed agreement with the client.

(4) Documentation must be kept for:

(a) The amount loaned;

(b) Payments; and

(c) The balance owed.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-670, filed 10/26/01, effective 1/1/02.]

WAC 388-820-680 When must a service provider pay a client? A service provider must pay a client when:

(1) A service provider or staff has stolen, misplaced, or mismanaged client funds.

(2) There are service charges incurred on a trust account that the service provider operates for a client.

(3) A client performs work for the service provider.

(a) The service provider must pay the client at least the current minimum wage.

(b) Clients who work for a service provider must be paid according to federal and state law requirements.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-680, filed 10/26/01, effective 1/1/02.]

WAC 388-820-690 What must service providers do to support a client's health? (1) The service provider must give necessary assistance to the client in accessing health, mental health, and dental services.

(2) For clients who receive an average of thirty hours or more of service per month, the service provider must:

(a) Maintain health records;

(b) Assist the client in arranging appointments with health professionals;

(c) Monitor medical treatment prescribed by health professionals;

(d) Communicate directly with health professionals when needed; and

(e) Ensure that the client receives an annual physical and dental examination unless the appropriate medical professional gives a written exception.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-690, filed 10/26/01, effective 1/1/02.]

WAC 388-820-700 May a client refuse health care services? A client may refuse to participate in health care services. Service providers must document these situations, according to WAC 388-820-100.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-700, filed 10/26/01, effective 1/1/02.]

WAC 388-820-710 When may client funds be used for health services? (1) Client funds for health services may be used when no other funding is available.

(2) A service provider must document all denials from:

(a) DSHS' medical assistance administration; and/or

(b) Private insurance companies or other carriers of primary medical insurance.

(3) The written documentation must be given to the client's DDD case resource manager and kept in the client's files.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-710, filed 10/26/01, effective 1/1/02.]

WAC 388-820-720 How must the service provider be involved with a client's transportation needs? (1) The service provider must provide transportation or ensure that clients have a way to get to:

(a) Emergency medical care;

(b) Medical appointments; and

(c) Therapies.

(2) Within available resources, the service provider must provide necessary assistance with transportation to and from:

(a) Work, school or other publicly funded services;

(b) Leisure or recreation activities;

(c) Client-requested activities; and

(d) ISP- or IISP-related activities.

(3) A vehicle that the service provider uses to transport clients must be:

(a) In safe operating condition; and

(b) Properly insured for its usage.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-720, filed 10/26/01, effective 1/1/02.]

WAC 388-820-730 Who may delegate nursing care tasks? (1) Any registered nurse (RN) may delegate specified nursing care tasks to staff who become qualified nursing assistants. Qualified nursing assistants may perform nursing care tasks only for the client who is specified by the RN to receive care.

(2) One nursing assistant must not transfer delegated authority to perform nursing care tasks to another nursing assistant.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-730, filed 10/26/01, effective 1/1/02.]

WAC 388-820-740 What training is required before staff are qualified to perform delegated tasks? (1) Before performing delegated tasks, staff must:

(a) Be registered or certified as a nursing assistant (NAR or NAC, respectively);

(b) Complete nurse delegation core training approved by DSHS and receive a certificate; and

(c) Receive client-specific training from the delegating registered nurse.

(2) In addition, registered nursing assistants must complete thirty-two hours of staff training required by WAC 388-820-330 before doing nursing care tasks. Certified nursing assistants may perform delegated tasks before completing the required thirty-two hours of staff training.

(3) After the staff member completes the required training, the service provider must keep:

(a) Written instructions provided by the delegating registered nurse; and

(b) A copy of the current registration or certification for each employee.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-740, filed 10/26/01, effective 1/1/02.]

WAC 388-820-750 Do nursing assistants need to comply with department of health requirements? Nursing assistants must comply with department of health (DOH) requirements under chapter 246-840 WAC.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-750, filed 10/26/01, effective 1/1/02.]

WAC 388-820-760 Who is authorized to provide consent for a client's receiving health care? (1) Before nursing assistants perform nursing care tasks for a client, the regis-

tered nurse must obtain consent from the client or person authorized to give consent.

(2) Under RCW 7.70.065, if a client is unable to give consent or is incapacitated, certain people are authorized to provide consent for a client's receiving health care. These people must be one of the following in this priority order:

(a) The legal guardian, if any;

(b) An individual who holds a durable power of attorney for health care decisions;

(c) The client's spouse;

(d) The client's children who are at least eighteen years of age;

(e) The client's parents; and

(f) The client's adult siblings.

(3) Proof of consent must be kept in the client's files.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-760, filed 10/26/01, effective 1/1/02.]

WAC 388-820-770 What rights do nursing assistants have concerning the delegation of nursing care tasks? Nursing assistants have certain rights when nursing care tasks are delegated by the registered nurse.

(1) The nursing assistant:

(a) May consent or refuse to consent to perform a delegated nursing care task; and

(b) Must not receive employer reprisal for refusing to accept the delegation of a nursing care task if the refusal is based on client safety issues.

(2) The service provider must post the toll-free telephone number (1-800-562-6078), established by DSHS' aging and adult services administration, for complaints about the delegation of nursing tasks to nursing assistants. This phone number is on DSHS forms: 13-678B, 13-680 and 13-681.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-770, filed 10/26/01, effective 1/1/02.]

WAC 388-820-780 Are nursing assistants liable for errors while doing nursing care tasks? If nursing assistants are following written directions from the delegating nurse, they are not liable for errors in doing nursing care tasks.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-780, filed 10/26/01, effective 1/1/02.]

WAC 388-820-790 What happens if unqualified staff do a nursing task? (1) DSHS must impose a civil fine on any service provider who knowingly performs or permits an employee to perform a nursing task without proper delegation. (See chapter 18.88A RCW and chapter 246-840 WAC.) The minimum amount of this fine is two hundred fifty dollars. The maximum fine allowed is one thousand dollars.

(2) When assessing civil fines, DSHS must consider:

(a) Severity of occurrence;

(b) Frequency of occurrence; and

(c) Other relevant factors relating to the occurrence.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-790, filed 10/26/01, effective 1/1/02.]

WAC 388-820-800 What technical assistance may service providers get from DSHS for nurse delegation requirements? (1) DSHS must offer technical assistance to service providers for purposes of education and assistance to help service providers comply with nurse delegation requirements and protocols.

(2) The DSHS technical assistance program must include:

(a) Technical assistance visits where DSHS informs the service provider of violation of law or service provider rules;

(b) Information about how to get technical assistance;

(c) Printed information;

(d) Information and assistance by phone;

(e) Training meetings;

(f) Other appropriate methods to provide technical assistance; and

(g) A list of organizations that provide technical assistance.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-800, filed 10/26/01, effective 1/1/02.]

WAC 388-820-810 What happens when DSHS finds a service provider in violation of nurse delegation requirements? (1) Before imposing a civil fine, DSHS may take the following steps after discovering that a service provider is in violation of rules:

(a) Notify the service provider in writing about the concerns;

(b) Give the service provider an opportunity to explain circumstances or present additional information that may clarify concerns; and

(c) Request the service provider to provide additional information, if necessary.

(2) DSHS must inform the service provider in writing about the outcome of findings and any required actions.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-810, filed 10/26/01, effective 1/1/02.]

WAC 388-820-820 May a service provider have a chance to correct violations before being fined? The service provider must be given a reasonable period of time to correct violations of nurse delegation requirements before any civil penalty is imposed.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-820, filed 10/26/01, effective 1/1/02.]

WAC 388-820-830 May civil fines be imposed during technical assistance visits? A civil fine may be issued during a technical assistance visit if:

(1) The service provider has previously been found out of compliance for the same statute or rule; or

(2) The service provider's violation is likely to place a person in danger of death or bodily harm.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-830, filed 10/26/01, effective 1/1/02.]

WAC 388-820-840 How does DSHS impose a civil fine? DSHS gives a service provider written notice of any civil fines. This notice must:

(1) State the amount and reasons for the fine and the applicable law under which the fine is imposed; and

(2) Inform the service provider of the right to request a hearing.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-840, filed 10/26/01, effective 1/1/02.]

WAC 388-820-850 When is payment due for a civil fine? (1) A civil fine becomes due twenty-eight days after the receipt of the written notice of the fine.

(2) **Exception:** If a service provider requests a hearing under chapter 34.05 RCW and RCW 43.20A.215, DSHS must stop the fine while waiting for a final decision on the matter.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-850, filed 10/26/01, effective 1/1/02.]

WAC 388-820-860 May a service provider disagree with DSHS findings of a violation? (1) When a service provider disagrees with DSHS' finding of a violation under this chapter, the service provider has the right to have the violation reviewed under the department's dispute resolution process.

(2) No service provider may discriminate or retaliate in any manner against a person who makes a complaint or has cooperated in the complaint investigation.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-860, filed 10/26/01, effective 1/1/02.]

WAC 388-820-870 May a service provider contest a civil fine? (1) A service provider may contest DSHS' decision to impose a civil fine.

(2) Within twenty-eight days of receiving the decision, the service provider must file a written application for a hearing, showing proof of receipt with the Board of Appeals, P.O. Box 42489, Olympia, WA 98504-2489. The application must include:

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

(b) A copy of the contested department decision.

(3) Hearings are governed by chapter 34.05 RCW and RCW 43.20A.215, and chapter 388-02 WAC. If any provision in this section conflicts with chapter 388-02 WAC, the provision in this section governs.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-870, filed 10/26/01, effective 1/1/02.]

WAC 388-820-880 May an agency or service provider contest a DSHS decision? (1) An agency or service provider may contest a DSHS decision about certification within twenty-eight days of being notified of the decision.

(2) Within this twenty-eight day period, the agency or service provider must request in writing that the DDD director or designee review the decision. The agency or service provider must:

(a) Sign the request;

(b) Identify the challenged decision and the date it was made;

(c) State specifically the issues and regulations involved and the grounds for the service provider's disagreement; and

(d) Include with the request copies of any supporting documentation for the service provider's position.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-880, filed 10/26/01, effective 1/1/02.]

WAC 388-820-890 When does an administrative review conference occur? (1) After receiving the agency or service provider's timely written request to review a decision, DSHS has twenty-eight days to contact the service provider to schedule an administrative review conference at a mutually convenient time.

(2) **Exception:** The agency or service provider and DSHS may agree in writing to a specific later date for the conference.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-890, filed 10/26/01, effective 1/1/02.]

WAC 388-820-900 May an administrative review conference be conducted by telephone? (1) The administrative review conference between DSHS and an agency or service provider may be conducted by telephone.

(2) **Exception:** If either the department, or the agency or service provider requests in writing that the conference be held in person, the conference may not be conducted by telephone.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-900, filed 10/26/01, effective 1/1/02.]

WAC 388-820-910 What happens during the administrative review conference? (1) The agency or service provider requesting an administrative review conference and appropriate DSHS representatives must attend the conference.

(2) The agency or service provider must bring to the conference, or give to DSHS before the conference, any supporting documentation for the service provider's position.

(3) The parties must clarify and attempt to resolve the issues at the conference.

(4) If additional documentation is needed to resolve issues, a second session of the conference must be scheduled. The second conference must be scheduled no later than twenty-eight days after the initial session unless both parties agree in writing to a specific later date.

(5) The director of the division of developmental disabilities must give a written decision to the service provider after the end of the conference.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-910, filed 10/26/01, effective 1/1/02.]

WAC 388-820-920 May an agency or service provider contest the decision from the administrative review conference? At the administrative review conference, an agency or service provider may contest a decision made by the director of the division of developmental disabilities. To contest a decision, the agency or service provider may request a hearing. The hearing procedure follows the requirements under chapter 388-02 WAC.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-920, filed 10/26/01, effective 1/1/02.]

WAC 388-820-930 Does DSHS make exceptions to the requirements in this chapter? DSHS may grant service providers exceptions to the requirements specified in this chapter as long as the following conditions are met:

(1) The service provider must submit a written request for an exception to the DDD regional administrator of the region where the contract is held.

(2) DSHS must evaluate requests for exceptions, considering:

(a) The health and safety of the clients;

(b) The quality of the services;

(c) Supervision; and

(d) The impact on client services.

(3) DSHS must send a copy of those requests that have significant impacts on client services to the client(s) involved. DSHS must then give the client an opportunity to comment before granting an exception.

(4) The DDD director or designee must approve or deny the request in writing within sixty calendar days after receiving the request from the service provider.

(5) Any exception granted must be in line with the legislative intent of Title 71A RCW.

(6) Service providers must retain a copy of each DSHS-approved exception.

(7) Service providers do not have hearing rights when they receive a denial from DSHS for an exception to the rules in this chapter.

[Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-930, filed 10/26/01, effective 1/1/02.]

Chapter 388-825 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES RULES

(Formerly chapter 275-27 WAC)

WAC

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 twelve dollars per year for community guide services for your family.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-226, filed 12/14/01, effective 1/14/02. 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 fifty 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, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-228, filed 12/14/01, effective 1/14/02. 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 388-825-238 What amount of serious need funding is available to my family? (1) The maximum amount of funding available is four hundred fifty-two dollars per month or two thousand seven hundred twelve 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 fifty 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, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-238, filed 12/14/01, effective 1/14/02. 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 388-825-254 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 one hundred fifty-six dollars per month or two thousand four hundred sixty-two 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 five hundred twelve dollars per month;

(B) If the combined total of family support services at this maximum plus in-home support is less than one thousand one hundred fifty-six dollars additional family support can be authorized to bring the total to one thousand one hundred fifty-six dollars.

(ii) Clients designated for service need level two may receive up to four hundred fifty-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 fifty-six dollars per month;

(B) If the combined total of family support services at this maximum plus in-home support is less than fifty-six hundred four dollars, additional family support can be authorized to bring the total to four hundred fifty-six dollars.

(iii) Clients designated for service need level three may receive up to two hundred fifty-six 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-eight dollars per month; and

(iv) Clients designated for service level four may receive up to one hundred twenty-eight 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, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-254, filed 12/14/01, effective 1/14/02. 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.]

Chapter 388-835 WAC

ICF/MR PROGRAM AND REIMBURSEMENT SYSTEM

(Formerly chapter 275-38 WAC)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-835-010 Terms—Definitions. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-015 Exemptions. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-020 ICF/MR care. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-025 Name of IMR. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-030 Closure of an IMR facility. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-035 Adequate IMR care. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-040 Continuity of resident care. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-045 IMR contract—Noncompliance. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-050 Minimum staff requirements. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-055 Placement of client. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-060 Transfer of client—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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-065 Resident rights—Relocation redetermination of eligibility. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-070 Transfer or discharge planning. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-075 Discharge, readmission, and incident reporting. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-080 Social leave for IMR residents. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-085 Superintendent's limited authority to hold. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-090 Prospective cost-related reimbursement. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-095 Conditions of participation. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-100 Projected budget for new contractors. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-105 Change of ownership. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-110 Termination of contract. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-115 Due dates for reports. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-120 Requests for extensions. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-125 Reports. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-130 Failure to submit final reports. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-135 Improperly completed or late reports. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-140 Completing reports and maintaining records. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-145 Certification requirement. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-150 Reports—False information. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-155 Amendments to reports. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-160 Requirement for retention of reports by the department. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-165 Requirements for retention of records by the contractor. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-170 Disclosure of IMR facility reports. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-175 Desk review. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-180 Field audits. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-185 Preparation for audit 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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-190 Scope of field audits. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-195 Inadequate documentation. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-200 Deadline for completion of audits. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-205 Disclosure of audit narratives and summaries. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-210 Resident trust accounts. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-215 Accounting procedures for resident trust accounts. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-220 Trust moneys—Imprest fund. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-225 Trust moneys control or disbursement. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-230 Trust moneys availability. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-235 Accounting upon change of ownership. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-240 Procedure for refunding trust money. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-245 Liquidation of trust fund. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-250 Resident property records. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-255 Allowable costs. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-260 Substance prevails over form. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-265 Offset of miscellaneous revenues. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-270 Costs of meeting standards. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-275 Limit on costs to related organizations. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-280 Start-up costs. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-285 Organization costs. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-290 Education and training. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-295 Total compensation—Owners, relatives, and certain administrative personnel. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-300 Owner or relative—Compensation. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-305 Allowable interest. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-310 Offset of interest income. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-315 Operating leases of facilities and 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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-320 Rental expense paid to related organizations. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-325 Capitalization. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-330 Depreciation expense. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-335 Depreciable assets. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-340 Depreciation base. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-345 Depreciation base—Donated or inherited assets. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-350 Lives. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-355 Methods of depreciation. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-360 Retirement of depreciable assets. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-365 Handling of gains and losses upon retirement of depreciable assets. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-370 Handling of gains and losses upon retirement of depreciable assets—Other periods. [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.] Repealed by 01-10-

013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-375 Handling of gains and losses upon retirement of depreciable assets. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-380 Recovery of excess over straight-line depreciation. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-385 Unallowable costs. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-390 Reimbursement principles. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-395 Program services not covered by the reimbursement rate. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-400 Prospective reimbursement rate for new contractors. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-405 Rate determination. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-410 Desk review for rate determination. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-415 Cost centers. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-420 Resident care and habilitation cost center rate. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-425 Administration, operations, and property cost center rate. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-430 Food rate component. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-435 Maximum allowable compensation of certain administrative personnel. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-440 Management agreements, management fees, central office services, and board of directors. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-445 Administration and operations rate component. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-450 Property rate component. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-455 Return on equity. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-460 Upper limits to reimbursement rate. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-465 Principles of settlement. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-470 Procedures for overpayments and underpayments. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-475 Preliminary settlement. [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.] Repealed by 01-10-013, filed

4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-480 Final settlement. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-485 Interim rate. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-490 Final payment. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-495 Notification of rates. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-500 Adjustments required due to errors or omissions. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-505 Receivership. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-510 Adjustments to prospective rates. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-515 Public review of rate-setting methods and standards. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-520 Public disclosure of 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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-525 Billing period. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-530 Billing procedures. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-535 Charges to residents. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-540 Payment. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-545 Suspension of payment. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-550 Termination of payments. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-555 Disputes. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-560 Recoupment of undisputed overpayments. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-565 Administrative review—Adjudicative proceeding. [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.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

WAC 388-835-0005 What is the purpose of this chapter? (1) The purpose of this chapter is to establish rules authorized by Title 71A RCW, Developmental disabilities that:

(a) Regulate the purchase and provision of services in intermediate care facility for the mentally retarded (ICF/MR); and

(b) Assure adequate ICF/MR care, service, and protection are provided through licensing and certification procedures; and

(c) Establish standards for providing habilitative training, health-related care, supervision, and residential services to eligible persons.

(2) Except where specifically referenced, this chapter supersedes and replaces any and all sections affecting ICF/MR facilities or programs contained in chapter 388-96 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0005, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0010 What terms and definitions are important to understanding this chapter? Unless the context clearly requires otherwise, the following terms and definitions are used consistently throughout the chapter:

"Accrual method of accounting" is a method of accounting where:

(1) Revenues are reported when they are earned, regardless of when they are collected; and

(2) Expenses are reported when they are incurred, regardless of when they are paid.

"Active treatment," as used in this chapter, is defined in 42 CFR 483.440(a) and includes implementation of an individual program plan for each resident as outlined in 42 CFR 483.440 (c) through (f).

"Administration and management" means activities used to maintain, control, and evaluate an organization's use of resources while pursuing its goals, objectives and policies.

"Admission" means entering a state-certified facility and being authorized to receive services from it.

"Allowable costs" are documented costs that:

(1) Are necessary, ordinary, and related to providing ICF/MR services to ICF/MR residents; and

(2) Not expressly declared **"nonallowable"** by applicable statutes or regulations.

"Appraisal" is a process performed by a professional person either designated 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 appraisal process is used to establish the fair market value of an asset or to reconstruct the historical cost of an asset that was acquired in a past period. The appraisal process includes recording and analyzing property facts, rights, investments and values based on a personal inspection and a property inventory.

"Arm's-length transaction" is a transaction resulting from good faith bargaining between a buyer and seller who hold adverse positions in the market place. Arm's-length transactions are presumed to be objective transactions. A sale or exchange of ICF/MR or nursing home facilities among two or more parties where all parties continue to own one or more of the facilities involved in the transaction is not considered an arm's-length transactions. The sale of an ICF/MR facility that is subsequently leased back to the seller within five years of the date of sale is not considered an arm's-length transaction for purposes of chapter 388-835 WAC.

"Assets" are economic resources of the provider, recognized, and measured in conformity with generally accepted accounting principles. Assets also include deferred charges that are recognized and measured according to generally accepted accounting principles. (The value of assets acquired in a change of ownership transaction entered into after September 30, 1984, cannot exceed the acquisition cost of the owner of record as of July 18, 1984.)

"Bad debts" or **"uncollectable accounts"** are amounts considered uncollectable from accounts and notes receivable. Generally accepted accounting principles must be followed when accounting for bad debts.

"Beds," unless otherwise specified, means the number of set-up beds in an ICF/MR facility. The number of set-up beds cannot exceed the number of licensed beds for the facility.

"Beneficial owner": For a definition, see WAC 388-835-0015.

"Boarding home" means any home or other institution licensed according to the requirements of chapter 18.20 RCW.

"Capitalization" means recording expenditures as assets.

"Capitalized lease" is a lease that is recorded, according to generally accepted accounting principles, as an asset with an associated liability.

"Cash method of accounting" is a method of accounting where revenues are recorded only when cash is received and expenses are not recorded until cash is paid.

"Change of ownership," see WAC 388-835-0020.

"Charity allowances" are reductions in a provider's charges because of the indigence or medical indigence of a resident.

"Consent" means the process of obtaining a person's permission before initiating procedures or actions against that person.

"Contract" means a contract between the department and a provider for the delivery of ICF/MR services to eligible Medicaid recipients.

"Provider" means an entity contracting with the department to deliver ICF/MR services to eligible Medicaid recipients.

"Courtesy allowances" are reductions in charges to physicians, clergy, and others for services received from a provider. Employee fringe benefits are not considered courtesy allowances.

"Custody" means the immediate physical confinement, sheltering and supervision of a person in order to provide them with care and protect their welfare.

"DDD" means the division of developmental disabilities of the department.

"Department" means the department of social and health services (DSHS) and its employees.

"Depreciation" is the systematic distribution of the cost (or depreciable base) of a tangible asset over its estimated useful life.

"Discharge" means the process that takes place when:

(1) A resident leaves a residential facility; and

(2) The facility relinquishes any responsibility it acquired when the resident was admitted.

"Donated asset" is an asset given to a provider without any payment in cash, property, or services. An asset is not considered donated if the provider makes a nominal payment when acquiring it. An asset purchased using donated funds is not a donated asset.

"Entity" means an individual, partnership, corporation, public institution established by law, or any other association of individuals, capable of entering into enforceable contracts.

"Equity capital" is the total tangible and other assets that are necessary, ordinary, and related to resident care listed on a provider's most recent cost report minus the total related long-term debt from the same cost report plus working capital as defined in this section.

"Exemption" means a department approved written request asking for an exception to a rule in this chapter.

"Facility" means a residential setting certified, according to federal regulations, as an ICF/MR by the department. A state facility is a state-owned and operated residential living center. A private facility is a residential setting licensed as a nursing home under chapter 18.51 RCW or a boarding home licensed under chapter 18.20 RCW.

"Fair market value" is the purchase price of an asset resulting from an arm's-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

"Financial statements" are statements prepared and presented according to generally accepted accounting principles and practice and the requirements of this chapter. Financial statements and their related notes include, but are not limited to, balance sheet, statement of operations, and statement of change in financial position.

"Fiscal year" is the operating or business year of a provider. Providers report on the basis of a twelve-month fiscal year, but this chapter allows reports covering abbreviated fiscal periods.

"Funded capacity," for a state facility, is the number of beds on file with the office of financial management.

"Generally accepted accounting principles" are the accounting principles currently approved by the financial accounting standard board (FASB).

"Generally accepted auditing standards" are the auditing standards currently approved by the American Institute of Certified Public Accountants (AICPA).

"Goodwill" is the excess of the purchase price of a business over the fair market value of all identifiable, tangible, and intangible assets acquired. **"Goodwill"** also means the excess of the price paid for an asset over fair market value.

"Habilitative services" means those services required by an individual habilitation plan.

"Harmful" is when an individual is at immediate risk of serious bodily harm.

"Historical cost" is the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies.

"Imprest fund" is a fund:

(1) Regularly replenished for the amounts expended from it; and

(2) The cash in the fund and the receipts for expenditures should always equal a predetermined amount.

(3) An example of an imprest fund is a petty cash fund.

"ICF/MR" means a facility certified by Title XIX as an intermediate care facility for providing services to persons with mental retardation or related conditions.

"Interest" is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the borrower.

"Joint facility costs" are any expenses incurred that benefit more than one facility or a facility and any other entity.

"Lease agreement" is a contract for a specified period of time between two parties regarding the possession and use of real or personal property and/or assets in exchange for specified periodic payments.

"Medicaid program" means either the state medical assistance program provided under RCW 74.09.500 or authorized state medical services.

"Medical assistance recipient" is an individual that the department declares eligible for medical assistance services provided in chapter 74.09 RCW.

"Modified accrual method of accounting" is a method of accounting that records revenues only when cash is received and records expenses when they are incurred, regardless of when they are paid.

"Net book value" is the historical cost of an asset less its accumulated depreciation.

"Nonallowable costs" are costs that are not documented, necessary, ordinary and related to providing services to residents.

"Nonrestricted funds" are donated funds not restricted to a specific use by the donor. General operating funds are an example of nonrestricted funds.

"Nursing facility" means a home, place, or institution, licensed or certified according to chapter 18.51 RCW.

"Operating lease" is a lease, according to generally accepted accounting principles, that requires rental or lease payments to be charged to current expenses when they are incurred.

"Ordinary costs" are costs that, by their nature and magnitude, a prudent and cost conscious management would pay.

"Owner" means a sole proprietor, general or limited partner, or beneficial interest holder of at least five percent of a corporation's outstanding stock.

"Ownership interest" means all beneficial interests owned by a person (calculated in the aggregate) regardless of the form such beneficial ownership takes. Also, see WAC 388-835-0015.

"Per diem costs" or **"per resident day costs"** are total allowable costs for a fiscal period divided by total resident days for that same period.

"Prospective daily payment rate" is the daily amount the department assigns to each provider for providing services to ICF/MR residents. The rate is used to compute the department's maximum participation in the provider's cost.

"Qualified mental retardation professional (QMRP)" means QMRP as defined under 42 CFR 483.430(a).

"Qualified therapist," see WAC 388-835-0030.

"Regression analysis" is a statistical technique used to analyze the relationship between a dependent or criterion variable and a set of independent or predictor variables.

"Regional services" are the services of a local office of the division of developmental disabilities.

"Related organization" is an entity that either controls another entity or is controlled by another entity or provider. Control results from common ownership or the ability to exercise significant influence on the other entity's activities. Control occurs when an entity or provider has:

(1) At least a five percent ownership interest in the other entity; or

(2) The ability to influence the activities of the other.

"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.

"Resident" or **"person"** means a person the division determines is, under RCW 71A.16.040 eligible for division-funded services.

"Resident day" means a calendar day of resident care. When computing calendar days of resident care, the day of admission is always counted. The day of discharge is counted only when discharge and admission occur on the same day. For the purpose of this definition, a person is considered admitted when they are assigned a bed and a resident record is opened for them.

"Resident care and training staff" are staff whose primary responsibility is the care and development of the residents, including:

(1) Resident activity program;

(2) Domiciliary services; and

(3) Habilitative services under the supervision of a QMRP.

"Restricted fund" is a fund where the donor restricts the use of the fund principal or income to a specific purpose. Restricted funds generally fall into one of three categories:

(1) Funds restricted to specific operating purposes; or

(2) Funds restricted to additions of property, plant, and equipment; or

(3) Endowment funds.

"RHC" - Residential habilitation center. A facility owned and operated by the state and is certified as an ICF/MR or a nursing facility.

"Secretary" means the secretary of DSHS.

"Start-up costs" are the one-time costs incurred from the time preparations begin on a newly constructed or purchased building until the first resident is admitted. Such **"preopening"** costs include, but are not limited to, administrative and nursing salaries, utility costs, taxes, insurance, repairs and maintenance, and training costs. Start-up costs do not include expenditures for capital assets.

"Superintendent" means the superintendent of a residential habilitation center (RHC) or the superintendent's designee.

"Title XIX" means the 1965 amendments to the Social Security Act, P.L. 89-07, as amended.

"Uniform chart of accounts" means a list of department established account titles and related code numbers that providers must use when reporting costs.

"Vendor number" or **"provider number"** is a number assigned by the department to each provider who delivers ICF/MR services to ICF/MR Medicaid recipients.

"Working capital" is the difference between the total current assets that are necessary, ordinary, and related to resident care, as reported in a provider's most recent cost report, and the total current liabilities necessary, ordinary, and related to resident care reported in the same cost report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0010, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0015 What is a "beneficial owner"? A beneficial owner is any person who:

(1) Has or shares, by contract, arrangement, understanding, relationship, or otherwise, the power to:

(a) Vote or direct the voting of an ownership interest; and/or

(b) Invest, including the power to dispose of or direct the disposition of an ownership interest.

(2) Creates or uses a trust, proxy, power of attorney, pooling arrangement, or any other contract, arrangement, or device to divest a beneficial owner of their ownership or prevent the vesting of their ownership in order to evade the reporting requirements of this chapter;

(3) Has the right to acquire a beneficial ownership interest within sixty days of one of the following occurring:

(a) Exercising any option, warrant, or right;

(b) Converting an ownership interest;

(c) Revoking a trust, discretionary account, or similar arrangement; or

(d) Automatically terminating a trust, discretionary account, or similar arrangement.

(e) Any person acquiring an ownership interest by exercising (a), (b) or (c) of this subsection must be deemed the beneficial owner of that interest.

(4) In the ordinary course of business, according to a written pledge agreement, becomes a pledge of an ownership interest. A pledge must not be deemed the beneficial owner of a pledged ownership interest except when all of the following conditions are met:

(a) The pledge must follow all the steps in the pledge agreement and:

(i) Declare a default and determine the power to vote;

(ii) Direct the vote; or

(iii) Dispose of the pledged ownership interest; or

(iv) Direct how the disposition of the pledged ownership interest will take place.

(b) The agreement must:

(i) Be bona fide;

(ii) Not change or influence a provider's control; and

(iii) Not be related to any transaction attempting to change or influence a provider's control.

(c) The agreement, before default, cannot grant the pledge the power to:

(i) Vote or direct the vote of the pledged ownership interest; or

(ii) Dispose or direct the disposition of the pledged ownership interest except where credit is extended and the pledge is a broker or dealer.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0015, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0020 What is a "change in ownership"? (1) A "change in ownership" is a change in the individual or legal organization responsible for the daily operation of an ICF/MR facility.

(2) Types of events causing a change in ownership include but are not limited to:

(a) Changing the form of legal organization of the owner, such as a sole proprietorship becomes a partnership or corporation;

(b) Transferring the title to the ICF/MR enterprise from the provider to another party;

(c) Leasing the ICF/MR facility to another party or an existing lease is terminated;

(d) When the provider is a partnership, any event that dissolves the partnership;

(e) When the provider is a corporation and the corporation:

(i) Is dissolved;

(ii) Merges with another corporation which is the survivor; or

(iii) Consolidates with one or more other corporations to form a new corporation.

(3) Ownership does not change when:

(a) The provider contracts with another party to manage the facility and act as the provider's agent subject to the provider's general approval of daily operating decisions; or

(b) When the provider is a corporation, some or all of its corporate stock is transferred.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0020, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0025 How can lease agreements be terminated? (1) Lease agreements can be terminated by:

(a) Eliminating or adding parties to the agreement;

(b) Expiration of the agreement;

(c) Modifying of any lease term in the agreement;

(d) Terminating the agreement by any means by either party; or

(e) Extending or renewing the agreement, even if done according to its renewal provision, creates a new agreement and effectively terminates the old one.

(2) A strictly formal change in a lease agreement modifying the method, frequency, or manner in which lease payments are made without increasing the total payment obligation of the lessee is not considered a modification of the lease terms.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0025, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0030 What is a "qualified therapist"? A qualified therapist is any of the following:

(1) An activity specialist who has department specified specialized education, training, or experience;

(2) An audiologist eligible for a certificate of clinical competency in audiology or possessing the equivalent education and clinical experience;

(3) A dental hygienist defined, licensed and regulated by chapter 18.29 RCW;

(4) A dietitian either:

(a) Eligible for registration by the American Dietetic Association under requirements in effect on January 17, 1974; or

(b) With a baccalaureate degree whose major studies covered food and nutrition, dietetics, or food service management; plus one year supervisory experience in the dietetic service of a health care institution; and annual participation in continuing dietetic education;

(5) An occupational therapist who graduated from a program in occupational therapy or who possesses the equivalent of such education or training and meets all Washington state legal requirements;

(6) A pharmacist who is licensed by the Washington state board of pharmacy to engage in the practice of pharmacy;

(7) A physical therapist, meaning someone practicing physical therapy as defined in RCW 18.74.010(3). Physical therapist does not include massage operators as defined in RCW 18.108.010;

(8) A physician as defined, licensed and regulated by chapter 18.71 RCW or an osteopathic physician as defined, licensed and regulated by chapter 18.57 RCW;

(9) A psychologist as defined, licensed and regulated by chapter 18.83 RCW;

(10) A qualified mental retardation professional;

(11) A registered nurse as defined by chapter 18.88A RCW;

(12) A social worker who is a graduate of a school of social work; or

(13) A speech pathologist either:

(a) Eligible for a certificate of clinical competence in speech pathology; or

(b) Possessing the equivalent education and clinical experience.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0030, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0035 Does DSHS grant exemptions to these rules? (1) DSHS may approve an exemption to a specific rule in this chapter if an:

(a) Assessment of the request concludes that the exemption will not undermine the legislative intent of Title 71A RCW, Developmental disabilities; and

(b) Evaluation of the request shows that the exemption will not adversely effect the quality of service, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers must retain a copy of each department-approved exemption.

(3) Actions regarding exemption requests are not subject to appeal.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0035, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0040 What general requirements apply to ICF/MR care facilities? The following general requirements apply:

(1) The division will recognize only the official name of an ICF/MR as shown on the license.

(2) All state and private ICF/MR facilities must be certified as a Title XIX IMR ICF/MR facility.

(3) All private ICF/MR facilities with a certified capacity of at least sixteen beds must be licensed as a nursing home under chapter 18.51 RCW, Nursing homes.

(4) All private ICF/MR facilities with a certified capacity of less than sixteen beds must be licensed as a boarding home for the aged under chapter 18.20 RCW.

(5) All facilities certified to provide ICF/MR services must comply with all applicable Title XIX, Section 1905 of the Social Security Act 42 U.S.C federal regulations as amended. In addition, all private-operated facilities must comply with state regulation governing the licensing of nurs-

ing homes or boarding homes for the aged and any other relevant state regulations.

(6) All certified facilities must only admit persons with developmental disabilities as residents.

(7) State facilities may not exceed funded capacity unless authorized by the secretary to do so (see RCW 71A.20.090).

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0040, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0045 What are the minimum staff requirements for an ICF/MR facility? All ICF/MR facilities must provide sufficient number of qualified staff to meet the needs of their residents.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0045, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0050 What general requirements apply to the quality of ICF/MR services? (1) DSHS is responsible for assuring the:

(a) Health care and habilitative training needs of an individual are identified and met according to state and federal regulations.

(b) Individual is placed in a facility certified as capable of meeting their needs.

(2) DDD regional service staff is responsible for authorizing changes in residential services.

(3) All services provided must be essential to the resident's habilitation and health care needs and to achieving the primary goal of attaining the highest level of independence possible for each individual resident.

(4) A resident in an ICF/MR is eligible for community residential services when such services meet their needs.

(5) Every ICF/MR must provide habilitative training and health care that at least includes the following:

(a) Active treatment;

(b) Services according to the identified needs of the individual resident and provided by or under the supervision of qualified therapists;

(c) Routine items and supplies provided uniformly to all residents;

(d) Providing necessary surgical appliances, prosthetic devices, and aids to mobility for the exclusive use of individual residents;

(e) Nonreusable supplies not usually provided to all residents may be individually ordered. A department representative must authorize requests for such supplies.

(6) Each ICF/MR facility is responsible for providing transportation for residents. This responsibility may include the guarantee of a resident's use of public transportation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0050, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0055 What are the resident's rights if DSHS decides that they are no longer eligible for ICF/MR services? (1) A resident, their guardian, next-of-kin, or responsible party must be informed by DSHS in writing thirty days before any redetermination of their eligibility for ICF/MR services takes place.

(2) The redetermination notice must include:

(a) The reasons for the proposed eligibility change;

(b) A statement that the resident or any other individual designated by the resident has a right to a conference with a DDD representative within thirty days of receipt of the notice;

(c) A statement that the resident has the right to request a hearing to contest the department's decision within thirty days of the notice;

(d) Information as to how a hearing can be requested;

(e) A statement that the resident has the right to be represented at the hearing by an authorized representative; and

(f) Information regarding the availability and location of legal services within the resident's community.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0055, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0060 What are DSHS responsibilities when it decides to redetermine a resident eligibility for ICF/MR services? DSHS must send a hearing request form with the notice of redetermination.

(1) If the resident requests a hearing within the thirty-day time period, DSHS must not redetermine eligibility until a hearing decision is reached or appeal rights have been exhausted unless redetermination is warranted by the resident's health or safety needs.

(2) If the secretary or the secretary's designee concludes that redetermination is not appropriate, no further action will be taken to redetermine eligibility unless there is a change in the situation or circumstances. If there is a change in the situation or circumstances, the request may be resubmitted.

(3) If the secretary or the secretary's designee affirms the decision to change the resident's eligibility and no judicial review is filed within thirty days of the receipt of notice of redetermination, the department must proceed with the planned action.

(4) If the secretary or secretary's designee affirms the decision to change the resident's eligibility and a request for judicial review has been filed, any proposed redetermination must be delayed until the appeal process is complete unless a delay jeopardizes the resident's health or safety.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0060, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0065 Do residents always have a right to a hearing? Advance notice and planning does not include a right to a hearing for a resident when the department concludes that the facility where the resident resides cannot provide Title XIX services due to:

(1) Termination of the facility's contract;

(2) Decertification of the facility;

(3) Nonrenewal of the facility's contract;

(4) Revocation of the facility's license; or

(5) An emergency suspension of the facility's license.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0065, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0070 What requirements apply to the placement of individuals in an ICF/MR facility? (1) Plac-

ing individuals in an ICF/MR facility is the responsibility of the division of developmental disabilities and must be done according to applicable federal and state regulations.

(2) A facility may not admit an individual who requires services the facility cannot provide.

(3) Department representatives must determine an individual's eligibility for ICF/MR services before payment can be approved.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0070, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0075 What if an individual is transferred between facilities? (1) When an individual is transferred between facilities, all essential information concerning the individual, their condition, regimen of care and training must be transmitted, in writing, by the sending facility to the receiving facility at the time of the transfer.

(2) "Transferred between facilities" means transferred from:

(a) An ICF/MR to ICF/MR;

(b) An ICF/MR to a hospital;

(c) A hospital to an ICF/MR; or

(d) An ICF/MR or hospital to alternative community placement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0075, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0080 What if an ICF/MR facility is closed? (1) When a facility plans to close, it must notify the department, in writing, at least one hundred and eighty days before the date of closure.

(2) Upon receipt of a notice of closure, the department must stop referring individuals to the facility and begin the orderly transfer of its residents.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0080, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0085 Why is an individual transferred or discharged? An individual admitted to a facility can be transferred or discharged only for:

(1) Medical reasons;

(2) A change in the individual's habilitation needs;

(3) The individual's welfare;

(4) The welfare of other residents; or

(5) At the request of the resident or legal guardian.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0085, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0090 What is the basis of the decision to transfer or discharge an individual? The decision to transfer or discharge an individual must be based on:

(1) An assessment of the resident in consultation with the service provider and the parent or guardian; and

(2) A review of the relevant records.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0090, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0095 Is a transfer plan required for each resident? (1) DDD must prepare a written plan for each resident to be transferred.

(2) These plans must:

(a) Identify the location of available facilities that provide services appropriate and consistent with the resident's needs;

(b) Provide for coordination between the staffs of the old and new agencies;

(c) Allow for a pretransfer visit, when the resident's condition permits, to the new facility, so the resident can become familiar with the new surroundings and residents;

(d) Encourage active participation by the resident's guardian or family in the transfer preparation;

(e) Facilitate discussions between the staffs of the old and new facilities regarding expectations;

(f) Provide opportunities for consultations on request between the two staffs; and

(g) Require follow-up by DDD to monitor the effects of the transfer.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0095, filed 4/20/01, effective 5/21/01.]

WAC 388-835-010 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0100 Why would an individual move? An individual may move if:

(1) The services provided to an individual do not meet their needs;

(2) A facility's ICF/MR certification or license is revoked or suspended;

(3) Medical reasons dictate relocation;

(4) A resident's welfare would be improved;

(5) The welfare of the other residents would be enhanced;

(6) There is no payment for services provided to the resident during their stay at the facility; or

(7) The resident and/or guardian make a formal request.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0100, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0105 What are DSHS' responsibilities for placing individuals? (1) When services available to an individual do not meet their needs, the department is responsible for initiating and facilitating the resident's relocation.

(2) The department may enforce immediate movement of a resident from an ICF/MR facility when the facility's ICF/MR certification or license is revoked or suspended.

(3) The department must notify a resident and their guardian, next of kin, or responsible party, in writing, when:

(a) DSHS or Health Care Financing Administration (HCFA) determines a facility no longer meets certification requirements as an ICF/MR;

(b) DSHS determines the facility does not meet contract requirements; or

(c) A facility voluntarily terminates their contract with DSHS or stops participating in the ICF/MR program.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0105, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0110 Is DSHS required to give written notice when it intends to transfer an individual? (1) WAC 388-835-054 requires that DSHS give the resident and their guardian, next of kin, or responsible party thirty days notice, in writing, of it's intent to transfer the resident.

(2) If there is a serious and immediate threat to the resident's health or safety, DSHS is not required to give the resident and their guardian, next of kin, or responsible party thirty days notice of it's intent to transfer the resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0110, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0115 Can a facility request that an individual be transferred? Facilities can request that a resident be transferred for the following reasons:

(1) Medical reasons;

(2) A change in the individual's habilitation needs;

(3) The individual's welfare;

(4) The welfare of the other residents; or

(5) Nonpayment for services provided to the resident during the resident's stay at the facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0115, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0120 What steps must be followed when a facility makes a transfer request? The following steps apply when a facility wants a resident transferred:

(1) The facility must send their request to the department in writing. The request must explain why the relocation is necessary and document that the interdisciplinary team responsible for developing the resident's habilitation plans agrees with the request.

(2) DSHS must approve or deny the request within fifteen working days of receiving it. The department's decision must be based upon:

(a) An on-site visit with the resident; and

(b) A review of the resident's records.

(3) The facility administrator must be informed of the department's decision.

(4) If the facility's request is approved, the department must give the resident and their guardian, next of kin, or responsible party thirty days notice, in writing, of it's intent to transfer the resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0120, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0125 Can residents request a transfer? (1) Every resident has a right to:

(a) Request a transfer; and

(b) Select where they wish to move.

(2) If the resident's selection is available and appropriate to their habilitation and health care needs, the department must make all reasonable attempts to accomplish transfer.

(3) If the selection is neither appropriate nor available, the resident may make another selection.

(4) All requests by the resident or their guardian must be in writing.

(5) DDD is solely responsible for arranging the resident's transfer.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0125, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0130 What rights are available to a resident regarding a proposed transfer? (1) A resident, their guardian, next-of-kin, or responsible party must be notified in writing at least thirty days before any transfer occurs.

(2) The transfer notice must include:

(a) The reasons supporting the proposed transfer;

(b) A statement that the resident or any other individual designated by the resident has a right to a conference with a DDD representative within twenty-eight days of receipt of the notice;

(c) A statement that the resident has the right to request a hearing to contest the department's decision within thirty days of the notice;

(d) Information as to how a hearing can be requested;

(e) A statement that the resident has the right to be represented at the hearing by an authorized representative; and

(f) Information regarding the availability and location of legal services within the resident's community.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0130, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0135 What are DSHS responsibilities when it decides to transfer a resident? DSHS must send a hearing request form with the notice of transfer.

(1) If the resident requests a hearing within the thirty-day time period, DSHS must not transfer the resident until a hearing decision is reached or appeal rights have been exhausted unless the transfer is warranted by the resident's health or safety needs or the welfare of the other residents.

(2) If the secretary or the secretary's designee concludes that the transfer is not appropriate, no further action is to be taken to transfer unless there is a change in the situation or circumstances surrounding the transfer request. If there is a change in the situation or circumstances, the request may be resubmitted.

(3) If the secretary or the secretary's designee affirms the decision to transfer the resident and no judicial review is filed within thirty days of the receipt of notice of transfer, DSHS must proceed with the planned action.

(4) If the secretary or secretary's designee affirms the decision to transfer the resident and a request for judicial review has been filed, any proposed transfer must be delayed until the appeal process is complete unless a delay jeopardizes the resident's health or safety or the welfare of other residents.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0135, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0140 Do residents always have a right to a hearing? Advance notice and planning does not include a right to a hearing for a resident when the department con-

cludes that the facility where the resident resides cannot provide Title XIX services due to:

(1) Termination of the facility's contract;

(2) Decertification of the facility;

(3) Nonrenewal of the facility's contract;

(4) Revocation of the facility's license; or

(5) An emergency suspension of the facility's license.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0140, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0145 Does a facility have a responsibility to report incidents involving residents? Any facility that has an ICF/MR contract with DSHS must immediately contact their DDD regional services office regarding unauthorized leaves, disappearances, serious accidents, or other traumatic incidents effecting a resident or the resident's health or welfare.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0145, filed 4/20/01, effective 5/21/01.]

WAC 388-835-015 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0150 When does DSHS require discharge and readmission of a resident? DSHS requires discharge and readmission for all residents admitted as hospital inpatients.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0150, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0155 What requirements apply to social leaves for ICF/MR residents? (1) All social leaves should be consistent with the goals and objectives in the resident's individual habilitation plan.

(2) Any facility vacancies resulting from a resident's social leave will be reimbursed if the leave complies with the individual habilitation plan and the following conditions:

(a) The facility must notify the DDD director or their designee of all social leaves exceeding fifty-three hours.

(b) All social leaves exceeding seven consecutive days must receive prior written approval from the DDD director or their designee.

(c) The DDD director or their designee must give written approval before a resident can accumulate more than seventeen days of social leave per year.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0155, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0160 Can residential habilitation center (RHC) superintendents involuntarily detain residents? (1) When an RHC resident decides to initiate a voluntarily discharge, the superintendent must determine if the discharge is harmful to the resident.

(2) If the superintendent concludes that the discharge is harmful, they may detain the resident for up to forty-eight hours until the harm passes. The superintendent may also refer the resident to a mental health professional as defined in RCW 71.05.150.

(3) At the end of the forty-eight hour detention period, the superintendent must release the resident.

(4) If, within six months, the superintendent detains the resident a second time, they must refer the resident to a mental health professional within eight hours of the second detention. During this second detention, the resident may only be held until the mental health professional:

(a) Investigates and evaluates the specific facts surrounding the situation; and

(b) Determines if further detention is necessary (see RCW 71.05.150).

(5) Nothing in this section prevents a superintendent or their designee from allowing a resident to leave the RHC for specified periods necessary for their habilitation or care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0160, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0165 Is a superintendent required to give notice when they detain a resident? (1) When a superintendent detains an RHC resident, the superintendent or their designee must notify the resident and their legal representative as required in RCW 71A.10.070.

(2) If the resident's legal representative is not available, the superintendent must also notify one or more of the following persons in the order of priority listed:

(a) A parent of the resident;

(b) Other persons of close kinship relationship to the resident;

(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 a DSHS employee or an ICF/MR but who, in the superintendent's opinion, is concerned with the resident's welfare.

(3) Nothing in this section prevents a superintendent from notifying:

(a) A mental health professional;

(b) Local law enforcement;

(c) Adult protective services;

(d) Child protective services;

(e) Other agencies as appropriate; or

(f) Director, division of developmental disabilities, or designee.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0165, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0170 What is a superintendent's responsibility when a resident voluntarily leaves an RHC? When a resident voluntarily leaves RHC programs and services, the superintendent must initiate discharge proceedings.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0170, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0175 What if a facility violates its ICF/MR contract? (1) If a facility violates the terms of their contract, DSHS may temporarily suspend referring residents to it.

(2) Whenever DSHS suspends referrals it must notify the facility immediately, in writing, and give the reasons for its action.

(3) The suspension may continue until DSHS determines that the circumstances leading to it have been corrected.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0175, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0180 What if an ICF/MR contract is terminated? (1) Before a contract is terminated, the provider must give DSHS one hundred and eighty days written notice of the termination.

(2) When a contract is terminated, the provider must submit final reports to DSHS according to the requirements of WAC 388-835-124.

(3) When notified of a contract termination, DSHS must determine, by preliminary or final settlement calculations, the amount of any overpayments made to the provider, including overpayments disputed by the provider. If preliminary or final settlements are not available for any periods before the termination date of the contract, DSHS must use available relevant information to make a reasonable estimate of any overpayments or underpayments.

(4) The provider must file a properly completed final cost report (see the requirements in WAC 388-835-0225, 388-835-0230, and 388-835-0235). This report may be audited by DSHS. A final settlement must be determined within ninety days after the audit process is completed (including any administrative review of the audit requested by the provider) or within twelve months of the termination of the contract if an audit is not performed.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0180, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0185 Does DSHS withhold payment for services when a contract is terminated? (1) Payment for services provided before a contract was terminated, equal to the amount determined in WAC 388-835-0180(3), may be withheld by DSHS until the provider files a properly completed final annual cost report and a final settlement has been calculated.

(2) Instead of withholding payments, DSHS may allow a provider to offer security equal to the determined and/or estimated overpayments even when the overpayments are being disputed in good faith. Types of security acceptable to DSHS are:

(a) A surety bond issued by a bonding company acceptable to DSHS;

(b) An assignment of funds to DSHS;

(c) Collateral acceptable to DSHS;

(d) A purchaser's assumption of liability for the provider's overpayment; or

(e) Any combination of (a) through (d) of this subsection.

(3) DSHS must release any payments withheld if a provider gives acceptable security equal to the determined and/or estimated overpayments.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0185, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0190 What happens to withheld payments and security from a provider when a final settlement is determined? (1) When a final settlement is determined, security held by DSHS must be released to the provider after any related overpayments owed to the department have been paid.

(2) If the provider disagrees with the settlement and does not repay any overpayments owed, DSHS must retain security equal to the amount of the disputed overpayments until the administrative appeal process is completed.

(3) If the total of withheld payments, bonds, and assignments is less than the total of the determined and/or estimated overpayments, the unsecured portion of the overpayments is a debt owed to the state of Washington. This debt becomes a lien against the provider's real and personal property when DSHS files with the auditor in the county where the provider resides or owns property. This lien has preference over all unsecured creditor claims against the provider.

(4) If the total existing overpayments exceed the value of the security held by DSHS, DSHS may use whatever legal means are available to recover the difference.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0190, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0195 What requirements apply to surety bonds or assigned funds used as security by a provider? All surety bonds or assignment of funds, offered as security, must be:

(1) At least equal in amount to the determined and/or estimated overpayments minus any withheld payments even if the overpayments are the subject of a good faith dispute;

(2) Issued or accepted by a bonding company or financial institution licensed to transact business in Washington state;

(3) For a term sufficient to cover the time period needed to determine a final settlement and exhaust administrative and judicial remedies;

(4) Forfeited to DSHS if the term proves insufficient and the bond or assignment is not renewed for an amount equal to any remaining overpayment in dispute;

(5) Paid to DSHS if a properly completed final cost report is not filed by the provider or if financial records supporting this report are not retained and available to the auditor; and

(6) Paid to DSHS if the provider does not pay the refund owed within sixty days following receipt of a written demand to do so or the conclusion of any administrative or judicial proceedings held to settle the dispute.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0195, filed 4/20/01, effective 5/21/01.]

WAC 388-835-020 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0200 Does decertification, termination or nonrenewal of a contract stop payment of Title XIX funds? A decertification, termination, or nonrenewal of a contract stops the payment of Title XIX funds. Actions such as these do not affect a facility's right to operate as a nursing

home or boarding home, but they do disqualify the facility from operating as an ICF/MR facility and receiving federal funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0200, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0205 How does a change in ownership affect an ICF/MR contract with DSHS? (1) On the effective date of a change of ownership, DSHS's contract with the former owner is terminated. The former owner must give DSHS one hundred and eighty days written notice before the contract is terminated. When a certificate of need is required for the new owner and the new owner wishes to continue to provide services to residents without interruption, a certificate of need must be obtained before the former owner submits their notice of termination (see chapter 70.38 RCW for certificate of need requirements).

(2) If the new provider plans to participate in the cost related reimbursement system, they must meet the conditions specified in WAC 388-835-0215 and submit the projected budget required in WAC 388-835-0220. The new owner's CF/MR contract is effective on the date ownership changes.

(3) When a contract is terminated, the provider must reverse any accumulated liabilities assumed by a new owner against the appropriate accounts.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0205, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0210 What is the prospective cost related reimbursement system (PCRRS)? PCRRS is the system used by DSHS pay for ICF/MR services provided to ICF/MR residents. Reimbursement rates for such services are determined according to the principles, methods, and standards contained in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0210, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0215 What are the requirements for participating in PCRRS? To participate in PCRRS, an entity responsible for operating an ICF/MR facility must:

(1) Obtain a state certificate of need as required by chapter 70.38 RCW, Health planning and development;

(2) Possess a current license to operate an appropriate facility (e.g., nursing home, boarding home);

(3) Be currently certified under Title XIX to provide ICF/MR services;

(4) Hold a current contract to provide ICF/MR services and comply with all of its provisions; and

(5) Comply with all applicable federal and state regulations, including the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0215, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0220 What are the projected budget requirements for new providers? (1) Unless the DDD director approves a shorter period, each new provider must submit a one-year projected budget to DSHS at least sixty days before the contract will become effective.

(2) The projected budget must cover the twelve months immediately following the date the provider will enter the program.

(3) The projected budget must:

(a) Be prepared according to DSHS instructions;

(b) Be completed on the forms provided by DSHS; and

(c) Include all earnest money, purchase, and lease agreements involved in the change of ownership transaction.

(4) A new provider must also clearly identify, in their projected budget, all individuals and organizations having a beneficial ownership interest in the:

(a) Current operating entity;

(b) Land, building, or equipment used by the facility; and

(c) Purchasing or leasing entity.

(5) For purposes of this section, a "new provider" is one:

(a) Operating a new facility;

(b) Acquiring or assuming responsibility for operating an existing facility; or

(c) Obtaining a certificate of need approval due to an addition to or renovation of a facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0220, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0225 How should cost reports be prepared? (1) All cost reports must be legible and reproducible. All entries must be in black or dark blue ink or submitted in an acceptable, indelible copy.

(2) All providers must complete reports according to the instructions provided by DSHS. If no specific instruction covers a particular situation, generally accepted accounting principles must be followed.

(3) All providers must use the accrual method of accounting, except for governmental institutions operated on a modified accrual basis.

(4) All revenue and expense accruals not received or paid within one hundred twenty days after the accrual is made must be reversed against the appropriate accounts, unless special circumstances are documented that justify continuing to carry all or part of the accrual (e.g., contested billings). Accruals for vacation pay, holiday pay, sick pay and taxes may be carried for longer periods if it is the provider's usual policy to do so and generally accepted accounting principles are followed.

(5) Methods of allocating costs, including indirect and overhead costs, must be consistently applied. Providers operating multi-service facilities or facilities incurring joint facility costs must allocate those costs according to the benefits received from the resources represented by those costs.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0225, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0230 Must a cost report be certified? (1) Every provider cost report required by DSHS must be accompanied by a certification signed on behalf of the provider who was responsible to DSHS during the reporting period.

(2) If a provider files a federal income tax return, the person normally signing the return and the ICF/MR facility administrator must sign the certification.

(3) If someone, who is not an employee of the provider, prepares the cost report, they must submit, as part of the certification, a signed statement indicating their relationship to the provider.

(4) Only original signatures must be affixed to certifications submitted to DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0230, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0235 When are cost reports due to DSHS? (1) Each private provider must submit an annual cost report to DSHS for the period January 1 through December 31 (calendar year) of the preceding year.

(2) Annual calendar year cost reports for a private facility must be submitted to DSHS by March 31 of the following year.

(3) Each state facility must submit an annual cost report to DSHS for the period from July 1 of the preceding year through June 30 of the current year (state fiscal year).

(4) Annual fiscal year cost reports for state facilities must be submitted to DSHS by December 31 following the end of the fiscal year.

(5) If a contract is terminated, the provider must submit a final cost report and any other reports due under subsection (2) within one hundred twenty days after the effective date of termination or the expiration of the final extension granted by DSHS (see WAC 388-835-0340). For these reports, the reporting period is January 1 of the year of termination to the effective date of termination.

(6) A new provider must submit a cost report to DSHS by March 31 of the year following the effective date of their contract or the expiration of the final extension granted by DSHS (see WAC 388-835-0340). The period to be reported is the period extending from the contract's effective date through December 31 of that year.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0235, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0240 Does DSHS grant extensions for cost reporting deadlines? (1) DSHS, after receiving a written request stating why an extension is necessary, may grant a maximum of two thirty-day extensions for filing any required reports. However, the written request must be received at least ten days before the due date of the reports.

(2) DSHS grants extensions only when it is clear why the due date cannot be met and the circumstances requiring the extension were not foreseeable by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0240, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0245 What if a provider fails to submit a final report? (1) If a provider does not submit a final report, all payments received by the provider for the unreported period become a debt owed to DSHS. After receiving DSHS's written demand for repayment, the provider has thirty days to repay this debt.

(2) Interest, at the rate of one percent per month on any unpaid balance, will begin to accrue thirty days after the provider receives DSHS's written demand for repayment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0245, filed 4/20/01, effective 5/21/01.]

WAC 388-835-025 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0250 What if a provider submits improperly completed or late reports? (1) All providers must submit an annual report, including their proposed settlement by cost center, that is prepared according to this chapter's requirements and DSHS instructions. If an annual cost report is not properly prepared, DSHS may return it, in whole or in part, to the provider for correction and/or completion.

(2) If DSHS does not receive a properly completed report, including any approved extensions, on or before its due date, all or part of any payments due under the contract may be withheld until the report is properly completed and received by DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0250, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0255 What if a provider files a report containing false information? (1) Knowingly filing a report with false information (or with reason to know) is cause for termination of a provider's contract with DSHS.

(2) Any required adjustments to reimbursement rates because a false report was filed will be made according to WAC 388-835-0900.

(3) DSHS may refer for prosecution under applicable statues, any provider who files a false report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0255, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0260 Can providers amend annual cost reports filed with DSHS? DSHS must consider amendments to annual reports only when:

(1) Determining allowable costs affecting a final settlement computation, and

(2) Filed before the provider receives notification that a DSHS field audit has been scheduled.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0260, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0265 Can providers file amendments if a DSHS field audit has been scheduled? (1) A provider may file amendments after receiving a notice of a field audit only when reimbursement rates need to be adjusted because significant errors or omissions were made when they were calculated.

(2) Errors of omissions are considered "significant" if they result in 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.

(3) Only the pages requiring changes and the certification required by WAC 388-835-0332 must be filed with the amendment.

(4) Any adjustments to reimbursement rates resulting from an amended report will be made according to WAC-388-385-0885.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0265, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0270 Can providers file amendments if DSHS does not conduct a field audit? If DSHS does not conduct a field audit and the preliminary settlement report becomes the final report, DSHS must consider amendments only when filed within thirty days after the provider receives the final settlement report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0270, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0275 What requirements apply when amendments are filed? (1) When amendments are filed, a provider must report:

(a) The circumstances surrounding the amendments;

(b) The reasons why the amendments are needed; and

(c) All relevant supporting documentation.

(2) DSHS may refuse to consider any amendment that gives a provider a more favorable settlement or rate if the amendment is the result of:

(a) Circumstances over which the provider has control; or

(b) Good-faith error using the system of cost allocation and accounting in effect during the reporting period in question.

(3) Acceptance or use by DSHS of an amendment to a cost report does not a release a provider from civil or criminal liability.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0275, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0280 Do ICF/MR providers have to maintain records related to their contracts? (1) A provider must, according to the terms of their contract, maintain adequate records so DSHS can audit reported data to verify provider compliance with generally accepted accounting principles and DSHS reimbursement principles and reporting instructions.

(2) If a provider maintains records based upon a chart of accounts other than the one established by DSHS, they must give DSHS a written schedule clearly illustrating how their individual account numbers correspond to those used by DSHS.

(3) After filing a report with DSHS, a provider must keep for five years, at a location in Washington state specified by the provider, all records supporting the report.

(4) If at the end of five years there are unresolved audit issues related to the report, the records supporting the report must be kept until the issues are resolved.

(5) Providers, according to the terms of their contract, must make records available for review upon demand by authorized personnel from DSHS and the United States Department of Health and Human Services during normal business hours at a location in Washington state specified by the provider.

(6) When a contract is terminated, final settlement must not be made until accessibility to and preservation of the provider's records within Washington state is assured.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0280, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0285 What if a provider fails to maintain records or refuses to let them be reviewed? (1) If a provider fails to maintain adequate records or fails to allow their inspection by authorized personnel, DSHS may suspend all or part of subsequent reimbursement payments due under the contract.

(2) Once the provider complies with the recording keeping and inspection provisions of their contract, DSHS must resume current contract payments and must release payments suspended while the provider was out of compliance.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0285, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0290 Does DSHS have a responsibility to retain provider reports? (1) DSHS must retain required reports for five years following their filing date.

(2) If at the end of five years there are unresolved audit issues surrounding a report, the report must be retained until those issues are resolved.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0290, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0295 Are the reports submitted to DSHS by providers available to the public? According to chapter 388-01 WAC, all required financial and statistical reports submitted by ICF/MR facilities to DSHS are public documents and available to the public upon request.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0295, filed 4/20/01, effective 5/21/01.]

WAC 388-835-030 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0300 What is an ICF/MR field audit? A field audit consists of an on-site audit of the provider's financial records to verify that information provided on the cost report for the period being audited is accurate and represents allowable cost.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0300, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0305 When does DSHS schedule a field audit? (1) DSHS may schedule cost report field audits using auditors employed by or under contract with DSHS. DSHS must notify a facility selected for an audit within one hundred twenty days after the facility submits a completed and correct cost report.

(2) DSHS must give priority to field audits of final annual reports and, whenever possible, must begin these audits within ninety days after a properly completed final annual report is received.

(3) DSHS normally notifies a provider at least ten working days before the field audit begins.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0305, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0310 When does DSHS complete a field audit? (1) If auditors are given timely access to a ICF/MR facility and to all records necessary to conducting their audit, DSHS must complete an audit within one year:

(a) Of receiving a properly completed annual cost report; or

(b) After the facility is notified it has been selected for an audit.

(2) For a state ICF/MR, DSHS must complete a field audit within three years after a properly completed cost report is received if auditors are given timely access to the facility and all records necessary to conducting their audit.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0310, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0315 How should a provider prepare for a field audit? (1) A provider must allow auditors access to the ICF/MR facility and all financial and statistical records. These records must be available at a location in the state of Washington specified by the provider. They must include:

(a) All income tax returns relating to the audited cost report and work papers supporting the report's data; or

(b) Work papers related to resident trust funds.

(2) The provider must reconcile reported cost data with:

(a) Applicable federal income and payroll tax returns; and

(b) The financial statements for the period covered by the report.

(c) The reconciliation must be in a form that facilitates verification by the auditors.

(3) The provider must designate and make available to the auditors at least one individual familiar with the internal operations of the facility being audited. The designated individual(s) must have sufficient knowledge and access to records to effectively respond to auditor questions and requests for information and documentation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0315, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0320 What is the scope of a field audit? (1) Auditors must review a provider's record keeping and accounting practices and, where appropriate, make written recommendations for improvements.

(2) Auditors must examine a provider's financial and statistical records to verify that:

(a) Supporting records are in agreement with reported data; and

(b) Only assets, liabilities, and revenue and expense items that DSHS has specified as allowable costs have been included by the provider when computing the cost of services provided under the contract;

(c) Allowable costs have been accurately determined and are necessary, ordinary, and related to resident care;

(d) Related organizations and beneficial ownership interests have been correctly disclosed; and

(e) Resident trust funds have been properly maintained.

(3) Auditors must give the provider a draft of their audit narrative and summaries for review and comment before the final narratives and summaries are prepared.

(4) When an audit discloses material discrepancies, undocumented costs, or mishandling of patient trust funds, DSHS auditors, in order to determine if similar problem exist and take corrective action, may:

(a) Reopen a maximum of two prior unaudited cost reporting or trust fund periods; and/or

(b) Select future periods for audit.

(c) DSHS auditors may select reported costs and trust fund accounts for audit on a random or other basis.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0320, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0325 What if an auditor discovers that provider reports are inadequately documented? (1) An auditor must disallow any assets, liabilities, revenues, or expenses reported as allowable that are not supported by adequate documentation in the provider's financial records.

(2) Adequate documentation must show that reported costs were:

(a) Incurred during the period covered by the report;

(b) Related to resident care and training; and

(c) Necessary, ordinary and prudent.

(3) Adequate documentation must also show that reported assets were used to provide resident care and training.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0325, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0330 Are final audit narratives and summaries available to the public? The auditor's final audit narrative and summaries are considered public documents and will be available to the public through the public disclosure process in chapter 388-01 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0330, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0335 What general requirements apply to accounting for resident trust accounts? (1) A provider must establish and maintain a bookkeeping system for all resident money received by the facility on behalf of the resident.

(2) This system must be incorporated into the facility's business records and be capable of being audited.

(3) The bookkeeping system must apply to residents that are:

(a) Incapable of handling their money and whose guardian, relative, DDD regional service office administrator, or physician requests in writing that the facility accept this responsibility. (If the Social Security Form SSA-780, "Certificate of Applicant for Benefits on Behalf of Another," is used as documentation, it must be signed by one of the persons designated in this subsection.)

(b) Capable of handling their own money, but they ask the facility, in writing, to accept this responsibility for them.

(4) It is the facility's responsibility to maintain written authorization requests in a resident's file.

(5) A resident must be given at least a quarterly reporting of all financial transactions affecting their account. The resident's representative payee, guardian and/or other designated

agents must be sent a copy of this quarterly report or any other reports related to the resident's account.

(6) Facilities must purchase surety bonds, or otherwise provide assurances or security satisfactory to DSHS, that assures the security of all resident personal funds deposited with them.

(7) Facilities may not require residents to deposit personal funds with them. A facility may hold a resident's personal funds only if the resident or resident's guardian gives written authorization to do so.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0335, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0340 What specific accounting procedures apply to resident trust accounts? (1) A provider must maintain a subsidiary ledger with an account for each resident for whom the provider holds money in trust.

(2) Each account and related supporting information must be:

(a) Maintained at the facility;

(b) Kept current;

(c) Balanced each month; and

(d) Detailed, with supporting verification, showing all money received on behalf of the individual resident and how that money was used.

(3) A provider must make each resident trust account available to DSHS representatives for inspection and audit.

(4) A provider must maintain each resident trust accounts for a minimum of five years.

(5) A provider must notify the DDD regional service office when an individual's account balance is within one hundred dollars of the amount listed on their award letter.

(6) A resident can accumulate funds by:

(a) Not spending their entire clothing and personal incidentals allowance; and

(b) Saving other income DSHS specifically designates as exempt.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0340, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0345 Can residents overdraw their trust account? (1) A resident may not overdraw their account (show a debit balance).

(2) If residents want to spend an amount greater than the balance in their trust account, the facility may loan the residents money from facility funds.

(3) The facility can collect loans to residents by installments from the portion of the resident's allowance remaining at the end of each month.

(4) The facility cannot charge residents interest on these loans.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0345, filed 4/20/01, effective 5/21/01.]

WAC 388-835-035 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0350 Can a resident trust account be charged for Title XIX services? Resident trust accounts cannot be charged for services provided under Title XIX.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0350, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0355 Can a resident trust account be charged for medical services, drugs, therapy and equipment? (1) Any properly made charge to a resident's trust account for medical services must be supported by a written denial from DSHS.

(2) Any request for additional equipment such as a walker, wheelchair or crutches must have a written denial from DSHS before a resident's trust account can be charged.

(3) A request for physical therapy, certain drugs or other medical services must have a written denial from DSHS before a resident's trust account can be charged.

(4) A written denial from DSHS 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 that the program does not cover the drugs is sufficient.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0355, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0360 Can providers create petty cash funds for residents? (1) Providers may maintain petty cash funds for residents.

(2) The fund must be an imprest type fund.

(3) The cash for the fund must come from trust money.

(4) The amount of the fund must be reasonable and necessary for the size of the facility and the needs of the residents, but must not exceed five hundred dollars.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0360, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0365 Can providers create checking accounts for residents? (1) A provider must deposit all money, over and above the trust fund petty cash amount, intact into a trust fund checking account that is separate and apart from any other bank account(s) of the facility or other facilities.

(2) Deposits of resident allowances must be made intact into the trust checking account within one week from the time payment is received from DSHS, social security administration, or any other payor.

(3) A provider must make any related bankbooks, bank statements, check book, check register, all voided and all canceled checks available to DSHS representatives for audit and inspection. The provider must retain these supporting records and documents for at least five years.

(4) Resident trust money cannot be used to pay checking account service charges.

(5) Each banks trust account must be reconciled each month to the trust account ledger for each resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0365, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0370 What controls must a provider use to ensure the safety of trust fund money? (1) A provider must not release trust fund money to anyone other than the:

(a) Resident or, with their written consent, their guardian;

(b) Resident's designated agent as appointed by power of attorney; or

(c) Appropriate DSHS personnel designated by the DDD regional services administrator.

(2) A provider must complete a receipt, in duplicate, when money is received. One copy must be given to the person making the payment or deposit and the other copy must remain in the receipt book for easy reference.

(3) All residents must endorse, with their own signature, any checks or state warrants they receive. Only when a resident is incapable of signing their own name may the provider use the resident's "X" mark followed by their printed name and the signature of two witnesses.

(4) When both a general fund account and a trust fund account are kept at the same bank, the trust account portion of any deposit can be deposited directly to the trust account.

(5) A provider must credit a resident's trust account ledger sheet when the resident's allowance is received. This entry must be referenced with the receipt number and must be supported by a copy of the deposit slip (one copy for all deposits made).

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0370, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0375 Can a resident withdraw trust money? Any money held in trust for a resident must be available to them for their personal and incidental needs upon their request or the request of one of the individuals designated in WAC 388-835-0335.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0375, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0380 What happens to resident funds when a change of ownership occurs? (1) When a facility is sold or some other transfer of ownership takes place, the former provider must provide the new provider with a written accounting, based upon generally accepted auditing standards, of all resident funds being transferred. The former provider must also obtain a written receipt for the funds from the new provider.

(2) Before any transfer of ownership occurs, the facility must give each resident, or their representative, a written accounting of any personal funds held by the facility.

(3) If there is disagreement regarding the accounting offered by the former provider, the resident retains all rights and remedies provided under state law.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0380, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0385 How are trust fund monies refunded? When a resident is discharged and/or transferred, the balance of their trust account, along with a receipt, will be returned to the individual designated in WAC 388-835-0335 within thirty days of the resident's transfer or discharge.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0385, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0390 How are trust funds liquidated? (1) In the case of deceased resident, the provider must obtain a receipt from the next-of-kin, guardian, or duly qualified agent when the balance of the trust fund is released. If the next-of-kin, guardian or duly qualified agent cannot be identified, the DDD regional service office must be contacted, in writing within seven days of the resident's death, to assist in the release of the resident's trust fund money. A check or other document showing payment to the next-of-kin, guardian, or duly qualified agent will serve as a receipt.

(2) In situations where the resident leaves the ICF/MR facility without authorization and their whereabouts is unknown, the facility:

(a) Will make a reasonable attempt to locate the missing resident. A "reasonable attempt" includes, but is not limited to, contacting friends, relatives, police, the guardian, and the DDD regional office in the area; and

(b) If the resident cannot be located after ninety days, the facility must notify the department of revenue regarding the existence of "abandoned property" (see chapter 63.29 RCW Uniform Unclaimed Property Act). The facility must deliver to the department of revenue the balance of the resident's trust fund account within twenty days following their notification.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0390, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0395 How must a facility maintain resident property records? (1) A facility must maintain a current, written record for each resident that includes written receipts for all personal property entrusted to the facility by the resident.

(2) All property records must be available to the resident or designated resident representative (see WAC 388-835-0645).

(3) A facility must issue or obtain written receipts when taking possession or disposing of a resident's personal property. The facility must retain copies and/or originals of these receipts.

(4) A facility must maintain all resident property records so they are available to auditors and in a manner that facilitates the audit process.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0395, filed 4/20/01, effective 5/21/01.]

WAC 388-835-040 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0400 What are allowable costs? (1) Allowable costs are documented costs that are necessary, ordinary, related to providing ICF/MR services to ICF/MR residents, and not expressly declared nonallowable by applicable statutes or regulations. Costs are ordinary if they are of the nature and magnitude that a prudent and cost conscious management would pay.

(2) Allowable costs do not include increased costs resulting from transactions or the application of accounting methods which circumvent the principles of the prospective cost-related reimbursement system.

(3) DSHS does 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).

(4) When a provider requests a rate adjustment according to WAC 388-835-0900 or 388-835-0905, any cost audited previously and not disallowed is subject to DSHS review and reconsideration according to the criteria in this section.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0400, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0405 What are unallowable costs? (1) Costs are unallowable if they are not documented, necessary, or ordinary and do not relate to providing services to ICF/MR residents.

(2) Examples of 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 not be allowed even if indirectly reimbursed by DSHS as a result of an authorized reduction in resident contribution.

(b) Costs of services and items provided to ICF/MR residents covered by DSHS's medical care program but not included in ICF/MR services.

(c) Costs associated with a capital expenditure subject to Section 1122 approval (part 100, Title 42 CFR) if DSHS found the expenditure was not consistent with applicable standards, criteria, or plans. If DSHS was not given timely notice of a proposed capital expenditure, all associated costs will not be allowed as of the date the costs were determined to be nonreimbursable under applicable federal regulations.

(d) Costs associated with a construction or acquisition project that requires certificate of need approval according to chapter 70.38 RCW and that approval was not obtained.

(e) Costs associated with 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) All salaries or other compensation of officers, directors, stockholders, and others associated with the provider or home office, except compensation paid for services related to resident care and training.

(g) Costs in excess of limits set in this chapter or costs violating principles contained in this chapter.

(h) Costs resulting from transactions or the application of accounting methods used to circumvent 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 cost to the related organization or market meaning the price paid for comparable services, facilities or supplies when purchased in an arms length transaction.

(j) Balances of accounts that cannot be collected (bad debts or uncollectable accounts).

(k) Charity and courtesy allowances.

(l) Cash, assessments, or other contributions to political parties, and cost incurred to improve community or public relations. Dues to charitable organizations, professional organizations and trade associations are allowable costs.

(m) Any portion of trade association dues for legal and consultant fees and costs related to lawsuits or other legal action against DSHS.

(n) Travel expenses for trade association boards of directors in excess of the twelve allowable meetings per calendar year.

(o) Vending machine expenses.

(p) Expenses for barber or beautician services not included in routine care.

(q) Funeral and burial expenses.

(r) Costs of gift shop operations and inventory.

(s) Personal items such as cosmetics, smoking materials, newspapers and magazines, and clothing, except items used in resident activity programs or in ICF/MR programs where clothing is a part of routine care.

(t) Fund-raising expenses except those directly related to the resident activity program.

(u) Penalties and fines.

(v) Expenses related to telephones, televisions, radios, and similar appliances in a resident's private accommodations.

(w) Federal, state, and other income taxes.

(x) Costs of special care services, except where authorized by DSHS.

(y) Expenses for "key-person" insurance and other insurance or retirement plans not available to all employees.

(z) Expenses of profit-sharing plans.

(aa) Expenses related to the purchase and/or use of private or commercial aircraft that exceed what a prudent provider would spend for ordinary and economical transportation when conducting resident care business.

(bb) Personal expenses and allowances of owners or relatives.

(cc) All expenses of maintaining professional licenses or membership in professional organizations.

(dd) Costs related to agreements not to compete.

(ee) Goodwill and the amortization of goodwill.

(ff) Expenses related to vehicles in excess of what a prudent provider would expend for the ordinary and economic provision of transportation needs related to resident care.

(gg) Legal and consultant fees related to a fair hearing against DSHS. Including but not limited to, fees for accounting services used to prepare for an administrative judicial review resulting in a final administrative decision favorable to DSHS or where DSHS's decision is allowed to stand.

(hh) Legal and consultant fees related to a lawsuit against DSHS, including suits appealing administrative decisions.

(ii) Lease acquisition costs and other intangibles not related to resident care and training.

(jj) 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.

(kk) Travel expenses outside the states of Idaho, Oregon, and Washington and the Province of British Columbia except travel to and from the home and central office of a chain orga-

nization operation outside those areas if the travel is necessary, ordinary, and related to resident care and training.

(ll) Moving expenses of employees when a demonstrated, good-faith effort has not been made to recruit employees within the states of Idaho, Oregon, and Washington and Province of British Columbia.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0405, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0410 Can a provider offset miscellaneous revenues against allowable costs? (1) A provider must reduce allowable costs whenever the item, service, or activity covered by the costs generate revenue or financial benefits (e.g., purchase discounts or rebates) other than through the provider's normal billing for ICF/MR services.

(2) A provider must not deduct unrestricted grants, gifts, endowments, and interest earned from them from the allowable costs of a nonprofit facility.

(3) When goods or services are sold, the reduction in allowable costs must be the actual cost of the item, service, or activity. If actual cost cannot be accurately determined, the reduction must be the full amount of the revenue received. When financial benefits such as purchase discounts or rebates are received, the reduction must be the amount of the discount or rebate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0410, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0415 Are the costs of meeting required standards allowable costs? (1) All necessary and ordinary expenses incurred by a provider to meet required standards associated with providing ICF/MR services are allowable costs.

(2) Examples are the cost of:

(a) Meeting licensing and certification standards;

(b) Fulfilling accounting and reporting requirements imposed by this chapter; and

(c) Performing any resident assessment activity required by DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0415, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0420 Are costs associated with related organizations allowable costs? (1) DSHS allows costs applicable to services, facilities, and supplies furnished to a provider by a related organization only to the following extent:

(a) The costs do not exceed the lower of the cost to the related organization; or

(b) Market, meaning the price paid for comparable services, facilities, or supplies when purchased in an arm's length transaction.

(2) Private facilities must make all cost documentation regarding related organizations available to the auditors at the time and place the entity's financial records are audited. State facilities must make all cost documentation regarding related organizations available to the auditors at DSHS's offices of accounting services, financial recovery, or budget when the facility is audited.

(3) DSHS disallows all payments to or for the benefit of a related organization where the cost to the related organization cannot be documented.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0420, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0425 Are start-up costs allowable costs? DSHS allows all necessary and ordinary start-up costs in the administration and operations rate component. Start-up costs must be amortized over at least sixty consecutive months beginning with the month the first resident is admitted for care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0425, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0430 Are organizational costs allowable costs? (1) DSHS allows necessary and ordinary costs directly related to the creation of a provider's corporation or other form of business that are incurred before the admission of the first resident.

(2) DSHS allows these costs in the administration and operation cost area if they are amortized over at least sixty consecutive months beginning with the month in which the first resident is admitted for care.

(3) Examples of 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.

(4) Organization costs do not include costs relating to the issuance and sale of shares of stock or other securities.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0430, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0435 Are education and training costs allowable costs? (1) DSHS allows ordinary expenses associated with on-the-job and in-service training required for employee orientation and certification when those expenses directly relate to performing an employee's assigned duties.

(2) Ordinary expenses for staff training are allowable costs.

(3) Necessary and ordinary expenses for recreational and social activity training conducted by a provider for volunteers are allowable costs.

(4) Training program expenses for other nonemployees are not allowable costs, except the costs associated with training county-contracted training program employees by an ICF/MR as a condition of the ICF/MR's agreement with the county-contracted training program.

(5) DSHS must allow expenses for travel in the states of Idaho, Oregon, and Washington and Province of British Columbia associated with education and training if the expenses meet the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0435, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0440 Are operating lease costs allowable costs? Facility and/or equipment rental or lease costs associated with an arm's length operating lease are allowable costs.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0440, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0445 Are rental expenses paid to related organizations allowable costs? The expense of renting facilities or equipment from a related organization are allowable to the extent that the rent paid does not exceed the related organization's costs of owning (e.g., depreciation, interest on a mortgage) or leasing the assets. Computing the related organization's cost of owning or leasing the asset must be according to the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0445, filed 4/20/01, effective 5/21/01.]

WAC 388-835-045 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0450 What is allowable interest? (1) DSHS allows a provider's necessary and ordinary interest costs incurred for working capital loans and capital indebtedness.

(a) "Necessary" means the interest expense must be incurred in connection with a loan satisfying a financial need of the provider and for a purpose related to resident care and training. Interest expense related to a business opportunity or goodwill is unallowable.

(b) "Ordinary" means the interest rate for the loan must not exceed the rate a prudent borrower would pay, in an arm's length transaction, for a comparable loan in the money market at that time.

(c) Interest expense must include amortization of bond discounts and expenses related to the bond issue. The amortization period must be the period from the date the bonds are sold to their maturity date or their date of extinguishment if they are retired before they mature.

(d) Interest expense for assets acquired in a change of ownership after September 30, 1984, is disallowed on any loan principal in excess of the former owner's depreciation base on July 18, 1984.

(2) Interest that is paid to or for the benefit of a related organization is allowed but only to the extent that the actual interest does not exceed the related organization's cost of using the funds.

(3) For construction loans, a provider must capitalize interest expense and loan origination fees incurred during the period of construction. Such costs must be amortized over the life of the constructed asset beginning with the date the first resident is admitted or the date the asset is put into service, whichever occurs first.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0450, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0455 Can a provider offset interest income against allowable costs? Except for nonprofit facilities, a provider must deduct from allowable interest expense all interest income earned from either investing or lending nonrestricted and restricted funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0455, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0460 How does DSHS calculate total compensation for owners and relatives? (1) Total compensation means the compensation provided in the employment contract, including benefits. The employment contract can be written, verbal, or inferred from the acts of the parties.

(2) In the absence of a contract, total compensation includes gross salary or wages and fringe benefits (e.g., health insurance) available to all employees.

(3) Total compensation does not include payroll taxes paid by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0460, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0465 How does DSHS define owner or relative compensation? (1) DSHS limits the total compensation of an owner or an owner's relative 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 established in this chapter.

(b) A service is necessary if it is related to resident care and training and would have to be performed by another person if the owner or relative did not perform it.

(2) A provider, in maintaining customary time records adequate for audit, must include time records for owners and relatives receiving compensation. These records must document how compensated time was spent performing necessary services.

(3) For purposes of this section, if the provider is a corporation, "owner" includes all corporate officers and directors.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0465, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0470 What requirements apply to capitalizing equipment, including furniture and furnishings? A provider must capitalize equipment, including furniture and furnishings according to the following table:

Equipment, including furniture and furnishings	Historical cost	Useful life
For settlement purposes beginning January 1, 1881 and for rate setting purposes beginning July 1, 1982	At least $500 per item	At least one year from date asset is put into service
For settlement purposes beginning January 1, 1990 and for rate setting purposes beginning July 1, 1990	At least $1,000 per item	At least one year from date asset is put into service
For settlement purposes beginning January 1, 1996 and for rate setting purposes beginning July 1, 1996	At least $500 per item	At least one year

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0470, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0475 What requirements apply to capitalizing buildings, other real property items, components, improvements and leasehold improvements? Buildings and other real property items, components, improvements and leasehold improvements must be capitalized if they are:

(1) Required or authorized by the lease agreement;

(2) Cost more than five hundred dollars; and

(3) Involve at least one of the following:

(a) Increase the interior floor space of the structure;

(b) Increase or renew paved areas outside the structure that are either adjacent to the structure or provide access to it;

(c) Modification to 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; or

(f) Increasing the structure's useful life by at least two years.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0475, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0480 How are the useful lives of leasehold improvements determined? The useful lives for all leasehold improvements are based upon the American Hospital Association (AHA) guidelines for the applicable asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0480, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0485 What are depreciable assets? Depreciable assets are tangible assets that are subject to depreciation and in which a provider has an ownership interest.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0485, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0490 What are some examples of depreciable assets? Some examples of depreciable assets are:

(1) Buildings, meaning the basic structure or shell and additions to it.

(2) Equipment such as elevators, heating system, and air conditioning system that are attached to a building and characterized by:

(a) An economic useful life of at least three years but shorter than the life of the building to which it is attached;

(b) Incapable of being removed from the building to which it is attached;

(c) A unit cost sufficiently large enough to justify ledger control; and

(d) A physical size and identity that makes control by identification tags possible.

(3) Equipment not attached to buildings.

(4) Land improvements such as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, wall, etc., where replacement is the responsibility of the provider.

(5) Leasehold improvements and additions made by the lessee belong to the lessor after the lease expires.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0490, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0495 What is "minor equipment"? (1) Minor equipment includes items such as wastebaskets, bedpans, syringes, catheters, silverware, mops, and buckets.

(2) Minor equipment is generally characterized as:

(a) Not occupying a fixed location and is used by a variety of departments;

(b) Small in size and unit cost;

(c) Subject to inventory control;

(d) A fairly large number of items are in use; and

(e) Possessing a useful life of one to three years.

(3) If properly capitalized (see WAC 388-835-0230), minor equipment is depreciated. If not properly capitalized, minor equipment is expensed when acquired.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0495, filed 4/20/01, effective 5/21/01.]

WAC 388-835-050 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0500 Is land a depreciable asset? Because the economic useful life of land is considered to be unlimited, land is not a depreciable asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0500, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0505 What costs are included in the capitalized cost of land? Examples of costs that are capitalized as land costs include the cost of:

(1) Off-site sewer and water lines;

(2) Public utility charges necessary to service the land;

(3) Government assessments for street paving and sewers;

(4) Permanent roadways and grading of a nondepreciable nature; and

(5) Curbs and sidewalks, the replacement of which is not the responsibility of the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0505, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0510 What is the depreciation base of a tangible asset? (1) The depreciation base of a tangible asset is the asset's historical cost at the time it is acquired by the provider in an arm's length transaction:

(a) Plus the cost of preparing the asset for use;

(b) Less the asset's estimated salvage value, if any, where the straight-line or sum-of-the-years digits methods of depreciation is used;

(c) Less any goodwill; and

(d) Less any accumulated depreciation incurred during periods the asset was used by the provider personally or in another business.

(2) When depreciable assets are acquired from a related organization, the provider's depreciation base cannot exceed the base the related organization had or would have had under a contract with DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0510, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0515 Can an appraisal be used to establish historical cost? (1) If DSHS challenges the historical cost of an asset or if a provider is unable to adequately document the historical cost of an asset, the department may use an appraisal process to establish the asset's fair market value at the time of purchase.

(2) If an appraisal process is used to establish the fair market value of equipment, vendors dealing in that particular type of equipment must perform the appraisals.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0515, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0520 What is the depreciation base of a donated or inherited asset? (1) The depreciation base of donated and/or inherited assets is the lesser of:

(a) Fair market value at the date of donation or death, less goodwill. (Any estimated salvage value must be deducted from fair market value when either the straight-line or sum-of-the-years digits method of depreciation is used); or

(b) The historical cost of the last owner to contract with DSHS, if any.

(2) If the donation or distribution is between related organization, the base must be the lesser of:

(a) Fair market value, less goodwill and, where appropriate, salvage value, or

(b) The depreciation base the related organization used or would have used when contracting with DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0520, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0525 How is the useful life of a depreciable asset determined? (1) Except for buildings, a provider must not adopt useful lives shorter than the guideline lives contained in the Internal Revenue Service class life ADR system or published by the American Hospital Association. Thirty years is the shortest useful life a provider can adopt for buildings.

(2) Useful life is measured from the date of the most recent arm's length acquisition of the asset.

(3) Building improvements to owned or leased buildings must be depreciated over the remaining useful life of the building or fifteen years, whichever is greater, except for improvements to licensed boarding home facilities required by the Fire Safety Evaluation System (FSES) of the 1984 Life Safety Code. Improvements to these licensed boarding home facilities must be depreciated for at least five years. A provider must receive DSHS approval before following this exception.

(4) Improvements to leased property that are, according to the lease agreement, the responsibility of the provider must be depreciated over the useful life of the improvement, except for improvements to licensed boarding home facilities required by the Fire safety Evaluation System (FSES) of the 1984 Life Safety Code. Improvements to these licensed boarding home facilities must be depreciated for at least five years. A provider must receive DSHS approval before following this exception.

(5) A provider may change the estimated useful life of an asset to a longer period if necessary.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0525, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0530 What depreciation methods are approved by DSHS? (1) Buildings, building improvements, land improvements, leasehold improvements, and fixed equipment must be depreciated using the straight-line method.

(2) Equipment must be depreciated using the straight-line method, the sum-of-the-years digits method, or the declining balance method at a rate not to exceed one hundred fifty percent of the straight-line rate. Providers electing to use either the sum-of-the-years digits method or the declining balance method may change to the straight-line method without permission of the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0530, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0535 What is depreciation expense? (1) Depreciation expense on tangible assets used to provide ICF/MR services is an allowable cost.

(2) Depreciation expense must be:

(a) Identifiable and recorded in the provider's accounting records; and

(b) Computed using the depreciation base, useful lives and methods specified in this chapter.

(3) If a provider reports annual depreciation expense that includes depreciation on assets unrelated to resident care and training, the annual reported expense must be reduced accordingly.

(4) Once a tangible asset is fully depreciated, no additional depreciation can be claimed unless a new depreciation base is established according to the rules of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0535, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0540 Can providers claim depreciation on assets that are abandoned, retired or disposed of in some other way? (1) Depreciation cannot be claimed on tangible assets that are sold, traded, scrapped, exchanged, stolen, wrecked or destroyed by fire or some other casualty.

(2) Depreciation cannot be claimed on permanently abandoned assets.

(3) If an asset has been retired from active use but is being held for stand-by or emergency service and DSHS has determined that the asset is needed and can be effectively used in the future, depreciation may be claimed by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0540, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0545 How must providers account for gains and losses on the retirement of tangible assets? For settlement purposes beginning with January 1 1981 and for rate setting purposes beginning with the July 1, 1982 rate period, the rules in WAC 388-835-0265 through WAC 388-835-0275 apply.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0545, filed 4/20/01, effective 5/21/01.]

WAC 388-835-055 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0550 How are gains and losses calculated when a tangible asset is retired? When a tangible asset is retired, the difference between the assets undepreciated base and any proceeds received from its retirement is considered a gain or loss on retirement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0550, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0555 How must providers account for gains and losses on retired assets that are replaced? If a provider replaces a retired asset, any gain or loss on retirement must be deducted from or added to the cost of the replacement asset, respectively. However, a loss on retirement can only be added to the replacement asset's cost if the provider makes a reasonable effort to recover at least the outstanding book value of the retired asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0555, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0560 How must providers account for gains and losses on retired assets that are not replaced? (1) If a retired asset is not replaced the gain or loss on retirement must be spread over the actual life of the asset up to the date of retirement. However, a loss can only be spread if the provider has made a reasonable effort to recover at least the outstanding book value of the retired asset.

(2) DSHS will calculate any difference between the actual reimbursements paid and the amount of reimbursement that should be paid after the gain or loss is spread. If the difference results from a gain DSHS must recover the difference from the provider. If the difference results from a loss the difference will be added to allowable costs when determining the settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0560, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0565 How must providers account for gains and losses on retired assets if they terminate their contract with DSHS? If a retired asset is not replaced and the provider is terminating their contract with DSHS, the gain or loss on retirement must be accounted for according to the requirements in WAC 388-835-0280.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0565, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0570 Can DSHS recover reimbursements for depreciation expense? If a provider terminates their contract without selling or otherwise retiring equipment that was depreciated using an accelerated method, depreciation schedules for this equipment for those periods when the provider participated in the ICF/MR program must be adjusted. DSHS will recover any difference between reimbursement actually paid for depreciation and the reimbursement that would have been paid if the straight-line method had been used.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0570, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0575 What requirements apply to calculating ICF/MR reimbursement rates? (1) Medicaid program reimbursement rates established according to this chapter apply only to facilities holding appropriate state licenses and certified to provide ICF/MR services according to state and federal laws and regulations.

(2) All rates must be reasonable and adequate to meet the costs incurred by economically and efficiently operated facilities providing ICF/MR services according to state and federal laws and regulations.

(3) For private facilities:

(a) Final payments must be the lower of the facility's prospective rate or allowable costs.

(b) Prospective rates must be determined according to WAC 388-835-0845, 388-835-0850, 388-835-0860, 388-835-865, 388-835-0870, 388-835-0875, and 388-835-0880.

(c) Final payments must be determined according to WAC 388-835-0880.

(4) For state facilities:

(a) Final payments must be the facility's allowable costs.

(b) Interim rates must be calculated using the most recent annual reported costs (see WAC 388-835-0845) divided by the total resident days during the reporting period. These costs may be adjusted to incorporate federal, state, or department changes in program standards or services.

(c) Final payments must be determined according to WAC 388-835-0880.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0575, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0580 What program services are not covered by DSHS prospective reimbursement rates? Medical services that are part of DSHS's medical care program but not included in ICF/MR services are not covered by prospective reimbursement rates. Payments are made directly to the service provider according to WAC 388-835-0835 requirements.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0580, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0585 What requirements apply to prospective reimbursement rates for new providers? (1) A prospective reimbursement rate for a new provider must be established within sixty days after DSHS receives a properly completed projected budget from the provider. The effective date of the reimbursement rate must be the same as the effective date of the contract.

(2) The prospective reimbursement rate must be based on the:

(a) Provider's projected cost of operation;

(b) Costs and payment rates of the prior provider, if any; and/or

(c) Costs and payment rates, taking into account applicable lids or maximums, of other providers in comparable circumstances.

(3) If DSHS does not receive a properly completed projected budget at least sixty days before the contract's effective date, a preliminary rate, based on information from former and/or comparable providers, will be prepared by DSHS. This preliminary rate must remain in effect until an initial prospective rate can be set.

(4) If a change of ownership takes place that does not result from an arm's length transaction, the new provider's prospective rates for administration, operations and property costs cannot exceed the former provider's rates. The former provider's rates can be adjusted, if necessary, to reflect changes in economic trends.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0585, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0590 How are reimbursement rates calculated? (1) Each provider's reimbursement rate must be recalculated once each calendar year. The recalculated rate will be implemented prospectively. The recalculated rate will be effective on July 1 of the calendar year in which it was computed. Rates may be recalculated to reflect legislative inflation adjustments or to comply with the requirements of WAC 388-835-0900.

(2) If a provider participated in the ICF/MR program for at least six months during the previous calendar year, their rates must be based on the prior period's allowable costs. If the provider participated in the program for less than six months in the previous calendar year, their rates must be calculated according to WAC 388-835-0840 requirements.

(3) Unless circumstances beyond DSHS's control interfere, all providers submitting correct and complete cost reports by March 31 must receive notification of their new rates by July 1.

(4) When calculating a provider's rate, DSHS must use data from the most recent and complete cost report submitted by the provider and reviewed by DSHS as described in WAC 388-835-0700.

(5) Inflation factor adjustments are based on the Implicit Price Deflator for Personal Consumption from the state of Washington, Economic and Revenue Forecast prepared by the Office of the Forecast Council.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0590, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0595 When does DSHS review a provider's annual cost report? DSHS must review and analyze each annual cost report within six months after it is properly completed and filed with the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0595, filed 4/20/01, effective 5/21/01.]

WAC 388-835-060 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0600 What is the purpose of reviewing a provider's annual cost report? DSHS reviews and analyzes annual cost reports to determine if the information contained in them is correct, complete, and reported according to generally accepted accounting principles, the requirements of this chapter and any other applicable rules and instructions issued by the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0600, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0605 What is the scope of an annual cost report review? (1) DSHS' review and analysis may include, but is not limited to:

(a) An examination of prior years reported costs;

(b) An examination of any cost report review adjustments made in prior years and their final disposition;

(c) An examination of findings, if any, from prior year cost report field audits; and

(d) Findings, if any, from the field audit of the cost report currently being reviewed.

(2) If it appears that a provider incorrectly calculated or reported their costs, DSHS may:

(a) Request additional information from the provider;

(b) Schedule a special field audit of the provider; or

(c) Make adjustments to the reported information. If adjustments are made, DSHS must give the provider a schedule of the adjustments including an explanation for each one and the dollar amount associated with each one.

(3) If the provider believes that DSHS adjustments are incorrect, the adjustments must be reviewed according to WAC 388-835-0900. If this review does not satisfactorily resolve the dispute, the adjustment must be further reviewed according to WAC 388-835-0910.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0605, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0610 Can DSHS accumulate cost report information and use if for department purposes? DSHS may accumulate data from properly completed cost reports for:

(1) Use in exception profiling and establishing rates; and

(2) Analytical, statistical, or informational purposes that the department considers important.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0610, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0615 What are component rates and cost centers? (1) A provider's overall ICF/MR resident reimbursement rate consists of five component rates within three cost centers.

(2) The five component rates are:

(a) Resident care and habilitative services;

(b) Food;

(c) Administration and operations;

(d) Property; and

(e) Return on equity.

(3) The three cost centers are:

(a) Resident care and habilitation;

(b) Administration, operations, and property; and

(c) Return on equity.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0615, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0620 What reimbursement requirements apply to resident care and habilitation cost centers? (1) Resident care and habilitation cost centers at facilities with at least sixteen residents and licensed as a nursing facility, must, according to applicable federal and state regulations, reimburse for resident living services, habilitative and training services, recreation services, and nursing services.

(2) Resident care and habilitation cost centers at facilities with less than sixteen residents and licensed as a boarding home, must, according to applicable federal and state regulations, reimburse for resident living services, habilitative and training services, recreation services, and nursing services. These cost centers must also reimburse for resident care and training staff who perform any of the administration and operations functions specified in WAC 388-835-0870.

(3) A facility's resident care and habilitation cost center rate must be its most recent reported costs per resident day adjusted for inflation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0620, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0625 What requirements apply to administration, operations and property cost center rates? Administration, operations, and property cost center rates are the sum of three separate rate components:

(1) The food rate component established by WAC 388-835-0865;

(2) The administration and operations rate component established by WAC 388-835-0870; and

(3) The property rate component established by WAC 388-835-0875.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0625, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0630 What is the food rate component? The food rate component reimburses for the necessary and ordinary costs of a resident's bulk and raw food, dietary supplements, beverages with meals and nourishment between meals.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0630, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0635 Is there a limit to the allowable cost for administrative personnel? Compensation for administrative personnel is an allowable cost within the limits contained in this section:

(1) For purposes of this section "compensation" means gross salaries, wages, and the applicable cost of fringe benefits made available to all employees. Compensation does not include payroll taxes paid by the provider.

(2) A licensed administrator's total compensation for actual services rendered to an ICF/MR facility on a full-time basis (at least forty hours per week, including reasonable vacation, holiday, and sick time) is allowable at the lower of:

(a) Actual compensation received; or

(b) For calendar year 2000, the amount specified in the following table that corresponds to the number of set-up beds in the facility.

Number of set-up beds	Maximum compensation
15 or less	$42,886
16 to 79	$47,739
80 to 159	$52,832
160 and up	$56,163

(c) The maximum compensation amounts will be adjusted annually for inflation. Inflation factor adjustments are based on the Implicit Price Deflator for Personal Consumption from the state of Washington, Economic and Revenue Forecast prepared by the Office of the Forecast Council.

(d) A licensed administrator's compensation will be allowed only if DSHS is notified in writing within ten days following the start of their employment.

(3) Total compensation of not more than one full-time licensed assistant administrator will be allowed if there are at least eighty set-up beds in the ICF/MR facility. Compensation is allowable at the lower of:

(a) Actual compensation received; or

(b) Seventy-five percent of the amount specified in the above table.

(4) Total compensation of not more than one full-time registered administrator-in-training is allowed at the lower of:

(a) Actual compensation received; or

(b) Sixty percent of the amount specified by DDD in the above table.

(5) The cost of a licensed administrator, assistant administrator, or administrator-in-training is not an allowable expense in ICF/MR facilities with fifteen beds or less. The facility's qualified mental retardation professional (QMRP) will provide administrative services.

(6) A QMRP's total compensation of wages and/or salary is allowable at the lower of:

(a) Actual compensation received; or

(b) The amount specified in DDD in the above table.

(7) If a licensed administrator, licensed assistant administrator, registered administrator-in-training, or QMRP are employed on a less than full-time basis, allowable compensation must be the lower of:

(a) Actual compensation received; or

(b) The maximum amount allowed multiplied by the percentage derived from dividing actual hours worked plus reasonable vacation, holiday and sick time, by two thousand and eighty hours.

(8) A provider must maintain time records for any licensed administrators, assistant administrators, administrators-in-training, or QMRPs they employ.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0635, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0640 Can a provider hire an individual or firm to manage their ICF/MR facility? (1) A provider can enter into an agreement with an individual or firm to manage their ICF/MR facility as the provider's agent, how-

ever, the provider must submit a copy of the agreement to DSHS at least sixty days before it becomes effective.

(2) Copies of any amendments to a management agreement must be received by DSHS at least thirty days before the amendment become effective.

(3) Management fees for periods before DSHS receives a copy of the agreement are not allowable costs.

(4) The department may waive the sixty-day notice requirement to protect the health and safety of facility residents. Any waiver of the sixty-day notice requirement by DSHS must be in writing.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0640, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0645 Are management fees allowable costs? Management fees are allowable costs only when there is:

(1) A written management agreement that:

(a) Creates a principal and/or agent relationship between the provider and the manager; and

(b) Identifies the items, services, and activities that the manager will provide.

(2) Documentation that verifies the management service was performed.

(3) Assurance that the service performed was necessary and did not duplicate any service provided by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0645, filed 4/20/01, effective 5/21/01.]

WAC 388-835-065 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0650 Are all management fee's allowable? Providers must limit the amount of allowable fees for general management services (including corporate management fees, business entity management fees, board of director fees and overhead and indirect costs associated with providing general management services) to:

(1) The maximum allowable compensation for a licensed administrator and, if the facility has at least eighty set-up beds, an assistant administrator even if one is not employed minus the actual compensation received by the licensed administrator and assistant administrator.

(2) The maximum allowable compensation for a QMRP at a ICF/MR facilities with fifteen beds or fewer, minus the actual compensation received by the QMRP.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0650, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0655 Are management fees involving a related organization allowable costs? (1) A management fee paid to or for the benefit of a related organization is allowable if it does not exceed the lesser of:

(a) The limits set out in WAC 388-835-0400; or

(b) The lower of the related organization's actual cost of providing necessary resident care and training services under the management agreement or the cost of comparable services purchased in an arm's length transaction elsewhere.

(2) If related organization costs are joint facility costs, their measurement must comply with the requirements of WAC 388-835-0400.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0655, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0660 How do overhead and indirect costs relate to allowable costs? (1) For general administrative and management services, costs such as central office costs, owner compensation, and other fees or compensation, including joint facility costs, must include the overhead and indirect costs associated with providing general management services that are not allocated to specific services.

(2) General administrative and management service costs as described in subsection (1) of this section are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0660, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0665 Are travel and housing expenses of nonresident staff working at a provider's ICF/MR facility allowable costs? (1) All necessary travel and housing expenses of nonresident staff working at a provider's ICF/MR facility are allowable costs if their visit does not exceed three weeks.

(2) If the nonresident staff visit extends beyond three weeks, any travel and housing expenses are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0665, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0670 Are bonuses paid to a provider's employees allowable costs? (1) Bonuses paid to employees at a provider's ICF/MR facility are compensation.

(2) Bonuses paid to central office employees are management costs that are subject to the management fee limits established in WAC 388-835-0405.

(3) Bonuses paid to other employees not located at an ICF/MR facility and performing managerial services are management costs that are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0670, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0675 Are fees paid to members of the board of directors or corporations allowable costs? Fees paid to board of director members or corporations operating ICF/MR facilities are management costs subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0675, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0680 How is the administration and operations rate component computed? (1) The administration and operations rate component includes reimbursement for the necessary and ordinary costs of:

(a) Overall administration and management of the facility;

(b) Operations and maintenance of the physical plant;

(c) Resident transportation;

(d) Dietary service (other than the cost of food and beverages);

(e) Laundry service;

(f) Medical and habilitative supplies;

(g) Taxes; and

(h) Insurance.

(2) An ICF/MR facility's administration and operations rate component is the lesser of:

(a) It's most recent reported cost per resident day adjusted for inflation; or

(b) The calculated rate that is at or above eighty-five percent of state and private facilities' most recent reported cost per resident day adjusted for inflation. This ranking must be based on cost reports used to determine rates for facilities with an occupancy level of at least eighty-five percent during the cost report period.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0680, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0685 How is the property rate component computed? (1) The property rate component reimburses an ICF/MR facility for the necessary and ordinary costs of leases, depreciation, and interest.

(2) It is the facility's most recent desk-reviewed cost per resident day.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0685, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0690 Does DSHS pay a return on equity to providers? DSHS pays a return on equity to proprietary providers.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0690, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0695 How is a return on equity calculated? Calculating return on equity is a three-step process.

(1) First, a provider's net equity is calculated using appropriate items from the provider's most recent cost report and relevant Medicare rules and regulations. Note: Goodwill is not included in the calculation of net equity. Also, monthly equity calculations will not be used.

(2) Second, the Medicare rate of return for the twelve-month period ending on the provider's cost report-closing date is multiplied by the provider's net equity.

(3) Finally, the amount calculated in subsection (2) is divided by the provider's annual resident days for the cost report period to determine a return on equity rate per resident day.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0695, filed 4/20/01, effective 5/21/01.]

WAC 388-835-070 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0700 What if a provider's cost report covers a period shorter than twelve months? If a provider's cost report covers less than a twelve-month period, annual resident days are estimated by using the actual resident days reported by the provider. The provider will then be paid a prospective rate per resident day. The prospective rate will either be the rate per resident day calculated in WAC 388-835-0010 or two dollars per resident day whichever is less.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0700, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0705 Are return on equity calculations subject to field audits? (1) All information used to calculate return on equity is subject to field audit.

(2) A field audit can be used to determine whether the providers reported equity exceeds the equity calculated according to Medicare and the rules of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0705, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0710 How does DSHS use field audit results? DSHS can use the field audit results to recalculate the provider's return on equity rate for the reported rate period. Any payments received by the provider in excess of the return on equity rate must be refunded to DSHS as part of the settlement procedure established in WAC 388-835-0720.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0710, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0715 Does DSHS place upper limits on the reimbursement rates it pays providers? DSHS limits its reimbursement rates to the following:

(1) Reimbursement rates for providers cannot exceed the provider's customary charge to the general public for the type of service covered by the rate.

(2) Public facilities rendering services for free or for a nominal charge will be reimbursed according to the methods and standards established in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0715, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0720 What general requirements apply to settlements between DSHS and providers? (1) Except as otherwise provided in this chapter, settlements must be calculated at the lower of a provider's prospective reimbursement rate or audited allowable costs.

(2) Each provider must complete a proposed preliminary settlement as part of their annual cost report. The due date for the proposed preliminary settlement is the same as the due date for the annual cost report. After reviewing the proposed preliminary settlement, DSHS must issue a preliminary settlement report to the provider.

(3) If a field audit is conducted, DSHS must evaluate the audit findings and issue a final settlement that incorporates the auditor's findings and DSHS's evaluation.

(4) If according to a preliminary or final settlement and the procedures in this chapter, a provider received overpayments from DSHS, they must refund those overpayments to the department. Conversely, DSHS must pay provider for any underpayments for which the department is responsible.

(5) Following a preliminary or final settlement, payment for services must be at the most recent available settlement rate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0720, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0725 What requirements apply to paying overpayments and underpayments? (1) Within thirty days after submitting a preliminary or final settlement report to the provider, DSHS must pay any underpayments it owes.

(2) If a provider received overpayments or payments in error from DSHS, they must refund those payments within thirty days after receiving the preliminary or final settlement report.

(3) If a provider fails to comply with subsection (2) and the contract has not been terminated, DSHS must deduct the amount the provider owes, plus interest, from the department's current monthly payment due to the provider. The interest rate charged by DSHS on any unpaid balance is one percent per month.

(4) If a provider fails to comply with subsection (2) and the contract has been terminated, DSHS may:

(a) Deduct the amount owed by the provider, plus interest, from any amounts due to the provider from the department. (The interest rate on any unpaid balance is of one percent per month); or

(b) Use whatever legal means is available to recover the overpayment or erroneous payment plus interest on the unpaid balance at the rate of one percent per month.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0725, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0730 What if the amount of overpayment or underpayment is being disputed? (1) A provider does not have to refund any disputed amounts if they, in good faith, disagree with a settlement report and file a timely request for an administrative or judicial hearing.

(2) DSHS cannot withhold any amount owed by a provider, plus interest, from current payments due to the provider if the provider's debt is being administratively reviewed or judicially appealed.

(3) DSHS may recover portions of refunds and assess interest on amounts not specifically disputed by a provider in an administrative hearing or judicial appeal.

(4) If the administrative or judicial remedy sought by the provider is not granted or is partially granted after all appeals are exhausted or terminated by mutual agreement, the provider must refund all amounts owed to DSHS. These amounts, plus interest, must be paid within sixty days following the date of an administrative or judicial decision or the date the dispute process was mutually terminated. Interest accrues on the amount owed from the date a review was requested to the date the debt is repaid.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0730, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0735 What requirements apply to a provider's proposed preliminary settlement? (1) Proposed preliminary settlements submitted by providers must use the prospective rate for the resident care and habilitation cost center at which the provider was paid during the report period, including any resident specific payment adjustments. Resident specific payments must be weighted by the number of paid resident days each rate was in effect and compared to the provider's allowable costs for the cost center divided by total resident days.

(2) A provider's administration, operations, and property cost center settlement rate must be the prospective rate for the report period, including any payment adjustments, weighted by the number of paid resident days each rate was in effect.

(3) A provider's return on equity settlement rate must be the prospective rate for the report period weighted by the number of paid resident days the rate was in effect.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0735, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0740 How must DSHS respond to a provider's proposed preliminary settlement? (1) DSHS has one hundred twenty days after receiving a proposed preliminary settlement to review it for accuracy and either accept or reject it.

(2) If accepted, the proposed preliminary settlement becomes the preliminary settlement report.

(3) If rejected, DSHS must issue a preliminary settlement report by cost center that fully substantiates disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0740, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0745 What recourse does a provider have if DSHS rejects their proposed preliminary settlement? A provider has thirty days after receiving a preliminary settlement report to contest it (see WAC 388-835-0950 and 388-835-0960). After thirty days, if the preliminary settlement report has not been contested, it cannot be reviewed.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0745, filed 4/20/01, effective 5/21/01.]

WAC 388-835-075 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0750 What requirements apply to final settlements? (1) A final settlement must be by cost center and must fully substantiate all:

(a) Disallowed costs;

(b) Refunds;

(c) Underpayments; or

(d) Adjustments to cost reports, financial statements, other reports, and schedules submitted by the provider.

(2) A final settlement report must use the prospective rate at which the provider was paid during the report period, including any resident specific payment adjustments made for resident care and training cost center. Resident specific payments must be weighted by the number of paid resident days reported for the period each rate was in effect. DSHS

must compare these payments to the provider's audited allowable costs for the period.

(3) A provider's administration operations and property cost center settlement rate is the prospective rate for the period weighted by the number of paid resident days each rate was in effect.

(4) A provider's return of equity rate is the prospective rate for the report period weighted by the number of paid resident days the rate was in effect.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0750, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0755 Can a provider disagree with a final settlement report? A provider has thirty days after receiving a final settlement report to contest it (see WAC 388-835-0950 and 388-835-0960). After thirty days, if the final settlement report has not been contested, it cannot be reviewed.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0755, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0760 What if DSHS conducts an audit during the final settlement process? (1) If DSHS conducts an audit, it must issue a final settlement report to the provider after the audit process is completed. Completing the audit process includes exhausting or mutual terminating the reviews and/or appeals of audit findings or determinations.

(2) If a provider, in good faith, is disputing audit findings or determinations through the administrative review or judicial appeal process, DSHS may issue a partial final settlement report to recover overpayments based on audit findings or determinations not being disputed.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0760, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0765 Why is a state facility settlement important? The state facility settlement is determined to establish a state facility's final payment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0765, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0770 How is a state facility settlement calculated? The settlement must be calculated as follows:

(1) If the state facility's allowable costs for the report period are greater than their interim payment, the amount owed to the facility is the allowable cost amount minus the interim payment.

(2) If the state facility's allowable costs for the report period are less than their interim payment, the amount owed by the department is the interim payment minus the allowable cost amount.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0770, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0775 How is a state facility settlement implemented? (1) The settlement is implemented in a two-step process consisting of the facility first submitting a proposed preliminary settlement to DSHS and DSHS responding with a final settlement report that it submits to the state facility.

(2) The proposed preliminary settlement must be:

(a) Submitted to DSHS when the state facility submits their cost report.

(b) Responded to by DSHS within one hundred twenty days after they receive it from the state facility. DSHS must verify the accuracy of the facility's proposal and issue a preliminary settlement substantiating the settlement amount.

(3) The final settlement is the preliminary settlement issued by DSHS if an audit is not conducted.

(4) If an audit is conducted, DSHS must submit a final settlement report to the state facility after the audit process is completed. This report must substantiate all disallowed costs, refunds, underpayments, or adjustments to the provider's financial statements, cost report, and final settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0775, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0780 Does DSHS have a responsibility to notify each provider regarding prospective reimbursement rates? (1) DSHS must give written notification to each provider regarding DSHS's prospective reimbursement rate.

(2) Unless 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.

(3) If a rate is changed because of a successful provider appeal, the effective date of the new rate is the same as the effective date of the old rate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0780, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0785 Can DSHS increase prospective reimbursement rates? (1) Except for the situations described in subsection (3) and (4) of this section, DSHS prospective reimbursement rates are the maximum provider payment rates for those periods to which they apply.

(2) DSHS does not grant rate adjustments for cost increases that are or were subject to management control or negotiations. Examples include, but are not limited to, all lease cost increases or any cost increases not expressly authorized in subsection (3) and (4).

(3) DSHS does adjust rates for any capitalized additions or replacements made as a condition for licensure or certification.

(4) DSHS does adjust rates for cost increases that must be incurred and cannot be met through the provider's prospective rate. Examples of such cost increases are:

(a) Program changes required by DSHS;

(b) Changes in staffing levels or consultants at a facility required by DSHS;

(c) Changes required by a survey; and

(d) Changes in revenue assessments required by the state legislature.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0785, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0790 How does a provider request a rate increase? (1) Any provider requesting a rate adjustment must submit a:

(a) Financial analysis showing the increased cost and an estimate of the rate increase needed to cover the increased cost. The estimated rate increase must be computed according to allowable methods;

(b) Written justification for granting the rate increase; and

(c) Certification and documentation that show the staffing changes and/or other improvements started or completed.

(2) Provider's requesting adjustments under WAC 388-835-0900 must submit a written plan identifying the staff they are going to add and the resident needs they have not met because of insufficient staffing.

(3) When reviewing provider requests made under WAC 388-835-0900, DSHS considers:

(a) If the additional staff requested by a provider is appropriate for meeting resident needs;

(b) Staffing level comparisons with facilities having similar characteristics;

(c) The facility's physical layout;

(d) Supervision and management of current staff;

(e) Historical trends regarding the facility's under-spending for resident care and habilitation;

(f) Number and position of existing staff; and

(g) Other resources available to the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0790, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0795 What requirements apply to providers who receive rate increases? (1) Providers that receive prospective rate increases may be required to submit quarterly reports showing how the additional funds were spent. If required, a quarterly report would begin on the first day of the month following the date the rate increase is granted.

(2) If the additional funds resulting from the rate increase are not spent on DSHS approved changes or improvements approved, DSHS may ask that they be returned immediately.

(3) If a facility gives written notice to DSHS that it intends to close by a specific date and that returning the funds would jeopardize its ability to provide for the health, safety, and welfare of its residents, it may not have to return the additional funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0795, filed 4/20/01, effective 5/21/01.]

WAC 388-835-080 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0800 What if DSHS discovers that a prospective rate calculation was affected by an error or omission? (1) DSHS may adjust prospective rates resulting from cost report errors, computational errors or omissions by either DSHS or the provider.

(2) In addition to adjusting the rate, DSHS must notify the provider in writing:

(a) Regarding the nature and substance of each adjustment;

(b) That the effective date of each adjustment is the same as the effective date of the original rate; and

(c) Of any amount due to either DSHS or the provider as a result of an adjustment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0800, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0805 What if a provider discovers an error or omission that affected their cost report? (1) If a provider discovers an error or omission that caused their cost report to be incorrect, the provider must submit amended cost report pages.

(2) Amended cost report pages must be certified and accompanied by a written explanation why the amendment is necessary. Amendments are not accepted by DSHS unless they comply with the requirements in WAC 388-835-0815.

(3) If DSHS concludes that the amendment changes are material, the amended pages must be audited by a field audit.

(4) If DSHS concludes that the amendments are incorrect or unacceptable as a result of the field audit or other information it receives, any rate adjustment based on the amendments is null and void. Any scheduled future rate payment increases resulting from the amendments must be canceled immediately.

(5) Any rate adjustment payments must be made according to the repayment provisions in WAC 388-835-0905.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0805, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0810 What other requirements apply to rate adjustments resulting from errors or omissions? (1) No adjustment can be made to a rate more than:

(a) One hundred twenty days after the field audit narrative and summary is sent to the provider; or

(b) One hundred twenty days after a preliminary settlement becomes a final settlement.

(2) A final settlement that is concluded within the one hundred twenty-day time limits could only be reopened to adjust prospective rates that are based upon errors or omissions.

(3) Only adjustments to prospective rates (and the related computations) resulting from errors or omissions can be reviewed if a timely request is filed according to the provisions of WAC 388-835-0950.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0810, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0815 What requirements apply to repayment of amounts owed due to errors or omissions? (1) Repayment (or starting repayment) of any amount owed to DSHS by a provider as a result of an error or omission rate adjustment must occur:

(a) Within sixty days after the provider receives a rate adjustment notification from DSHS; or

(b) According to a repayment schedule developed by DSHS.

(2) If a provider does not repay its debt to DSHS when it is due, DSHS may deduct the amount owed from the providers current DSHS payment.

(3) If a provider unsuccessfully contests the rate adjustment (see WAC 388-835-0950, they must repay DSHS (or start repayment) within sixty days after the administrative or judicial proceedings are completed.

(4) If DSHS owes a provider as a result of a rate adjustment, DSHS must pay the provider within thirty days after notifying the provider of the adjustment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0815, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0820 What role does the public play in setting prospective reimbursement rates? Each year before prospective reimbursement rates are set, DSHS will give all interested members of the public an opportunity to review and comment on the department's proposed rate setting methods and standards.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0820, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0825 What is DSHS' public disclosure responsibility regarding rate setting methodology? Without identifying individual ICF/MR facilities and in compliance with public disclosure statute and rule requirements, DSHS will provide the public with full and complete information regarding its rate setting methodology.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0825, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0830 How does a provider bill DSHS for services provided? (1) A provider must bill DSHS each month, from the first through the last day, for care provided to medical care recipients by completing and returning an IMR statement filed according to department instructions.

(2) A provider cannot bill DSHS for services provided to a resident until they receive a DSHS resident award letter. When the provider receives the award letter, they can bill for services provided since the resident's admission or eligibility date.

(3) A provider cannot bill DSHS for the day of a resident's death, discharge, or transfer from the ICF/MR facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0830, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0835 How does DSHS pay a provider? (1) DSHS will reimburse a provider for billed service rendered under the ICF/MR contract according to the appropriate rate assigned to the provider.

(2) For each resident, DSHS will pay an amount equal to the appropriate rates multiplied by the number of resident days each rate was in effect, less any amount a resident is required to pay (see WAC 388-835-0940).

(3) A provider must accept DSHS's reimbursement rates as full compensation for all services the provider is obligated to provide under their contract. The provider must not seek or accept additional compensation any contracted services from or on behalf of a resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0835, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0840 Can DSHS withhold provider payments? DSHS cannot withhold a provider payment until the provider is given written notification explaining why the payment is being withheld.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0840, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0845 Can DSHS terminate Medicaid Title XIX payments to providers? DSHS must terminate all Medicaid Title XIX payments to a provider no later than sixty days after a:

(1) Contract expires, is terminated or is not renewed;

(2) Facility license is revoked; or

(3) Facility is decertified as a Title XIX facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0845, filed 4/20/01, effective 5/21/01.]

WAC 388-835-085 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0850 Who is responsible for collecting from residents any amounts they may own for their care? (1) DSHS will notify a provider of the amount each resident is required to pay for care provided under the contract and the date the payment is due.

(2) The provider is responsible for:

(a) Collecting from the resident; and

(b) Accounting for, according to procedures established by DSHS, any authorized reduction in the resident's contribution.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0850, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0855 What if a resident's circumstances change causing a provider to contribute more to the resident's care? (1) If a provider receives documentation verifying a change in a resident's income or resources that will reduce the resident's ability to contribute to the cost of their care, the provider must report this information in writing to the DDD regional services office within seventy-two hours.

(2) Any necessary corrections should be made in the next ICF/MR statement and a copy of the supporting documentation should be attached.

(3) If a provider receives increased funds for a resident, the normal amount must be allowed for clothing, personal, and incidental expenses and the balance must be applied to the cost of care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0855, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0860 What is the role of a receiver when an ICF/MR facility is placed in receivership? If an ICF/MR facility is providing care to state medical assistance recipients and is placed under receivership, the receiver:

(1) Becomes the Medicaid provider during the receivership period;

(2) Assumes all new provider reporting responsibilities;

(3) Assumes all other new provider responsibilities established in this chapter; and

(4) Is responsible, during the receivership period, for refunding any Medicaid rate payments received that exceed cost of services provided.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0860, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0865 How does DSHS determine prospective reimbursement rates during receivership? When establishing prospective reimbursement rates during receivership, DSHS must consider:

(1) Court ordered compensation, if any, for the receiver. Receiver compensation may already be available through the:

(a) Return on equity cost center rate, or

(b) Facility administrator salary where the receiver is also the facility's administrator.

(c) In order to satisfy the court order when existing sources of compensation are less than the compensation ordered by the court, DSHS could consider the difference as an additional allowable cost when establishing prospective reimbursement rates.

(2) Start-up costs and costs of repairs, replacements, and additional staff needed for resident health, training, security, and welfare. No additional money will be added to the rate if these costs can be covered through the return on equity cost center rate; and

(3) Any other allowable costs contained in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0865, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0870 What if the court asks DSHS to recommend a receiver's compensation? If asked for a recommendation regarding receiver compensation by the court, DSHS must consider the:

(1) Range of compensation for private ICF/MR facility managers;

(2) Experience and training of the receiver;

(3) Size, location, and current condition of the facility; and

(4) Additional factors considered appropriate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0870, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0875 Can DSHS give emergency or transitional financial assistance to a receiver? (1) In response to a court order, DSHS must give up to thirty thousand dollars of emergency or transitional financial assistance to a receiver.

(2) DSHS must recover any emergency or transitional assistance given to a receiver from facility generated revenue that is not obligated for facility operations.

(3) If DSHS has not fully recovered the emergency or transitional assistance when the receivership ends, DSHS may file:

(a) An action against the former licensee or owner to recover what is owed; or

(b) A lien against the facility or the proceeds from the sale of the facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0875, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0880 What happens when a receivership ends? When a receivership ends, DSHS may revise the facility's Medicaid reimbursement as follows:

(1) The Medicaid reimbursement rate for the former owner or licensee must be what it was before receivership unless the former owner or licensee requests prospective rate revisions according to the requirements of this chapter.

(2) The Medicaid reimbursement rate for licensed replacement operators must be established according to the rules in this chapter governing prospective reimbursement rates for new providers.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0880, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0885 What disputes between providers and DSHS can be resolved through the administrative review process? A provider can use the administrative review process to contest:

(1) An "errors or omissions" reimbursement rate adjustment issued to the provider (see WAC 388-835-0845) or DSHS's refusal to adjust a rate the provider believes is incorrect due to errors or omissions. The provider must request an administrative review within thirty days of receiving notification that a rate has been adjusted or that DSHS refuses to adjust the rate.

(2) The way in which a DSHS rule, contract provision, or policy statement was applied when calculating the provider's prospective cost related reimbursement system's rate.

(3) An audit finding, other audit determination, a rate review or other settlement determination.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0885, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0890 What disputes cannot be resolved through the administrative review and fair hearing processes? DSHS' administrative review and fair hearing processes cannot be used to challenge the adequacy of any prospective or settlement reimbursement rate or rate component, either individually or collectively.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0890, filed 4/20/01, effective 5/21/01.]

WAC 388-835-090 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0900 How does a provider request an administrative review? (1) A provider challenging an audit or settlement determination has a maximum of thirty days after receiving the finding or decision to file a written request for an administrative review.

(2) Written requests must be filed with the:

(a) Office of Financial Recovery services when the provider challenges an audit finding (adjusting journal entries or AJEs) or other audit determination; or

(b) DDD Director when the provider challenges a rate, desk review, or other settlement determination.

(3) The written request must:

(a) Be signed by the provider or facility administrator;

(b) Identify the specific determination being challenged and the date it was issued;

(c) State, as specifically as possible, the issues and regulations involved and why the provider claims the determination was erroneous; and

(d) Be accompanied by any documentation that will be used to support the provider's position.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0900, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0905 What happens after a provider requests an administrative review? (1) After receiving a provider's request, DSHS must schedule a conference between the provider and appropriate department representatives.

(2) Unless both parties agree, in writing, to a specific later date, the conference must be scheduled at least fourteen days after DSHS notifies the provider that a conference will be held and no later than ninety days after DSHS receives the provider's review request.

(3) The conference may be conducted by telephone unless DSHS or the provider requests, in writing, that it be held in person.

(4) The provider and DSHS representatives must participate in the conference.

(5) Either at the conference or before, the provider must give DSHS any documentation:

(a) Requested by DSHS that the provider is required to maintain for audit purposes under WAC 388-835-0270; and

(b) The provider intends to use to support their position.

(6) At the conference DSHS and the provider must clarify the issues and attempt to resolve them.

(7) If additional documentation is necessary to resolve the issues, a second conference meeting must be scheduled. Unless both parties agree, in writing, to a specific later date, this second conference meeting must be scheduled not later than thirty days after the first session.

(8) Regardless of whether an agreement is reached, DSHS must give the provider a written decision within sixty days after the conference ends.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0905, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0910 What if a provider disagrees with the administrative review decision? (1) If they disagree with the administrative review decision, a provider has a right to request an adjudicative proceeding within thirty days of receiving the decision.

(2) To request an adjudicative proceeding, a provider must:

(a) File a written request with the office of administrative hearings (OAH);

(b) Sign the request or have it signed by the facility administrator;

(c) State as specifically as possible the issues and regulations involved;

(d) State the reasons for disagreeing with the administrative review decision; and

(e) Attach a copy of the contested decision and any documentation the provider will use to support their position.

(3) The adjudicative proceeding must be governed by the Administrative Procedure Act (chapter 34.05 RCW), this chapter, and chapter 388-02 WAC. If any part of this chapter conflict with chapter 388-02 WAC, this chapter prevails.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0910, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0915 Can DSHS withhold an undisputed overpayment amount from a current ICF/MR payment? DSHS is authorized to withhold from an ICF/MR's current payment all amounts found by a preliminary or final settlement to be overpayments if they are not identified by the ICF/MR as overpayments and challenged in an administrative or judicial review.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0915, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0920 Can DSHS withhold a disputed overpayment amount from a current ICF/MR payment? Once administrative and judicial review processes are complete, contested overpayments retained by an ICF/MR may be withheld from the ICF/MR's current payment but only to the extent DSHS's position or claims are upheld.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0920, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0925 What is the purpose of this section? The purpose of this chapter is to regulate the costs of care of mentally/physically deficient persons.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0925, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0930 How is the payment for residential facilities set? The department sets the payment for residential facilities by the methodology noted in chapter 388-835 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0930, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0935 How much of a resident's income is exempt from paying their care? Residents whose total resources are insufficient to pay the actual cost of care must be entitled to a monthly exemption from income in the amount of twenty-five dollars.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0935, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0940 What if the estate of a resident is able to pay all or a portion of their monthly cost? (1) If DSHS finds that the estate of a resident is able to pay all or a portion of their monthly costs for care, support, and treat-

ment, they must serve a written notice of 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

(c) The superintendent of the state school.

(2) If a resident is an adult and is not under a legal disability, the department must personally serve the NFR on the resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0940, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0945 If a resident or guardian is served by DSHS with a NFR when is payment due? If a resident or guardian is served by DSHS with an NFR, payment is due thirty days after receiving the notice.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0945, filed 4/20/01, effective 5/21/01.]

WAC 388-835-095 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-0950 May a resident or guardian request a hearing if they disagree with the NFR? If a resident or guardian disagrees with the NFR, they have the right to ask for a hearing under chapter 34.05 RCW. They must file a written hearing request within thirty days of receipt with the secretary of DSHS, ATTN: Determination Officer, P.O. Box 9768, Olympia, WA 98504.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0950, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0955 What information must be included in the request for a hearing? The request for hearing must include:

(1) A specific statement of the issues and law involved;

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

(3) A copy of the NFR being contested.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0955, filed 4/20/01, effective 5/21/01.]

WAC 388-835-100 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-105 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-110 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-115 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-120 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-125 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-130 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-135 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-140 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-145 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-150 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-155 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-160 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-165 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-170 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-175 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-180 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-185 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-190 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-195 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-200 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-205 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-210 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-215 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-220 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-225 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-230 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-235 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-240 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-245 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-250 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-255 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-260 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-265 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-270 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-275 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-280 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-285 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-290 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-295 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-300 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-305 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-310 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-315 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-320 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-325 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-330 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-335 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-340 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-345 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-350 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-355 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-360 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-365 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-370 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-375 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-380 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-385 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-390 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-395 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-400 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-405 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-410 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-415 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-420 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-425 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-430 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-435 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-440 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-445 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-450 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-455 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-460 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-465 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-470 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-475 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-480 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-485 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-490 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-495 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-500 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-505 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-510 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-515 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-520 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-525 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-530 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-535 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-540 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-545 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-550 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-555 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-560 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-835-565 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-860 WAC
JUVENILE INVOLUNTARY TREATMENT

WAC

388-860-010 through 388-860-317 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-860-010 Purpose. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-020 Definitions. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-240 Involuntary evaluation and treatment costs—Seventy-two hour detentions/fourteen-day commitments. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-250 Involuntary evaluation and treatment costs—One hundred eighty-day commitments. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-260 Involuntary treatment program administrative costs—Seventy-two hour/fourteen-day commitment. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-270 Involuntary treatment program transportation costs. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-280 Involuntary treatment program—Legal costs. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-290 Patient rights. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-300 Confidentiality. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-310 Confidentiality of court proceeding records. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-315 Mental health service provider license and certification fees. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-316 Fee payment and refunds. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-860-317 Denial, revocation, suspension, and reinstatement. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

WAC 388-860-010 through 388-860-317 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-861 WAC

VOLUNTARY ADMISSION—INVOLUNTARY COMMITMENT, TREATMENT AND/OR EVALUATION OF MENTALLY ILL PERSONS

WAC

388-861-010 through 388-861-402 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-861-010 Purpose. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-020 Definitions. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-030 Private agencies which may admit voluntary patients. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-040 Voluntary admission to public or private agency—Voluntary adult. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-081 Periodic review—Voluntary inpatient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-090 Limitation on length of stay—Readmission voluntary patients. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-110 Discharge of voluntary patient—Release of clinical summary. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority:

RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-115 Transfer of a patient between state-operated facilities for persons with mental illness. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-131 Nonadmission of involuntarily detained person—Transportation. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-141 Protection of patient's property—Involuntary patient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-151 Evaluation and examination—Involuntary patient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-161 Treatment prior to hearings—Involuntary patient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-171 Early release or discharge of involuntary patient—Release of clinical summary—Notification of court. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-181 Conditional release—Involuntary patient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-191 Revocation of conditional release—Secretary's designee—Involuntary patient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-201 Discharge of indigent patient—Involuntary patient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-211 Advising patient of rights. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-221 Restoration procedure for a former involuntarily committed person's right to firearm possession. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-231 Conversion to voluntary status by involuntary patient—Rights. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-241 Rights of patient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-261 Requirements for certifying evaluation and treatment components. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-263 Certification standards for evaluation and treatment program. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-271 Outpatient component. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-281 Emergency component. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-291 Short-term inpatient component. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-293 Certification procedure—Waivers—Provisional certification—Renewal of certification. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-295 Decertification. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-297 Appeal procedure. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-301 Alternatives to inpatient treatment. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-341 Use of restraints and seclusion by agency not certified as an evaluation and treatment facility. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-351 Research. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-361 Involuntary evaluation and treatment costs—Responsibility of involuntary patient. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-363 Involuntary evaluation and treatment costs—Collection by agency. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-365 Involuntary evaluation and treatment costs—Responsibility of county. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-367 Involuntary evaluation and treatment costs—Responsibility of department. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-371 Exceptions to rules—Waivers. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-400 Mental health service provider license and certification fees. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-401 Fee payment and refunds. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-861-402 Denial, revocation, suspension, and reinstatement. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

WAC 388-861-010 through 388-861-402 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-862 WAC
COMMUNITY MENTAL HEALTH PROGRAMS

WAC

388-862-010 through 388-862-470 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-862-010 Purpose and authority. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-020 Definitions. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-030 Waiver of rules. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-040 Department responsibilities and duties. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-050 Regional support networks—General responsibilities and duties. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW

71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-060 Regional support networks—Recognition and certification. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-070 Regional support networks—Penalties for noncompliance. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-080 Regional support networks—Governance and community accountability. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-090 Regional support networks—Financial management. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-100 Regional support network—Awareness of services. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-110 Regional support networks—Resource management. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-120 Regional support networks—Management information. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-130 Regional support networks—Staff qualifications. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-140 Regional support networks—Housing. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-150 Regional support networks and prepaid health plans—Quality improvement. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-160 Regional support networks and prepaid health plans—Ombuds service. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-170 Regional support networks and prepaid health plans—Consumer grievances. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-180 Prepaid health plans—Purpose. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-190 Prepaid health plans—Eligible consumers. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-200 Prepaid health plans—Exemptions. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-210 Prepaid health plans—Enrolled recipient's choice of primary care provider. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-220 Prepaid health plans—Other 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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-230 Prepaid health plans—Emergency services. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-240 Prepaid health plans—Consumer request for a second opinion. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-420 Community support services—Case management services. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-430 Community support services—Residential services. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-440 Community support services—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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-450 Community support services—Psychiatric and medical services. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-460 Community support services—In-home services. [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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

388-862-470 Community support services—Consumer or advocate run 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.] Repealed by 01-12-047, filed 5/31/01, effective 7/1/01. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335.

WAC 388-862-010 through 388-862-470 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

WAC

WAC 388-865-0100 Purpose. Chapter 388-865 of the Washington Administrative Code implements chapters 71.05, 71.24, and 71.34 RCW, and the mental health Title XIX Section 1915 (b) Medicaid waiver provisions.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0100, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0105 What the mental health division does and how it is organized. (1) The department of social and health services is designated by the legislature as the state mental health authority, and has designated the mental health division to administer the state mental health program.

(2) To request an organizational chart, contact the mental health division at 1-888-713-6010 or (360) 902-8070, or write to the Mental Health Division Director, PO Box 45320, Olympia, WA 98504.

(3) Local services are administered by regional support networks (RSN), which are a county, or combination of counties, whose telephone number is located in the local telephone directory and can also be obtained by calling the mental health division at the above telephone number.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0105, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0110 Access to records of registration. The mental health division, regional support networks, mental health prepaid health plans, and service providers must ensure that information about the fact that a consumer has or is receiving mental health services is not shared or released except as specified under RCW 71.05.390 and other laws and regulations about confidentiality as noted below in WAC 388-865-0115.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0110, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0115 Access to clinical records. There are numerous federal and state rules and regulations on the subjects of confidentiality and access to consumer clinical records. Many of the rules are located in chapter 70.02 RCW, RCW 71.05.390, 71.05.400, 71.05.410, 71.05.420, 71.05.430, 71.05.440, 71.05.445, 71.05.610 through 71.05.680, 71.34.160, 71.34.162, 71.34.170, 71.34.200, 71.34.210, 71.34.220, 71.34.225, 13.50.100(4)(b), and 42 C.F.R. 431 and 438, and 42 C.F.R. Part 2 of the Code of Federal Regulations and are not repeated in these rules.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0115, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0120 Waiver of a minimum standard of this chapter. (1) A regional support network, mental health prepaid health plan, service provider or applicant subject to the rules in this chapter may request a waiver of any sections or subsections of these rules by submitting a request in writing to the director of the mental health division. The request must include:

(a) The name and address of the entity that is making the request;

(b) The specific section or subsection of these rules for which a waiver is being requested;

(c) The reason why the waiver is necessary, or the method the entity will use to meet the desired outcome of the section or subsection in a more effective and efficient manner;

(d) A description of the plan and timetable to achieve compliance with the minimum standard or to implement, test, and report results of an improved way to meet the intent of the section or subsection. In no case will the mental health division write a waiver of minimum standards for more than the time period of the entity's current license and/or certificate.

(2) For agencies contracting with a regional support network or mental health prepaid health plan, a statement by the regional support network or mental health prepaid health plan recommending mental health division approval of the request, including:

(a) Recommendations, if any, from the quality review team or ombuds staff; and

(b) A description of how consumers will be notified of changes made as a result of the exception.

(3) The mental health division makes a determination on the waiver request within thirty days from date of receipt. The review will consider the impact on accountability, accessibility, efficiency, consumer satisfaction, and quality of care and any violations of the request with state or federal law.

(4) When granting the request, the mental health division issues a notice to the person making the request, and the involved regional support network if the regional support network is not the applicant, that includes:

(a) The section or subsection waived;

(b) The conditions of acceptance;

(c) The timeframe for which the waiver is approved;

(d) Notification that the agreement may be reviewed by the mental health division and renewed, if requested.

(5) When denying the request, the mental health division includes the reason for the decision in the notice sent to the person making the request.

(6) The mental health division does not waive any requirement that is part of statute.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0120, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0150 Definitions. "Adult" means a person on or after their eighteenth birthday. For persons eligi-

ble for the Medicaid program, adult means a person on or after his/her twenty-first birthday.

"Child" means a person who has not reached his/her eighteenth birthday. For persons eligible for the Medicaid program, child means a person who has not reached his/her twenty-first birthday.

"Clinical services" means those direct age and culturally appropriate consumer services which either:

(1) Assess a consumer's condition, abilities or problems;

(2) Provide therapeutic interventions which are designed to ameliorate psychiatric symptoms and improve a consumer's functioning.

"Consumer" means a person who has applied for, is eligible for or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

"Consultation" means the clinical review and development of recommendations regarding the job responsibilities, activities, or decisions of, clinical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations.

"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.

"Ethnic minority" or **"racial/ethnic groups"** means, for the purposes of this chapter, any of the following general population groups:

(1) African American;

(2) An American Indian or Alaskan native, which includes:

(a) A person who is a member of considered to be a member in a federally recognized tribe;

(b) A person determined eligible to be found Indian by the secretary of interior, and

(c) An Eskimo, Aleut, or other Alaskan native.

(d) A Canadian Indian, meaning a person of a treaty tribe, Metis community, or nonstatus Indian community from Canada.

(e) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off reservation Indian/Alaskan native community organization.

(3) Asian/Pacific Islander; or

(4) Hispanic.

"Medical necessity" or **"medically necessary"** - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Mental health division" means the mental health division of the Washington state department of social and health services (DSHS). DSHS has designated the mental health division as the state mental health authority to administer the state and Medicaid funded mental health program authorized by chapter 71.05, 71.24, and 71.34 RCW.

"Mental health professional" means:

(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(2) 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 persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(4) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.

"Mental health specialist" means:

(1) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and

(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of

service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(b) 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) A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, **"disabled"** means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

"Older person" means an adult who is sixty years of age or older.

"Service recipient" means for the purposes of a mental health prepaid health plan, a consumer eligible for the Title XIX Medicaid program.

"Substantial hardship" means that a consumer will not be billed for emergency involuntary treatment if he or she meets the eligibility standards of the medically indigent program that is administered by the DSHS medical assistance administration.

"Supervision" means 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.

"Underserved" means consumers who are:

(1) Minorities;

(2) Children;

(3) Older adults;

(4) Disabled; or

(5) Low-income persons.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0150, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0200 Regional support networks. The mental health division contracts with certified regional support networks to administer all mental health services activities or programs within their jurisdiction using available resources. The regional support network must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To gain and maintain certification, the regional support network must comply with all applicable federal, state and local laws and regulations, and all of the minimum standards of this section. The community mental health program administered by the regional support network includes the following programs:

(1) Administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapter 71.05 and 71.34 RCW;

(2) Resource management program as defined in RCW 71.24.025(15) and this section;

(3) Community support services as defined in RCW 71.24.025(7);

(4) Residential and housing services as defined in RCW 71.24.025(14);

(5) Ombuds services;

(6) Quality review teams;

(7) Inpatient services as defined in chapter 71.05 and 71.34 RCW; and

(8) Services operated or staffed by consumers, former consumers, family members of consumers, or other advocates. If the service is clinical, the service must comply with the requirements for licensed services. 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;

(c) Advocacy and referral services;

(d) Consumer and/or advocate operated household assistance programs;

(e) Self-help and peer support groups;

(f) Ombuds service; and

(g) Other services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0200, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0201 Allocation of funds to RSN/PHPs. This section describes how Medicaid and community mental health funds are allocated to the RSN/PHPs.

(1) Funding allocations are projected at the beginning of each fiscal year, using forecasted Medicaid enrollees for that fiscal year.

(2) Payments are made on the number of actual Medicaid enrollees each month, which may result in actual payments being higher or lower than projected payments, depending on whether actual Medicaid enrollees are more or less than forecasted enrollees.

(3) The mental health division (MHD) uses two different methodologies to allocate funds:

(a) Historical method;

(b) Eligibles method.

(4) For the period July 1, 2001 to June 30, 2005, the funds will be allocated using the methodologies as follows:

(a) For July, 1, 2001 to June 30, 2002, seventy-five percent of funds of will be allocated using the historical method and twenty-five percent of funds will be allocated using the prevalence method;

(b) For June 1, 2002 to June 30, 2003, fifty percent of funds will be allocated using the historical method and fifty

percent of funds will be allocated using the prevalence method;

(c) For June 1, 2003 to June 30, 2004, twenty-five percent of funds will be allocated using the historical method and seventy-five percent of funds will be allocated using the prevalence method;

(d) For June 1, 2004 forward, one hundred percent of funds will be allocated using the prevalence method. These percentages will remain in effect unless the department is directed otherwise by the state Legislature.

(5)(a) Historical method means that federal Medicaid funds projected to be paid to the RSN/PHPs are calculated using actuarially determined per member per month (PMPM) rates specific to each regional support network multiplied by the number of persons enrolled in the Medicaid program in each regional support network for each month during the fiscal year.

(b) The actuarially determined rates were determined at the beginning of the managed care program (1992 for outpatient services and 1997 for inpatient services) and have been increased periodically by the Legislature.

(i) Rates differ by RSN and by category of enrollee (disabled and nondisabled adults and disabled and nondisabled children).

(ii) These rates are tracked by MHD.

(iii) The number of Medicaid enrollees is tracked by the medical assistance administration.

(c) The product of rates and enrollees is the projected amount of Medicaid funding each RSN/PHP will receive during the year.

(i) This amount is divided into two portions - federal funds and state match funds.

(ii) The two portions of Medicaid funds are determined by a percentage known as the Federal Medicaid Assistance Percentage (FMAP). This percentage is set by the federal Health Care Financing Authority and changes each year.

(d) In the inpatient program, each RSN/PHP is allocated the amount of federal and state funds projected in the calculations explained above.

(e) State funds in the outpatient program (also called "consolidated") to be paid to the RSN/PHPs are set by the Legislature. These funds are allocated to the RSN/PHPs according to the RSN/PHP's calculated percentage of the total funds. The RSN/PHP's percentage is based primarily on historical fee-for-service data.

(i) The RSN/PHP percentages are tracked by MHD and are carried forward each year.

(ii) The percentage of consolidated funds paid to each RSN/PHP is adjusted each year by the Legislature through budget proviso direction, generally requiring that new funds in the program be allocated according to Medicaid enrollees in each RSN. Therefore, the amount of consolidated funds in the outpatient program at the beginning of the fiscal year (also called "base funds") are allocated according to the percentage tracked by MHD (put in place by the Legislature in the previous year).

(iii) New consolidated funds are allocated as directed by the Legislature, generally according to the number of Medicaid enrollees residing in each RSN.

(f) The base allocation and new consolidated allocations are combined into one percentage that serves as the RSN/PHP's percentage allocation for the next year's base funds.

(g) The sum of federal Medicaid funds, state match funds in the inpatient program, and consolidated funds equals the amount of funding provided to each RSN/PHP.

(6) Eligibles method.

(a) Medicaid and non-Medicaid funds are allocated based on a formula that reflects prevalence of mental disorders in each county. The formula takes into consideration each RSN's:

(i) Concentrations of priority populations;

(ii) Commitments to state hospitals under chapter 71.05 and 71.34 RCW;

(iii) Population concentrations in urban areas;

(iv) Population concentrations at border crossings at state boundaries; and

(v) Other demographic and workload factors such as number of MI/GA-U clients, commitments to community hospitals under chapter 71.05 and 71.34 RCW, and number of homeless persons.

(b) The RSN/PHP historical method rates for 2001 have been used to calculate a weighted average statewide rate (WASR) for each category of Medicaid eligible (disabled and nondisabled adults and disabled and nondisabled children).

(c) The WASR for each category is determined by:

(i) Adding the RSN/PHP's inpatient and outpatient rates to create one combined rate;

(ii) Multiplying each RSN/PHP's rate by the number of Medicaid enrollees residing in that RSN/PHP;

(iii) Adding the results; and

(iv) Dividing the sum by the statewide number of Medicaid eligibles.

(d) WASR rates are tracked by MHD.

(e) The number of Medicaid enrollees is tracked by the medical assistance administration.

(f) To project the amount of Medicaid funding each RSN/PHP will receive during the year, MHD multiplies the RSN/PHP's WASR for each category by the projected number of Medicaid enrollees in each category.

(i) This amount is divided into two portions - federal funds and state match funds.

(ii) Each RSN/PHP's projected allocation includes both portions of Medicaid funding (federal and state match funds).

(iii) Payments to the RSN/PHP are made based on the actual number of Medicaid enrollees.

(g) The level of non-Medicaid funds appropriated to the community mental health services program is determined by the state Legislature.

(i) Eighty percent of the non-Medicaid funds appropriated are allocated to the RSN/PHPs according to the number persons enrolled in the state funded general assistance - unemployable, medically indigent and state only "v" programs (persons in the state only "v" program are counted at thirteen percent of the total enrolled).

(A) The number of persons enrolled in these programs is tracked by the medical assistance administration.

(B) The projected number of persons in these programs residing in each RSN, divided by the total persons projected

to be in these programs, is multiplied by eighty percent of the total funds appropriated to determine the amount of funding provided to each RSN/PHP.

(ii) Twenty percent of the non-Medicaid funds appropriated are allocated according to a summary z score factor that is calculated using four subfactors:

(A) The number of urban counties in each RSN;

(B) The number of state and country border counties in each RSN;

(C) The number of homeless persons in each RSN; and

(D) The number of ITA commitments from each RSN.

These subfactors are weighted differently, with the urban factor weighted at 0.3, the border county factor weighted at 0.05, the homeless factor weighted at 1.0 and the ITA commitments factor weighted at 0.2. For each of these factors, information is tracked by MHD and the most recent complete year of data is used to calculate z score factors for each subfactor. These factors are combined into a summary z score factor for each RSN that is multiplied by the total funding available (twenty percent of non-Medicaid funds appropriated).

(7) The mental health division does not pay providers on a fee-for-service basis for services that are the responsibility of the mental health RSN or PHP, even if the RSN or PHP has not paid for the service for any reason.

(8) To the extent authorized by the state legislature, regional support networks and mental health prepaid health plans may use local funds spent on health services to increase the collection of federal Medicaid funds. Local funds used for this purpose may not be used as match for any other federal funds or programs.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0201, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0203 Allocation formula for state hospital beds. The mental health division (MHD) allocates nonforensic adult beds at the state hospital utilized by the regional support network (RSN) based on the number of beds funded by the Legislature at that hospital.

(1) The allocation formula is (M x 40%)+(U x 35%)+(P x 25%) x F.

(a) M is the average number of Medicaid eligible persons in the RSN during the period of January to December prior to the start of the biennium, divided by the average number of Medicaid eligible persons at each state hospital catchment area (westside for western state hospital and eastside for eastern state hospital) during the same period;

(b) U is the number of each regional support network's average daily census at the state hospital during the period of January to December prior to the start of each biennium divided by the average daily census at the hospital based on the utilization of beds by the regional support network included in the hospital catchment area during the same period;

(c) P is the percent of the general population that resides within the RSN based on the most recent population estimate on December 1 of the year prior to the start of the biennium divided by the general population in the hospital catchment area at the same time;

(d) F is the total number of funded nonforensic beds at each state hospital (westside for western state hospital and eastside for eastern state hospital);

(e) The MHD will project and distribute tentative allocations upon issuance of the Governor's budget, and upon enactment of the Legislative budget. The operative allocation will be made and distributed at the start of each fiscal year.

(2) This formula will be phased in as follows:

(a) For July 1, 2001 to June 30, 2002, twenty five percent of the bed allocation will be based on the new formula, and seventy five percent based on the 1999-2001 allocation;

(b) For July 1, 2002 to June 30, 2003, fifty percent of the allocation will be based on the new formula and fifty percent based on the 1999-2001 allocation;

(c) For July 1, 2003 to June 30, 2004, seventy-five percent of the allocation will be based on the new formula and twenty-five percent based on the 1999-2001 allocation;

(d) For July 1, 2004 to June 30, 2005 one hundred percent of the allocation will be based on the new formula;

(e) The formula will be recalculated on or about April 4, 2005 and each biennium thereafter based on data that is current at that time.

(3) If the in-residence census exceeds the funded capacity on any day or days within the fiscal year, the MHD will assess liquidated damages calculated on the following formula:

(a) Only RSNs who are in excess of their individual allocated census on the day or each day of over census will be assessed liquidated damages;

(b) The amount of liquidated damages charged for each day will be the number of beds over the funded capacity of the hospital multiplied by the state hospital daily bed charge consistent with RCW 43.20B.325;

(c) The amount of liquidated damages charged to each RSN will be a percentage based on the number of beds over their allocation divided by the total number of beds over the funded capacity on the day or each day of over census;

(d) The liquidated damages will be recovered by the MHD by a deduction from the monthly payment made by the MHD two months after the end of the month in which the in residence census exceeded the state bed allocation of that RSN.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0203, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0205 Initial certification of a regional support network. A regional support network is a county authority or group of county authorities that have a joint operating agreement. In order to gain certification as a regional support network, a county or group of counties must submit to the department:

(1) A statement of intent to become a regional support network;

(2) Documentation that the total population in the county or group of counties is not less than forty thousand;

(3) A joint operating agreement if the proposed regional support network is more than one county or includes a tribal authority. The agreement must include the following:

(a) Identification of a single authority with final responsibility for all available resources and performance of the contract with the department consistent with chapter 71.05, 71.24, and 71.34 RCW;

(b) Assignment of all responsibilities required by RCW 71.24.300; and

(c) Participation of tribal authorities in the agreement at the request of the tribal authorities.

(d) A preliminary operating plan completed according to departmental guidelines.

(4) Within thirty days of the submission the department will provide a written response either:

(a) Certifying the regional support network; or

(b) Denying certification because the requirements are not met.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0205, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0210 Renewal of regional support network certification. At least biennially the mental health division reviews the compliance of each regional support network with the statutes, applicable rules and regulations, applicable standards, and state minimum standards as defined in this chapter:

(1) If the regional support network is in compliance with the statutes, applicable rules and regulations, applicable standards, and state minimum standards, the mental health division provides the regional support network with a written certificate of compliance.

(2) If the regional support network is not in compliance with the statutes, applicable rules and regulations, the mental health division will provide the regional support network written notice of the deficiencies. In order to maintain certification, the regional support network must develop a plan of corrective action approved by the mental health division.

(3) If the regional support network fails to develop an approved plan of corrective action or does not complete implementation of the plan within the timeframes specified, the mental health division may initiate procedures to suspend, revoke, limit, or restrict certification consistent with the provisions of RCW 71.24.035 (7) through (11) and of 43.20A.205. The mental health division sends a written decision to revoke, suspend, or modify the former certification, with the reasons for the decision and informing the regional support network of its right to an administrative hearing.

(4) The mental health division may suspend or revoke the certification of a regional support network immediately if the mental health division determines that deficiencies imminently jeopardize the health and safety of consumers.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0210, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0215 Consumer eligibility and payment for services. (1) Within available resources as defined in RCW 71.24.025(2), the regional support network must serve consumers in the following order of priority as defined in RCW 71.24.035 (5)(b):

(a) Acutely mentally ill persons;

(b) Chronically mentally ill adults and severely emotionally disturbed children;

(c) Seriously disturbed persons.

(2) Consumers eligible for the Title XIX Medicaid program are entitled to receive covered medically necessary services from a mental health prepaid health plan without charge to the consumer;

(3) The consumer or the parent(s) of a child who has not reached their eighteenth birthday, the legal guardian, or the estate of the consumer is responsible for payment for services provided. The consumer may apply to the following entities for payment assistance:

(a) DSHS for medical assistance;

(b) The community support provider for payment responsibility based on a sliding fee scale; or

(c) The regional support network for authorization of payment for involuntary evaluation and treatment services for consumers who would experience a substantial hardship as defined in WAC 388-865-0150.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0215, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0220 Standards for administration. The regional support network must demonstrate that it meets the requirements of chapter 71.05, 71.24, and 71.34 RCW, and ensures the effectiveness and cost effectiveness of community mental health services in an age and culturally competent manner. The regional support network must:

(1) Establish a governing board that includes, where applicable, representation from tribal authorities, consistent with RCW 71.24.300;

(2) For multi-county regional support networks, function as described in the regional support network joint operating agreement;

(3) Ensure the protection of consumer and family rights as described in this chapter, and chapter 71.05 and 71.34 RCW; and other applicable statutes for consumers involved in multiservice systems;

(4) Collaborate with and make reasonable efforts to obtain and use resources in the community to maximize services to consumers;

(5) Educate the community regarding mental illness to diminish stigma;

(6) Maintain agreement(s) with sufficient numbers of certified involuntary inpatient evaluation and treatment facilities to ensure that persons eligible for regional support network services have access to inpatient care;

(7) Develop publicized forums in which to seek and include input about service needs and priorities from community stakeholders, including:

(a) Consumers;

(b) Family members and consumer advocates;

(c) Culturally diverse communities including consumers who have limited English proficiency;

(d) Service providers;

(e) Social service agencies;

(f) Organizations representing persons with a disability;

(g) Tribal authorities; and

(h) Underserved groups.

(8) Maintain job descriptions for regional support staff with qualifications for each position with the education, experience, or skills relevant to job requirements; and

(9) Provide orientation and ongoing training to regional support network staff in the skills pertinent to the position and the treatment population, including age and culturally competent consultation with consumers, families, and community members.

(10) Identify trends and address service gaps;

(11) The regional support network must provide an updated two-year plan biennially to the mental health division for approval consistent with the provisions of RCW 71.24.300(1). The biennial plan must be submitted to the regional support network governing board for approval and to the advisory board for review and comment.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0220, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0221 Public awareness of mental health services. The regional support network or its designee must provide public information on the availability of mental health services. The regional support network must:

(1) Maintain listings of services in telephone directories and other public places such as libraries, community services offices, juvenile justice facilities, of the service area. The regional support network or its designee must 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 consistent with WAC 388-865-0250, and local advocacy organizations that may assist consumers in understanding their rights.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0221, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0222 Advisory board. The regional support network must promote active engagement with persons with mental disorders, their families and services providers by soliciting and using their input to improve its services. The regional support network must appoint an advisory board that:

(1) Is broadly representative of the demographic character of the region and the ethnicity and broader cultural aspects of consumers served;

(2) Is composed of at least fifty-one percent:

(a) Current consumers or past consumers of public mental health services, including those who are youths, older adults, or who have a disability; and

(b) Family, foster family members, or care givers of consumers, including parents of emotionally disturbed children.

(3) Independently reviews and provides comments to the regional support network governing board on plans, budgets, and policies developed by the regional support network to implement the requirements of this section, chapter 71.05, 71.24, 71.34 RCW and applicable federal law and regulations.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0222, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0225 Resource management. The regional support network must establish mechanisms which maximize access to and use of age and culturally competent mental health services, and ensure eligible consumers receive appropriate levels of care. The regional support network must:

(1) Authorize admission, transfers and discharges for eligible consumers into and out of the following services:

(a) Community support services;

(b) Residential services; and

(c) Inpatient evaluation and treatment services.

(2) Ensure that services are provided according to the consumer's individualized service plan;

(3) Not require preauthorization of emergency services and transportation for emergency services that are required by an eligible consumer;

(4) Identify in the agreement with the mental health division any of these duties it has delegated to a subcontractor.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0225, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0229 Inpatient services. The regional support network must develop and implement age and culturally competent services that are consistent with chapter 71.24, 71.05, and 71.34 RCW. The regional support network must:

(1) For voluntary inpatient services: Develop and implement formal agreements with inpatient services funded by the regional support network regarding:

(a) Referrals;

(b) Admissions; and

(c) Discharges.

(2) For involuntary evaluation and treatment services:

(a) Maintain agreements with sufficient numbers of certified involuntary evaluation and treatment facilities to ensure that consumers eligible for regional support network services have access to involuntary inpatient care. The agreements must address regional support network responsibility for discharge planning;

(b) Determine which service providers on whose behalf the regional support network will apply on behalf of for certification by the mental health division;

(c) Ensure that all service providers or its subcontractors that provide evaluation and treatment services are currently certified by the mental health division and licensed by the department of health;

(d) Ensure periodic reviews of the evaluation and treatment service facilities consistent with regional support network procedures and notify the appropriate authorities if it believes that a facility is not in compliance with applicable statutes, rules and regulations.

(3) Authorize admissions, transfers and discharges into and out of inpatient evaluation and treatment services for eligible consumers including:

(a) State psychiatric hospitals:

(i) Western state hospital;

(ii) Eastern state hospital;

(iii) Child study and treatment center.

(b) Community hospitals;

(c) Residential inpatient evaluation and treatment facilities licensed by the department of health as adult residential rehabilitation centers; and

(d) Children's long-term inpatient program.

(4) Receive prior approval from the mental health division in the form of a single bed certification for services to be provided to consumers on a ninety- or one hundred eighty-day community inpatient involuntary commitment order consistent with the exception criteria in WAC 388-865-0502; and

(5) Identify in the agreement with the mental health division any of these duties is has delegated to a subcontractor.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0229, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0230 Community support services. The regional support network must develop and coordinate age and culturally competent community support services that are consistent with chapter 71.24, 71.05, and 71.34 RCW:

(1) Provide the following services directly, or contract with sufficient numbers and variety of licensed and/or certified service providers to ensure that persons eligible for regional support network services have access to at least the following services:

(a) Emergency crisis intervention services;

(b) Case management services;

(c) Psychiatric treatment including medication supervision;

(d) Counseling and psychotherapy services;

(e) Day treatment services as defined in RCW 71.24.300(5) and 71.24.035(7); and

(f) Consumer employment services as defined in RCW 71.24.035 (5)(e).

(2) Conduct prescreening determinations for providing community support services for persons with mental illness who are being considered for placement in nursing homes (RCW 71.24.025(7) and 71.24.025(9)); and

(3) Complete screening for persons with mental illness who are being considered for admission to residential services funded by the regional support network (RCW 71.24.025 and 71.24.025(9)).

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0230, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0235 Residential and housing services. The regional support network must ensure:

(1) Active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.

(2) Provision of services to families of eligible children and to eligible consumers who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination or linkage of services with shelter and housing.

(3) The availability of community support services, with an emphasis supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in RCW 71.24.025 (7) and (14); and chapter 71.24.025(14) RCW.

(4) That eligible consumers in residential facilities receive mental health services consistent with their individual service plan, and are advised of their rights, including long-term care rights (chapter 70.129 RCW).

(5) If supervised residential services are needed they are provided only in licensed facilities:

(a) An adult family home that is licensed under chapter 388-76 WAC.

(b) A boarding home facility that is licensed under chapter 388-78A WAC.

(c) An adult residential rehabilitative center facility that is licensed under chapter 246-325 WAC.

(6) The active search of comprehensive resources to meet the housing needs of consumers.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0235, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0240 Consumer employment services. The regional support network must coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services consistent with WAC 388-865-0464.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0240, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0245 Administration of the Involuntary Treatment Act. The regional support network must establish policies and procedures for administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapter 71.05 and 71.34 RCW. This includes:

(1) Designating mental health professionals to perform the duties of involuntary investigation and detention in accordance with the requirements of chapter 71.05 and 71.34 RCW.

(2) Documenting consumer compliance with the conditions of less restrictive alternative court orders by:

(a) Ensuring periodic evaluation of each committed consumer for release from or continuation of an involuntary treatment order. Evaluations must be recorded in the clinical record, and must occur at least monthly for ninety and one hundred eighty-day commitments.

(b) Notifying the county designated mental health professional if noncompliance with the less restrictive order impairs the individual sufficiently to warrant detention or

evaluation for detention and petitioning for revocation of the less restrictive alternative court order.

(3) Ensuring that when a peace officer or county designated mental health professional escorts a consumer to a facility, the county designated mental health professional must take reasonable precautions to safeguard the consumer's property including:

(a) Safeguarding the consumer's property in the immediate vicinity of the point of apprehension;

(b) Safeguarding belongings not in the immediate vicinity if there may be possible danger to those belongings;

(c) Taking reasonable precautions to lock and otherwise secure the consumer's home or other property as soon as possible after the consumer's initial detention.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0245, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0250 Ombuds services. The regional support network must provide unencumbered access to and maintain the independence of the ombuds service as set forth in this section and in the agreement between mental health division and the regional support network. The mental health division and the regional support network must include representatives of consumer and family advocate organizations when revising the terms of the agreement regarding the requirements of this section. Ombuds members must be current consumers of the mental health system, past consumers or family members. The regional support network must maintain an ombuds service that:

(1) Is responsive to the age and demographic character of the region and assists and advocates for consumers with resolving complaints and grievances at the lowest possible level;

(2) Is independent of service providers;

(3) Receives and investigates consumer, family member, and other interested party complaints and grievances;

(4) Is accessible to consumers, including a toll-free, independent phone line for access;

(5) Is able to access service sites and records relating to the consumer with appropriate releases so that it can reach out to consumers, and resolve complaints and/or grievances;

(6) Receives training and adheres to confidentiality consistent with this chapter and chapter 71.05, 71.24, and 70.02 RCW;

(7) Continues to be available to investigate, advocate and assist the consumer through the grievance and administrative hearing processes;

(8) Involves other persons, at the consumer's request;

(9) Assists consumers in the pursuit of formal resolution of complaints;

(10) If necessary, continues to assist the consumer through the fair hearing processes;

(11) Coordinates and collaborates with allied systems' advocacy and ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared clients;

(12) Provides information on grievance experience to the regional support network and mental health division quality management process; and

(13) Provides reports and formalized recommendations at least biennially to the mental health division and regional support network advisory and governing boards, quality review team, local consumer and family advocacy groups, and provider network.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0250, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0255 Consumer grievance process. The regional support network must develop a process for reviewing consumer complaints and grievances. A complaint is defined as a verbal statement of dissatisfaction with some aspect of mental health services. A grievance is a written request that a complaint be heard and adjudicated, usually undertaken after attempted resolution of a complaint fails. The process must be submitted to the mental health division for written approval and incorporation into the agreement between the regional support network and the mental health division. The process must:

(1) Be age, culturally and linguistically competent;

(2) Ensure acknowledgment of receipt of the grievance the following working day. This acknowledgment may be by telephone, with written acknowledgment mailed within five working days;

(3) Ensure that grievances are investigated and resolved within thirty days. This timeframe can be extended by mutual written agreement, not to exceed ninety days;

(4) Be published and made available to all current or potential users of publicly funded mental health services and advocates in language that is clear and understandable to the individual;

(5) Encourage resolution of complaints at the lowest level possible;

(6) Include a formal process for dispute resolution;

(7) Include referral of the consumer to the ombuds service for assistance at all levels of the grievance and fair hearing processes;

(8) Allow the participation of other people, at the grievant's choice;

(9) Ensure that the consumer is mailed a written response within thirty days from the date a written grievance is received by the regional support network;

(10) Ensure that grievances are resolved even if the consumer is no longer receiving services;

(11) Continue to provide mental health services to the grievant during the grievance and fair hearing process;

(12) Ensure that full records of all grievances are kept for five years after the completion of the grievance process in confidential files separate from the grievant's clinical record. These records must not be disclosed without the consumer's written permission, except as necessary to resolve the grievance or to DSHS if a fair hearing is requested;

(13) Provide for follow-up by the regional support network to assure that there is no retaliation against consumers who have filed a grievance;

(14) Make information about grievances available to the regional support network;

(15) Inform consumers of their right to file an administrative hearing with DSHS without first accessing the con-

tractor's grievance process. Consumers must utilize the regional support network grievance process prior to requesting disenrollment;

(16) Inform consumers of their right to use the DSHS prehearing and administrative hearing processes as described in chapter 388-02 WAC. Consumers have this right when:

(a) The consumer believes there has been a violation of DSHS rule;

(b) The regional support network did not provide a written response within thirty days from the date a written request was received;

(c) The regional support network, mental health prepaid health plan, the department of social and health services, or a provider denies services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0255, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0260 Mental health professionals and specialists. The regional support network must assure sufficient numbers of mental health professionals and specialists are available in the service area to meet the needs of eligible consumers. The regional support network must:

(1) Document efforts to acquire the services of the required mental health professionals and specialists;

(2) Ensure development of 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;

(3) If more than five hundred persons in the total population in the regional support network geographic area report in the U.S. census that they belong to racial/ethnic groups as defined in WAC 388-865-0150, the regional support network must contract or otherwise establish a working relationship with the required specialists to:

(a) Provide all or part of the treatment services for these populations; or

(b) Supervise or provide consultation to staff members providing treatment services to these populations.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0260, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0265 Mental health professional—Exception. The regional support network may request an exception of the requirements of a mental health professional for a person with less than a masters degree level of training. The mental health division may grant an exception of the minimum requirements on a time-limited basis and only with a demonstrated need for an exception under the following conditions:

(1) The regional support network has made a written request for an exception including:

(a) Demonstration of the need for an exception;

(b) The name of the person for whom an exception is being requested;

(c) The functions which the person will be performing;

(d) A statement from the regional support network that the person is qualified to perform the required functions based on verification of required education and training, including:

(i) Bachelor of Arts or Sciences degree from an accredited college or university;

(ii) Course work or training in making diagnoses, assessments, and developing treatment plans; and

(iii) Documentation of at least five years of direct treatment of persons with mental illness under the supervision of a mental health professional.

(2) The regional support network assures that periodic supervisory evaluations of the individual's job performance are conducted;

(3) The regional support network submits a plan of action to assure the individual will become qualified no later than two years from the date of exception. The regional support network may apply for renewal of the exception. The exception may not be transferred to another regional support network or to use for an individual other than the one named in the exception;

(4) If compliance with this rule causes a disproportionate economic impact on a small business as defined in the Regulatory Fairness Act, chapter 19.85 RCW, and the business does not contract with a regional support network, the small business may request the exception directly from the mental health division.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0265, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0270 Financial management. The regional support network must be able to demonstrate that it ensures the effectiveness and cost effectiveness of community mental health services. The regional support network must:

(1) Spend funds received by the mental health division in accordance with its contract and to meet the requirements of chapter 71.05, 71.24, 71.34 RCW, and the State Appropriations Act;

(2) Use accounting procedures that are consistent with applicable state and federal requirements and generally accepted accounting principles (GAAP), with the following additional requirements:

(a) Include as assets 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 must be accounted for and kept for use by the regional support network.

(c) Property, equipment, vehicles, and buildings must be properly inventoried with a physical inventory conducted at least every two years.

(d) Proceeds from the disposal of any assets must be retained by the regional support network for purposes of subsection (1) of this section.

(3) Comply with the 1974 county maintenance of effort requirement for administration of the Involuntary Treatment Act (chapter 71.05 RCW) and 1990 county maintenance of effort requirement for community programs for adults consistent with RCW 71.24.160, and in the case of children, no state funds shall replace local funds from any source used to

finance administrative costs for involuntary commitment procedures conducted prior to January 1, 1985 (chapter 71.34 RCW);

(4) Maintain accounting procedures to ensure that accrued interest and excess reserve balances are returned to the regional support network for use in the public mental health system.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0270, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0275 Management information system. The regional support network must be able to demonstrate that it collects and manages information that shows the effectiveness and cost effectiveness of mental health services. The regional support network must:

(1) Operate an information system and ensure that information about consumers who receive publicly funded mental health services is reported to the state mental health information system according to mental health division guidelines.

(2) Ensure that the information reported is:

(a) Sufficient to produce accurate regional support network reports; and

(b) Adequate to locate case managers in the event that a consumer requires treatment by a service provider that would not normally have access to treatment information about the consumer.

(3) Ensure that information about consumers is shared or released between service providers only in compliance with state statutes (see chapter 70.02, 71.05, and 71.34 RCW) and this chapter. Information about consumers and their individualized crisis plans must be available:

(a) Twenty-four hours a day, seven days a week to county-designated mental health professionals and inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(b) To the state and regional support network staff as required for management information and program review.

(4) Maintain on file a statement signed by regional support network, county or service provider staff having access to the mental health information systems acknowledging that they understand the rules on confidentiality and will follow the rules.

(5) Take appropriate action if a subcontractor or regional support network employee willfully releases confidential information, as required by chapter 71.05 RCW.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0275, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0280 Quality management process. The regional support network must implement a process for continuous quality improvement in the delivery of culturally competent mental health services. The regional support network must submit a quality management plan as part of the written biennial plan to the mental health division for approval. All changes to the quality management plan must be submitted to the mental health division for approval prior to implementation. The plan must include:

(1) Roles, structures, functions and interrelationships of all the elements of the quality management process, including but not limited to the regional support network governing board, clinical and management staff, advisory board, ombuds service, and quality review teams.

(2) Procedures to ensure that quality management activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to:

(a) Collect, analyze and display information regarding:

(i) The capacity to manage resources and services, including financial and cost information and compliance with statutes, regulations and agreements;

(ii) System performance indicators;

(iii) Quality and intensity of services;

(iv) Incorporation of feedback from consumers, allied service systems, community providers, ombuds and quality review team;

(v) Clinical care and service utilization including consumer outcome measures; and

(vi) Recommendations and strategies for system and clinical care improvements, including information from exit interviews of consumers and practitioners.

(b) Monitor management information system data integrity;

(c) Monitor complaints, grievances and adverse incidents for adults and children;

(d) Monitor contracts with contractors and to notify the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements;

(e) Immediately investigate and report allegations of fraud and abuse of the contractor or subcontractor to the mental health division;

(f) Monitor delegated administrative activities;

(g) Identify necessary improvements;

(h) Interpret and communicate practice guidelines to practitioners;

(i) Implement change;

(j) Evaluate and report results;

(k) Demonstrate use of all corrective actions to improve the system;

(l) Consider system improvements based on recommendations from all on-site monitoring, evaluation and accreditation/certification reviews;

(m) Review update, and make the plan available to community stakeholders.

(3) Targeted improvement activities, including:

(a) Performance measures that are objective, measurable, and based on current knowledge/best practice including at least those defined by the mental health division in the agreement with the regional support network;

(b) An analysis of consumer care covering a representative sample of at least ten percent of consumers or five hundred consumers, whichever is smaller;

(c) Efficient use of human resources; and

(d) Efficient business practices.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0280, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0282 Quality review teams. The regional support network must establish and maintain unencumbered access to and maintain the independence of a quality review team as set forth in this section and in the agreement between mental health division and the regional support network. The quality review team must include current consumers of the mental health system, past consumers or family members. The regional support network must assure that quality review teams:

(1) Fairly and independently review the performance of the regional support network and service providers to evaluate systemic customer service issues as measured by objective indicators of consumer outcomes in rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, including:

(a) Quality of care;

(b) The degree to which services are consumer-focused/directed and are age and culturally competent;

(c) The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and

(d) The adequacy of the regional support network's cross system linkages including, but not limited to schools, state and local hospitals, jails and shelters.

(2) Have the authority to enter and monitor any agency providing services for area regional support network consumers, including state and community hospitals, freestanding evaluation and treatment facilities, and community support service providers;

(3) Meet with interested consumers and family members, allied service providers, including state or community psychiatric hospitals, regional support network contracted service providers, and persons that represent the age and ethnic diversity of the regional support network to:

(a) Determine if services are accessible and address the needs of consumers based on sampled individual recipient's perception of services using a standard interview protocol developed by the mental health division. The protocol will query the sampled individuals regarding ease of accessing services, the degree to which services address medically necessary needs (acceptability), and the benefit of the service received; and

(b) Work with interested consumers, service providers, the regional support network, and DSHS to resolve identified problems.

(4) Provide reports and formalized recommendations at least biennially to the mental health division, the mental health advisory committee and the regional support network advisory and governing boards and ensure that input from the quality review team is integrated into the overall regional support network quality management process, ombuds services, local consumer and family advocacy groups, and provider network; and

(5) Receive training and adhere to confidentiality standards.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0282, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0284 Standards for contractors and subcontractors. The regional support network must not subcontract for clinical services to be provided using state funds unless the subcontractor is licensed and/or certified by the mental health division for those services or is personally licensed by the department of health as defined in chapter 48.43, 18.57, 18.71, 18.83, or 18.79 RCW. The regional support network must:

(1) Require and maintain documentation that contractors and subcontractors are licensed, certified, or registered in accordance with state or federal laws;

(2) Follow applicable requirements of the regional support network agreement with the mental health division;

(3) Demonstrate that it monitors contracts with contractors and notifies the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements; and

(4) Terminate its contract with a provider if the mental health division notifies the regional support network of a provider's failure to attain or maintain licensure or certification, if applicable.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0284, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0286 Coordination with a mental health prepaid health plan. If the regional support network is not also a mental health prepaid health plan, the regional support network must ensure continuity of services between itself and the mental health prepaid health plan by maintaining a working agreement about coordination for at least the following services:

(1) Community support services;

(2) Inpatient evaluation and treatment services;

(3) Residential services;

(4) Transportation services;

(5) Consumer employment services;

(6) Administration of involuntary treatment investigation and detention services; and

(7) Immediate crisis response after presidential declaration of a disaster.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0286, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0288 Regional support networks as a service provider. A regional support network may operate as a community support service provider under the following circumstances:

(1) Meeting the criteria specified in RCW 71.24.037 and 71.24.045;

(2) Maintaining a current license as a community support service provider from the mental health division.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0288, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0300 Mental health prepaid health plans. A mental health prepaid health plan is an entity that contracts with the mental health division to administer mental

health services for people who are eligible for the Title XIX Medicaid program. The mental health prepaid health plan must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To be eligible for a contract as a mental health prepaid health plan, the entity must:

(1) Provide documentation of a population base of forty-one thousand six hundred Medicaid eligible persons (covered lives) within the service area or receive approval from the mental health division based on submittal of an actuarially sound risk management profile;

(2) Maintain certification as a regional support network or licensure by the Washington state office of the insurance commissioner as a health care service contractor under chapter 48.44 RCW.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0300, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0305 Regional support network contracting as a mental health prepaid health plan. A regional support network contracting with the mental health division as a mental health prepaid health plan must comply with all requirements for a regional support network and the additional requirements for a prepaid health plan.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0305, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0310 Mental health prepaid health plans—Minimum standards. To be eligible for a contract, a mental health prepaid health plan must comply with all applicable federal, state, and local statutes and regulations and meet all of the minimum standards of WAC 388-865-300 through 388-865-355. The mental health prepaid health plan must:

(1) Provide medically necessary mental health services that are age and culturally competent for all Medicaid recipients in the service area within a capitated rate;

(2) Provide outreach to consumers, including homeless persons and families as defined in Public Law 100-77, and home-bound individuals;

(3) Demonstrate working partnerships with tribal authorities for the delivery of services that blend with tribal values, beliefs and culture;

(4) Develop and maintain written subcontracts that clearly recognize that legal responsibility for administration of the service delivery system remains with the mental health prepaid health plan, as identified in the agreement with the mental health division;

(5) Retain responsibility to ensure that applicable standards of state and federal statute and regulations and this chapter are met even when it delegates duties to subcontractors;

(6) Ensure the protection of consumer and family rights as described in chapter 71.05 and 71.34 RCW;

(7) Ensure compliance with the following standards:

(a) WAC 388-865-0220, Standards for administration;

(b) WAC 388-865-0225, Resource management program;

(c) WAC 388-865-0229, Inpatient services and treatment services;

(d) WAC 388-865-0230, Community support services;

(e) WAC 388-865-0250, Ombuds services;

(f) WAC 388-865-0255, Consumer grievance process;

(g) WAC 388-865-0260, Mental health professionals or specialists;

(h) WAC 388-865-0265, Mental health professional—Exception;

(i) WAC 388-865-0270, Financial management;

(j) WAC 388-865-0275, Management information system;

(k) WAC 388-865-0280, Quality management process;

(l) WAC 388-865-0282, Quality review teams; and

(m) WAC 388-865-0284, Standards for contractors and subcontractors.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0310, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0315 Governing body. The mental health prepaid health plan must establish a governing body responsible for oversight of the mental health prepaid health plan. The governing body must:

(1) Be free from conflict of interest and all appearance of conflict of interest between personal, professional and fiduciary interests of a governing body member and the best interests of the prepaid health plan and the consumers it serves.

(2) Have rules about:

(a) When a conflict of interest becomes evident;

(b) Not voting or joining a discussion when a conflict of interest is present; and

(c) When the body scan assign the matter to others, such as staff or advisory bodies.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0315, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0320 Utilization management. Utilization management is the way the mental health prepaid health plan authorizes or denies mental health services, monitors services, and follows the level of care guidelines. To demonstrate the impact on enrollee access to care of adequate quality, a mental health prepaid health plan must provide utilization management of the community mental health rehabilitation services (42 C.F.R. 440) that is independent of service providers. This process must:

(1) Provide effective and efficient management of resources;

(2) Assure capacity sufficient to deliver appropriate quality and intensity of services to enrolled consumers without a wait list consistent with the agreement with the mental health division;

(3) Plan, coordinate, and authorize community support services;

(4) Ensure that services are provided according to the individual service plan;

(5) Ensure assessment and monitoring processes are in place by which service delivery capacity responds to changing needs of the community and enrolled consumers;

(6) Develop, implement, and enforce written level of care guidelines for admission, placements, transfers and discharges into and out of services. The guidelines must address:

(a) A clear process for the mental health prepaid health plan's role in the decision-making process about admission and continuing stay at various levels is available in language that is clearly understood by all parties involved in an individual consumer's care, including laypersons;

(b) Criteria for admission into various levels of care, including community support, inpatient and residential services that are clear and concrete;

(c) Methods to ensure that services are individualized to meet the needs for all Medicaid consumers served, including consumers of different ages, cultures, languages, civil commitment status, physical abilities, and unique service needs; and

(d) To the extent authorization of care at any level of care or at continuing stay determinations is delegated, the mental health prepaid health plan retains a sufficiently strong and regular oversight role to assure those decisions are being made appropriately.

(7) Collect data that measures the effectiveness of the criteria in ensuring that all eligible people get services that are appropriate to his/her needs;

(8) Report to the mental health division any knowledge it gains that the mental health prepaid health plan or service provider is not in compliance with all state and federal laws and regulations.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0320, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0325 Risk management. The mental health prepaid health plan must:

(1) Assume the financial risk of providing community mental health outpatient rehabilitation services, community hospital services and operation of a capitated mental health managed care system for the Medicaid eligible persons in the service area;

(2) Maintain a risk reserve of annual premium payments as defined by chapter 48.44 RCW or the actuarial analysis submitted with the formal request for waiver for mental health approved by the Health Care Financing Administration. All other mental health reserves and undesignated fund balances shall be limited to no more than ten percent of annual revenues supporting the prepaid health plan's mental health program;

(3) Demonstrate solvency and manage all fiscal matters within the managed care system, including:

(a) Current pro forma;

(b) Financial reports;

(c) Balance sheets;

(d) Revenue and expenditure; and

(e) An analysis of reserve account(s) and fund balance(s) information including a detailed composition of capital, operating, and risk reserves and or fund balances.

(4) Maintain policies for each reserve account and have a process for collecting and disbursing reserves to pay for costs incurred by the mental health prepaid health plan;

(5) Demonstrate capacity to process claims for members of the contracted provider network and any emergency service providers accessed by consumers while out of the mental health prepaid health plan service area within sixty days using methods consistent with generally accepted accounting practices;

(6) Comply with the requirements of section 1128 (b) of the Social Security Act, which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to consumers;

(7) In accordance with the Medicaid section 1915b waiver, the mental health prepaid health plan is required to pay for psychiatric inpatient services in community hospitals either through a direct contract with community hospitals or through an agreement with the department. In the event that the mental health prepaid health plan chooses to use the department as its fiscal agent, the plan agrees to abide by all policies, rules, payment requirements, and levels promulgated by the medical assistance administration. If the plan chooses to direct contract, the plan is responsible for executing contracts for sufficient hospital capacity pursuant to a plan approved by the mental health division.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0325, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0330 Marketing/education of mental health services. The mental health prepaid health plan must demonstrate that it provides information to eligible persons so that they are aware of available mental health services and how to access them. The mental health prepaid health plan must:

(1) Develop and submit marketing/education plan(s) and procedures to the mental health division within the timeframes in the agreement with the mental health division for approval prior to issuance. The plan shall, at a minimum, include information on the following:

(a) Consumer rights and responsibilities;

(b) The service recipient's right to disenroll;

(c) Cross-system linkages;

(d) Access to mental health services for diverse populations, including other languages than English;

(e) Use of media;

(f) Stigma reduction;

(g) Subcontractor participation/involvement;

(h) Plan for evaluation of marketing strategy;

(i) Procedures and materials, and any revisions thereof; and

(j) Maintain listings of mental health services with toll-free numbers in the telephone and other public directories of the service area.

(2) Describe services and hours of operations through brochures and other materials and other methods of advertising;

(3) Assure that the materials and methods are effective in reaching people who may be visually impaired, have limited

comprehension of written or spoken English, or who are unable to read. At a minimum, all written materials generally available to service recipients shall be translated to the most commonly used languages in the service area;

(4) Post and otherwise make information available to consumers about ombuds services and local advocacy organizations that may assist consumers in understanding their rights;

(5) Ensure distribution of written educational material(s) to consumers, allied systems and local community resources including:

(a) Annual brochure(s) containing educational material on major mental illnesses and the range of options for treatment, supports available in the system, including medication and formal psychotherapies, as well as alternative approaches that may be appropriate to age, culture and preference of the service recipient;

(b) Information regarding the scope of available benefits (e.g., inpatient, outpatient, residential, employment, community support);

(c) Service locations, crisis response services; and

(d) Service recipients' responsibilities with respect to out-of-area emergency services; unauthorized care; noncovered services; complaint process, grievance procedures; and other information necessary to assist in gaining access.

(6) Ensure marketing plans, procedures and materials are accurate and do not mislead, confuse or defraud the service recipient.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0330, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0335 Consumer enrollment. (1) DSHS enrolls a Medicaid recipient in a mental health prepaid health plan when the person resides in the contracted service area;

(2) An enrolled Medicaid consumer who requests or receives medically necessary nonemergency community mental health rehabilitation services requests and receives such service from the assigned mental health prepaid health plan through authorized providers only;

(3) An enrolled Medicaid consumer does not need to request disenrollment from the mental health division when the recipient moves from one mental health prepaid health plan to another.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0335, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0340 Consumer disenrollment. (1) The mental health division must disenroll a Medicaid consumer from his/her mental health prepaid health plan only when the consumer:

(a) Loses eligibility for Title XIX Medicaid services; or

(b) Is deceased.

(2) On a case-by-case basis, the mental health division will disenroll a consumer from his/her mental health prepaid health plan when the consumer has "good cause" for disenrollment. For the purposes of this chapter, "good cause" is defined as the inability of the mental health prepaid health plan to provide medically necessary care that is reasonably available and accessible. A consumer will not be disenrolled in a mental health prepaid health plan solely due to an adverse change in the consumer's health. In determining whether the mental health prepaid health plan provides medically necessary care that is reasonably available and accessible the mental health division may consider, but is not limited to considering:

(a) The medically necessary services needed by the consumer;

(b) Whether services are or should be available to other consumers in the mental health prepaid health plan;

(c) Attempts the consumer has made to access services in his/her assigned mental health prepaid health plan;

(d) Efforts by the assigned mental health prepaid health plan to provide the medically necessary services needed by the consumer.

(3) A consumer wishing to disenroll from his/her assigned mental health prepaid health plan must utilize the local mental health prepaid health plan grievance process prior to requesting disenrollment from the mental health division;

(4) A consumer requesting disenrollment must make a request in writing to the mental health division fair hearing coordinator. The request must include:

(a) The consumer's name, address, phone number (or number where the consumer can receive a message), and the name of the consumer's current mental health prepaid health plan;

(b) A statement outlining the reasons why the consumer believes his/her current mental health prepaid health plan does not provide medically necessary care that is reasonably available and accessible.

(5) The mental health division will make a decision within forty-five days of the request for disenrollment or within time frames prescribed by the federal Health Care Financing Administration, whichever is shorter. The mental health division will screen the request to determine if there is sufficient information upon which to base a decision;

(6) The mental health division will notify the consumer within fifteen days of receipt of the request whether or not the request contains sufficient information. If there is not sufficient information to allow the mental health division to make a decision, additional information will be requested from the consumer. The consumer will have fifteen days to provide requested information. Failure to provide additional requested information will result in denial of the disenrollment request;

(7) The mental health division will send written notice of the decision to the consumer:

(a) If a decision to disenroll is made, the mental health division will notify the consumer ten days in advance of the effective date of the proposed disenrollment, including arrangements for continued mental health services;

(b) If the consumer's request to disenroll is denied, the notice will include the consumer's right to request a fair hearing, how to request a fair hearing, and how the consumer may access ombuds services in his/her area.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0340, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0345 Choice of primary care provider. The mental health prepaid health plan must ensure that each consumer who is receiving nonemergency community mental health rehabilitation services has a primary care provider who is responsible to carry out the individualized service plan. The mental health prepaid health plan must allow consumers, parents of consumers under the age of thirteen, and guardians of consumers of all ages to select a primary care provider from the available primary care provider staff within the mental health prepaid health plan.

(1) For an enrolled client with an assigned case manager, the case manager is the primary care provider;

(2) If the consumer does not make a choice, the mental health prepaid health plan or its designee must assign a primary care provider no later than fifteen working days after the consumer requests services;

(3) The mental health prepaid health plan or its designee must allow a consumer to change primary care providers in the first ninety days of enrollment with the mental health prepaid health plan and once during a twelve-month period for any reason;

(4) Any additional change of primary care provider during the twelve-month period may be made with documented justification at the consumer's request by:

(a) Notifying the mental health prepaid health plan (or its designee) of his/her request for a change, and the name of the new primary care provider; and

(b) Identifying the reason for the desired change.

(5) A consumer whose request to change primary care providers is denied may submit a grievance with the plan, or request an administrative hearing.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0345, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0350 Mental health screening for children. The mental health prepaid health plan is responsible for conducting mental health screening and treatment for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program. This includes:

(1) Providing resource management services for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program as specified in contract with the mental health division;

(2) Developing and maintaining an oversight committee for the coordination of the early and periodic screening, diagnosis and treatment program. The oversight committee must include representation from parents of Medicaid-eligible children.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0350, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0355 Consumer request for a second opinion. An enrolled consumer in a mental health prepaid health plan must have the right to a second opinion by another participating staff in the enrolled consumer's assigned mental health prepaid health plan:

(1) When the enrolled consumer needs more information about the medical necessity of the treatment recommended by the mental health prepaid health plan; or

(2) If the enrolled consumer believes the mental health prepaid health plan primary care provider is not authorizing medically necessary community mental health rehabilitation services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0355, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0360 Monitoring of mental health prepaid health plans. The mental health division will conduct an annual on-site medical audit and an administrative audit at least every two years for purposes of assessing the quality of care and conformance with the minimum standards of this section and the Title XIX Medicaid 1915(b) mental health waiver requirements. The monitoring will include a review of:

(1) The mental health prepaid health plan's conformance to monitoring its service provider network in accordance with the quality management plan approved by the mental health division that includes processes established under the Medicaid waiver for mental health services;

(2) Any direct services provided by the mental health prepaid health plan;

(3) Other provisions within the code of federal regulations for managed care entities, which may include access, quality of care, marketing, record keeping, utilization management and disenrollment functions.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0360, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0363 Coordination with the regional support network. If the mental health prepaid health plan is not also a regional support network, the mental health prepaid health plan must ensure continuity of services between itself and the regional support network by maintaining a working agreement about coordination for at least the following services:

(1) Residential services;

(2) Transportation services;

(3) Consumer employment services;

(4) Administration of involuntary treatment investigation and detention services; and

(5) Immediate crisis response after presidential declaration of a disaster.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0363, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0365 Suspension, revocation, limitation or restriction of a contract. The mental health division may suspend, revoke, limit or restrict a mental health prepaid health plan contract or refuse to grant a contract for failure to conform to applicable state and federal rules and regulations or for violation of health or safety considerations.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0365, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0400 Community support service providers. The mental health division licenses and certifies community support service providers. To gain and maintain licensure or certification, a provider must meet applicable local, state and federal statutes and regulations as well as the requirements of WAC 388-865-400 through 388-865-450 as applicable to services offered. The license or certificate lists service components the provider is authorized to provide to publicly funded consumers and must be prominently posted in the provider reception area. In addition, the provider must meet minimum standards of the specific service components for which licensure is being sought:

(1) Emergency crisis intervention services;

(2) Case management services;

(3) Psychiatric treatment, including medication supervision;

(4) Counseling and psychotherapy services;

(5) Day treatment services; and/or

(6) Consumer employment services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0400, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0405 Competency requirements for staff. The licensed service provider must ensure that staff are qualified for the position they hold and have the education, experience, or skills to perform the job requirements. The provider must maintain documentation that:

(1) All staff have a current Washington state department of health license or certificate or registration as may be required for their position;

(2) Washington state patrol background checks are conducted for employees in contact with consumers consistent with RCW 43.43.830;

(3) Mental health services are provided by a mental health professional, or under the clinical supervision of a mental health professional;

(4) Staff performing mental health services (not including crisis telephone) must have access to consultation with a psychiatrist or a physician with at least one year's experience in the direct treatment of persons who have a mental or emotional disorder;

(5) Mental health services to children, older adults, ethnic minorities or persons with disabilities must be provided by, under the supervision of, or with consultation from the appropriate mental health specialist(s) when the consumer:

(a) Is a child as defined in WAC 866-865-0150;

(b) Is or becomes an older person as defined in WAC 388-865-0150;

(c) Is a member of a racial/ethnic group as defined in WAC 866-865-0105 and as reported:

(i) In the consumer's demographic data; or

(ii) By the consumer or others who provide active support to the consumer; or

(iii) Through other means.

(d) Is disabled as defined in WAC 388-865-0150 and as reported:

(i) In the consumer's demographic data; or

(ii) By the consumer or others who provide active support to the consumer; or

(iii) Through other means.

(6) Staff receive regular supervision and an annual performance evaluation; and

(7) An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for his/her job description and the population served.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0405, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0410 Consumer rights. (1) The provider must document that consumers, prospective consumers, or legally responsible others are informed of consumer rights at admission to community support services in a manner that is understandable to the individual. Consumer rights must be written in alternative format for consumers who are blind or deaf, and must also be translated to the most commonly used languages in the service area consistent with WA 388-865-0260(3);

(2) The provider must post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours;

(3) The provider must develop a statement of consumer rights that incorporates the following statement or a variation approved by the mental health division: "You have the right to:

(a) Be treated with respect, dignity and privacy;

(b) Develop a plan of care and services which meets your unique needs;

(c) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;

(d) Refuse any proposed treatment, consistent with the requirements in chapter 71.05 and 71.34 RCW;

(e) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;

(f) Be free of any sexual exploitation or harassment;

(g) Review your clinical record and be given an opportunity to make amendments or corrections;

(h) Receive an explanation of all medications prescribed, including expected effect and possible side effects;

(i) Confidentiality, as described in chapters 70.02, 71.05, and 71.34 RCW and regulations;

(j) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;

(k) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;

(l) Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;

(m) If you are Medicaid eligible, receive all service which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from a provider within the regional support network about what services are medically necessary;

(n) Lodge a complaint with the ombuds, regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The ombuds may, at your request, assist you in filing a grievance. The ombuds' phone number is:_____."

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0410, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0415 Access to services. The community support service provider must document and otherwise ensure that eligible consumers have access to age and culturally competent services when and where those services are needed. The provider must:

(1) Identify and reduce barriers to people getting the services where and when they need them;

(2) Comply with the Americans with Disabilities Act and the Washington State Antidiscrimination Act, chapter 49.60 RCW;

(3) Assure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the consumer;

(4) Provide alternative service delivery models to make services more available to underserved persons as defined in WAC 388-865-0150;

(5) Provide access to telecommunication devices or services and certified interpreters for deaf or hearing impaired consumers and limited English proficient consumers;

(6) Bring services to the consumer or locate services at sites where transportation is available to consumers; and

(7) Ensure compliance with all state and federal nondiscrimination laws, rules and plans.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0415, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0420 Intake evaluation. The community support service provider must complete an intake evaluation in collaboration with the consumer within fourteen days of admission to service. If seeking this information presents a barrier to service, the item may be left incomplete provided that the reasons are documented in the clinical record. The following must be documented in the consumer's intake evaluation:

(1) A consent for treatment or copy of detention or involuntary treatment order;

(2) Consumer strengths, needs and desired outcomes in their own words. At the consumer's request also include the input of people who provide active support to the consumer;

(3) The consumer's age, culture/cultural history, and disability;

(4) History of substance use and abuse or other co-occurring disorders;

(5) Medical and mental health services history and a list of medications used;

(6) For children:

(a) Developmental history; and

(b) Parent's goals and desired outcomes.

(7) Sufficient information to justify the diagnosis;

(8) Review of the intake evaluation by a mental health professional.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0420, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0425 Individual service plan. Community support service providers must provide consumers with an individual service plan that meets his or her unique needs. Individualized and tailored care is a planning process that may be used to develop a consumer-driven, strength-based, individual service plan. The individual service plan must:

(1) Be developed collaboratively with the consumer and other people identified by the consumer within thirty days of starting community support services. The service plan should be in language and terminology that is understandable to consumers and their family, and include goals that are measurable;

(2) Address age, cultural, or disability issues of the consumer;

(3) Include measurable goals for progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, involving other systems when appropriate;

(4) Demonstrate that the provider has worked with the consumer and others at the consumer's request to determine his/her needs in the following life domains:

(a) Housing;

(b) Food;

(c) Income;

(d) Health and dental care;

(e) Transportation;

(f) Work, school or other daily activities;

(g) Social life; and

(h) Referral services and assistance in obtaining supportive services appropriate to treatment, such as substance abuse treatment.

(5) Document review by the person developing the plan and the consumer. If the person developing the plan is not a mental health professional, the plan must also document review by a mental health professional. If the person developing the plan is not a mental health specialist required per WAC 388-865-405(5) there must also be documented consultation with the appropriate mental health specialist(s);

(6) Document review and update at least every one hundred eighty days or more often at the request of the consumer;

(7) In the case of children:

(a) Be integrated with the individual education plan from the education system whenever possible;

(b) If the child is under three, the plan must be integrated with the individualized family service plan (IFSP) if this exists, consistent with Title 20, Section 1436.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0425, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0430 Clinical record. The community support service provider must maintain a clinical record for each consumer and safeguard the record against loss, defacement, tampering, or use by unauthorized persons. The clinical record must contain:

(1) An intake evaluation;

(2) Evidence that the consumer rights statement was provided to the consumer;

(3) A copy of any advance directives, powers of attorney or letters of guardianship provided by the consumer;

(4) The crisis treatment plan when appropriate;

(5) The individualized service plan and all changes in the plan;

(6) Documentation that services are provided by or under the clinical supervision of a mental health professional;

(7) Documentation that services are provided by, or under the clinical supervision, or the clinical consultation of a mental health specialist. Consultation must occur within thirty days of admission and periodically thereafter as specified by the mental health specialist;

(8) Periodic documentation of the course of treatment and objective progress toward established goals for rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices;

(9) A notation of extraordinary events affecting the consumer;

(10) Documentation of mandatory reporting of abuse, neglect, or exploitation of consumers consistent with chapter 26.44 and 74.34 RCW;

(11) Documentation of informed consent to treatment and medications by the consumer or legally responsible other;

(12) Documentation of confidential information that has been released without the consent of the consumer including, but not limited to provisions in RCW 70.02.050, 71.05.390 and 71.05.630.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0430, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0435 Consumer access to their clinical record. The service provider must provide access to clinical records for consumers, their designated representative, and/or the person legally responsible for the consumer, consistent with chapter 71.05, 70.02, and 71.34 RCW and RCW 13.50.400 (4)(b) for children. The provider must:

(1) Make the record available within fifteen days;

(2) Review the clinical record to identify and remove any material confidential to another person, agency, provider or reports not originated by the community support service provider;

(3) Allow the consumer appropriate time and privacy to review the clinical record;

(4) Provide a clinical staff member to answer questions at the request of the consumer; and

(5) Charge for copying at a rate not higher than that defined in RCW 70.02.010(12).

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0435, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0436 Clinical record access procedures. The community support service provider must develop policies and procedures to protect information and to ensure that information about consumers is shared or released only in compliance with state and federal law (see chapter 70.02, 71.05, 71.34, 74.04 RCW and RCW 13.50.100 (4)(b)) and this chapter.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0436, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0440 Availability of consumer information. (1) Consumer individualized crisis plans as provided by the consumer must be available twenty-four hours a day, seven days a week to county-designated mental health professionals, crisis teams, and voluntary and involuntary inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(2) Consumer information must be available to the state and regional support network staff as required for management information, quality management and program review.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0440, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0445 Establishment of procedures to bill for services. Consumers receiving services or the parent(s) of a person under the age of eighteen, the legal guardian, or the estate of the individual is responsible for payment for services received. The provider must establish policies and procedures to:

(1) Bill all third-party payors and private pay consumers. Persons eligible for the Medicaid program are not to be billed for medically necessary covered services.

(2) Develop a written schedule of fees that considers the consumer's available income, family size, allowable deductions and exceptional circumstances:

(a) Payment must not be required from consumers whose income is below TANF standards as defined in WAC 388-478-0020;

(b) The fee schedule must be posted in the agency and available to provider staff, consumers, the regional support network, and the mental health prepaid health plan.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0445, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0450 Quality management process. Community support service providers must ensure continued progress toward more effective and efficient age and culturally competent services and improved consumer satisfaction and outcomes, including objective measures of progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices

by maintaining an internal quality management process. The process must:

(1) Review the services offered and provided to improve the treatment of consumers, including the quality of intake evaluations and the effectiveness of prescribed medications;

(2) Review the work of persons providing mental health services at least annually; and

(3) Continuously collect, maintain, and use information to correct deficiencies and improve services. Such data must include but is not limited to reports of serious and emergent incidents as well as grievances filed by consumers or their representatives.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0450, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0452 Emergency crisis intervention services—Additional standards. The community support service provider that is licensed for emergency crisis intervention services must assure that required general minimum standards for community support services are met, plus the additional minimum requirements:

(1) Availability of staff to respond to crises twenty-four hours a day, seven days a week, including:

(a) Bringing services to the person in crisis when clinically indicated;

(b) Requiring that staff remain with the consumer in crisis to stabilize and support him/her until the crisis is resolved or a referral to another service is accomplished;

(c) Resolving the crisis in the least restrictive manner possible;

(d) A process to include family members, significant others, and other relevant treatment providers as necessary to provide support to the person in crisis; and

(e) Written procedures for managing assaultive and/or self-injurious patient behavior.

(2) Crisis telephone screening;

(3) Mobile outreach and stabilization services with trained staff available to provide in-home or in-community stabilization services, including flexible supports to the person where he/she lives.

(4) Provide access to necessary services including:

(a) Medical services, which means at least emergency services, preliminary screening for organic disorders, prescription services, and medication administration;

(b) Interpretive services to enable staff to communicate with consumers who have limited ability to communicate in English, or have sensory disabilities;

(c) Mental health specialists for children, elderly, ethnic minorities or consumers who are deaf or developmentally disabled;

(d) Voluntary and involuntary inpatient evaluation and treatment services, including a written protocol to assure that consumers who require involuntary inpatient services are transported in a safe and timely manner;

(e) Investigation and detention to involuntary services under chapter 71.05 RCW for adults and chapter 71.34 RCW for children who are thirteen years of age or older, including written protocols for contacting the county designated mental health professional.

(5) Document all telephone and face-to-face crisis response contacts, including:

(a) Source of referral;

(b) Nature of crisis;

(c) Time elapsed from the initial contact to face-to-face response; and

(d) Outcomes, including basis for decision not to respond in person, follow-up contacts made, and referrals made.

(6) The provider must have a written protocol for referring consumers to a voluntary or involuntary inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the county designated mental health professional and transporting consumers.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0452, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0454 Provider of crisis telephone services only. This section applies only to organizations that receive public mental health funds for the purpose of providing crisis telephone services but are not licensed community support providers. In order to be licensed to provide crisis telephone services, the following requirements must be met:

(1) Staff available to respond to crisis calls twenty-four hours a day, seven days a week;

(2) The agency must assure communication and coordination with the consumer's case manager or primary care provider;

(3) The agency must assure that staff are aware of and protect consumer rights as described in WAC 388-865-0410;

(4) The following sections of WAC subsections apply:

(a) WAC 388-865-0405, Competency requirements for staff;

(b) WAC 388-865-0410, Consumer rights;

(c) WAC 388-865-0440, Availability of consumer information;

(d) WAC 388-865-0450, Quality management process;

(e) WAC 388-865-0452 (6)(a) thru (d), Emergency crisis intervention services—Additional standards;

(f) WAC 388-865-0468, The process for licensing service providers;

(g) WAC 388-865-0472, Licensing categories;

(h) WAC 388-865-0474, Fees for community support licensure;

(i) WAC 388-865-0476, Licensure based on deemed status;

(j) WAC 388-865-0478, Renewal of the provider license;

(k) WAC 388-865-0480, Procedures to suspend or revoke a license;

(l) WAC 388-865-0482, Procedures to contest a licensing decision.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0454, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0456 Case management services—Additional standards. The community support service pro-

vider for case management services must assure that all general minimum standards for community support services and are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in their individualized service plan;

(2) Support consumer employment, education or participation in other daily activities appropriate to their age and culture;

(3) Make referrals to other needed services and supports, including treatment for co-occurring disorders and health care;

(4) Assist consumers to resolve crises in least-restrictive settings;

(5) Provide information and education about the consumer's illness so the consumer and family and natural supports are engaged to help consumers manage the consumer's symptoms;

(6) Include, as necessary, flexible application of funds, such as rent subsidies, rent deposits, and in-home care to enable stable community living.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0456, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0458 Psychiatric treatment, including medication supervision—Additional standards. The licensed community support service provider for psychiatric treatment, including medication supervision must meet all general minimum standards for community support in addition to the following minimum requirements:

(1) Document the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Document that consumers and, as appropriate, family members are informed about the medication and possible side effects in language that is understandable to the consumer, and referred to other health care facilities for treatment of nonpsychiatric conditions;

(2) Provider staff must inspect and inventory medication storage areas at least quarterly:

(a) Medications must be kept in locked, well-illuminated storage;

(b) Medications kept in a refrigerator containing other items must be kept in a separate container with proper security;

(c) No outdated medications must be retained, and medications must be disposed of in accordance with regulations of the state board of pharmacy;

(d) Medications for external use must be stored separately from oral and injectable medications;

(e) Poisonous external chemicals and caustic materials must be stored separately.

(3) Medical direction and responsibility is assigned to a physician who is licensed to practice under chapter 18.57 or 18.71 RCW, and is board-certified or -eligible in psychiatry;

(4) Medications are only prescribed and administered by persons consistent with their license and related requirements;

(5) Medications are reviewed at least every three months;

(6) Medication information is maintained in the clinical record and documents at least the following for each prescribed medication:

(a) Name and purpose of medication;

(b) Dosage and method of giving medication;

(c) Dates prescribed, reviewed, and renewed;

(d) The effects, interactions, and side effects the staff observes or the consumer reports spontaneously or as the result of questions from the staff;

(e) Any laboratory findings;

(f) Reasons for changing or stopping the medication; and

(g) Name and signature of prescribing person.

(7) Assessment and appropriate referrals to or consultation with a physician or other health care provider when physical health problems are suspected or identified;

(8) Address current medical concerns consistent with the individualized service plan;

(9) If the service provider is unable to employ or contract with a psychiatrist, a physician without board eligibility in psychiatry may be utilized, provided that:

(a) Psychiatrist 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.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0458, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0460 Counseling and psychotherapy services—Additional standards. The licensed community support service provider for counseling and psychotherapy services must assure that all general minimum standards for community support are met.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0460, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0462 Day treatment services—Additional standards. The licensed community support service provider for day treatment services must assure that all general minimum standards for community support are met. Day treatment services are defined as work or other activities of daily living for consumers:

(1) Services for adults include:

(a) Training in basic living and social skills;

(b) Supported work and preparation for work;

(c) Vocational rehabilitation;

(d) Day activities; and, if appropriate;

(e) Counseling and psychotherapy services.

(2) Services for children include:

(a) Age-appropriate living and social skills;

(b) Educational and prevocational services;

(c) Day activities; and

(d) Counseling and psychotherapy services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0462, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0464 Consumer employment services—Additional standards. The community support service provider licensed for employment services must assure that all general minimum standards for community support and are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in his/her individualized service plan and provide access to employment opportunities, including:

(a) A vocational assessment of work history, skills, training, education, and personal career goals;

(b) Information about how employment will affect income and benefits the consumer is receiving because of their disability;

(c) Active involvement with consumers served in creating and revising individualized job and career development plans;

(d) Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests;

(e) Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and

(f) Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Antidiscrimination law.

(2) Pay consumers according to the Fair Labor Standards Act; and ensure safety standards that comply with local and state regulations are in place if the provider employs consumers as part of the prevocational or vocational program;

(3) Coordinate efforts with other rehabilitation and employment services, such as:

(a) The division of vocational rehabilitation;

(b) The state employment services;

(c) The business community; and

(d) Job placement services within the community.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0464, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0466 Community support outpatient certification—Additional standards. In order to provide services to consumers on a less restrictive alternative court order, providers must be licensed to provide the psychiatric and medical service component of community support services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Document in the consumer clinical record and otherwise ensure:

(a) Detained and committed consumers are advised of their rights under chapter 71.05 or 71.34 RCW and as follows:

(i) To receive adequate care and individualized treatment;

(ii) To make an informed decision regarding the use of antipsychotic medication and to refuse medication beginning twenty-four hours before any court proceeding that the consumer has the right to attend;

(iii) To maintain the right to be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder;

(iv) Of access to attorneys, courts, and other legal redress;

(v) To have the right to be told statements the consumer makes may be used in the involuntary proceedings; and

(vi) To have the right to have all information and records compiled, obtained, or maintained in the course of treatment kept confidential as defined in chapter 71.05 and 71.34 RCW.

(b) A copy of the less restrictive alternative court order and any subsequent modifications are included in the clinical record;

(c) Development and implementation of an individual service plan which addresses the conditions of the less restrictive alternative court order and a plan for transition to voluntary treatment;

(d) That the consumer receives psychiatric treatment including medication management for the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Such services must be provided:

(i) At least weekly during the fourteen-day period;

(ii) Monthly during the ninety-day and one-hundred eighty day periods of involuntary treatment unless the attending physician determines another schedule is more appropriate, and they record the new schedule and the reasons for it in the consumer's clinical record.

(2) Maintain written procedures for managing assaultive and/or self-destructive patient behavior, and provide training to staff in these interventions;

(3) Have a written protocol for referring consumers to an inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis;

(4) For consumers who require involuntary detention the protocol must also include procedures for:

(a) Contacting the county designated mental health professional regarding revocations and extension of less restrictive alternatives, and

(b) Transporting consumers.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0466, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0468 Emergency crisis intervention services certification—Additional standards. In order to provide emergency services to a consumer who may need to be detained or who has been detained, the service provider must be licensed for emergency crisis intervention services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Be available seven-days-a-week, twenty-four-hours-per-day;

(2) Follow a written protocol for holding a consumer and contacting the county designated mental health professional;

(3) Provide or have access to necessary medical services;

(4) Have a written agreement with a certified inpatient evaluation and treatment facility for admission on a seven day a week, twenty four hour per day basis; and

(5) Follow a written protocol for transporting individuals to inpatient evaluation and treatment facilities.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0468, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0470 The process for initial licensing of service providers. An applicant for a community support license must comply with the following process:

(1) Complete and submit an application form, along with the required fee to the mental health division. A copy of the application form must be provided to the area regional support network. The regional support network may make written comments to the mental health division about the provider's application for licensure. The application must indicate the service components the applicant wants to offer, as listed in WAC 388-865-0400;

(2) A regional support network may submit an application to the mental health division to operate as a licensed community support service provider as defined in WAC 388-865-0288;

(3) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(4) The consumer chart review is conducted during a second site review within twelve months of the issuance of the provisional license for the agency or service component if the site review is being conducted in response to a license application for a new agency or a new service component in a currently licensed agency;

(5) The mental health division may include representatives of the regional support network or mental health prepaid health plan in the licensing review process. If a provider is licensed based on deemed status as outlined in WAC 388-865-0476, input from the accrediting agency may be considered;

(6) The on-site review concludes with an exit conference that includes:

(a) Discussion of findings, if any;

(b) Statement of deficiencies requiring a plan of correction;

(c) A plan of correction signed by the applicant agency director and the mental health division review team representative with a completion date no greater than sixty days from the date of the exit conference, unless otherwise negotiated with the review team representative. Consumer health and safety concerns may require immediate corrective action.

(7) If the provider fails to correct the deficiencies noted within the agreed-upon timeframes, licensure will be denied. The mental health division notifies the applicant in writing of the reasons for denial and the right to a review of the decision in an administrative hearing;

(8) If licensure is denied, the applicant must wait at least six months following the date of notification of denial before reapplying.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0470, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0472 Licensing categories. The mental health division assigns the community support service applicant or licensee one of the following types of licenses:

(1) Provisional license. This category is given only to a new applicant. The mental health division may grant a provisional license for up to one year if the provider, has:

(a) An acceptable detailed plan for the development and operation of the services;

(b) The availability of administrative and clinical expertise required to develop and provide the planned services;

(c) The fiscal management and existence or projection of resources to reasonably ensure stability and solvency; and

(d) A corrective action plan approved by the mental health division, if applicable, for any deficiencies.

(2) Full License. Full licensure means that the applicant or licensee is in substantial compliance with the law, applicable rules and regulations, and state minimum standards.

(3) Probationary license. The mental health division may issue a probationary license if the service provider is substantially out of compliance with the requirements of state and federal law, applicable rules and regulations and state minimum standards. The mental health division provides the service provider with a written notice of the deficiencies.

(a) If the deficiency has caused or is likely to cause serious injury, harm, impairment or death to a consumer, the deficiencies must be corrected within a timeframe specified by the mental health division;

(b) If the provider fails to complete a corrective action plan or correct deficiencies according to the corrective action plan, the license may be suspended or revoked;

(c) To regain full licensure, a service provider in probationary status must provide a written statement to the mental health division when it has made all required corrective actions and now complies with relevant federal and state law, applicable rules and regulations, and state minimum standards;

(d) The mental health division may conduct an on-site review to confirm that the corrections have been made.

(4) The mental health division may perform an onsite visit to determine the validity of a complaint or notice that a community support service provider is out of compliance with law, applicable rules and regulations, and state minimum standards.

(5) If the service provider does not demonstrate compliance with the requirements of this section, the mental health division may initiate procedures to suspend or revoke a license consistent with state and federal laws, rules and regulations consistent with the provisions of RCW 71.24.035 (7) through (11) and of 43.20A.205.

(6) A regional support network or prepaid health plan may choose to contract with a service provider with a provisional license, full license, or probationary license, but may not contract with a provider with a suspended or revoked license.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0472, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0474 Fees for community support service provider licensure. (1) Fees are due with an initial application or for annual license renewal;

(2) Fees must be paid for a minimum of one year;

(3) If an application is withdrawn prior to issuance or denial, one-half of the fees may be refunded at the request of the applicant;

(4) A change in ownership requires a new license and payment of fees;

(5) Fee payments must be made by check, electronic fund transfer, or money order made payable to the mental health division;

(6) Fees will not be refunded if a license or certificate is denied, revoked, or suspended;

(7) Failure to pay fees when due will result in suspension or denial of the license;

(8) The following fees must be sent with the application for a license or renewal:

Range	Service Hours	Annual Fee
1	0-3,999	$291.00
2	4,000-14,999	422.00
3	15,000-29,999	562.00
4	30,000-49,999	842.00
5	50,000 or more	1,030.00

(9) Annual service hours are computed on the most recent year. For new entities, annual service hours equals the projected service hours for the year of licensure. The provider must report the number of annual service hours based on the mental health division consumer information system data dictionary.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0474, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0476 Licensure based on deemed status. (1) The mental health division may deem compliance with state minimum standards and issue a community support service license based on the provider being currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division. Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency.

(2) The mental health division will only grant licensure based on deemed status to providers with a full license as defined in WAC 388-865-0472.

(3) Specific requirements of state regulation, contract or policy will be waived through a deeming process consistent with the working agreement between the mental health division and the accrediting agency;

(4) Specific requirements of state or federal law, or regulation will not be waived through a deeming process.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0476, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0478 Renewal of a community support service provider license. (1) Each year the community support service provider must renew its license. The community support service provider sends the reapplication for licensure to mental health division along with the required fee.

(2) If the service provider contracts with the regional support network or prepaid health plan it must send a copy of the application to the regional support network or mental health prepaid health plan. The regional support network or mental health prepaid health plan may make written comments to the mental health division about renewing the service provider's license. They must send the service provider a copy.

(3) The mental health division considers the request for renewal, along with any recommendations from the regional support network or mental health prepaid health plan and the results of any onsite reviews completed.

(4) If the provider is in compliance with applicable laws and standards, the mental health division sends the service provider a renewed license, with a copy to the regional support network or mental health prepaid health plan if applicable.

(5) Failure to submit the annual application for renewal license and/or to pay fees when due results in expiration of the license and the provider will be placed on probationary status.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0478, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0480 Procedures to suspend, or revoke a license. (1) The mental health division may suspend, revoke, limit or restrict the license of a community support service provider, or refuse to grant or renew a license for failure to conform to the law, applicable rules and regulations, or state minimum standards.

(2) The mental health division may suspend, revoke, limit or restrict the license of a service provider immediately if there is imminent risk to consumer health and safety.

(3) The mental health division sends a written decision to revoke, suspend, or modify the former licensure status under RCW 43.20A.205, with the reasons for the decision and informing the service provider of its right to an administrative hearing. A copy of the letter will be sent to the area regional support network.

(4) A regional support network or mental health prepaid health plan must not contract with a service provider with a suspended or revoked license.

(5) The mental health division may suspend or revoke a license when a service provider in probationary status fails to correct the health and safety deficiencies as agreed in the corrective action plan with the mental health division.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0480, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0482 Procedures to contest a licensing decision. To contest a decision by the mental health division, the service provider, regional support network, or mental health prepaid health plan must, within twenty-eight calendar days:

(1) File a written application for a hearing with a method that shows proof of receipt to: The Board of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(2) Include in the appeal:

(a) The issue to be reviewed and the date the decision was made;

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

(c) The grounds for contesting a decision of the mental health division; and

(d) A copy of the mental health division decision that is being contested.

(3) The appeal must be signed by the director of the service provider and include the address of the service provider.

(4) The decision will be made following the requirements of the Administrative Procedure Act, chapter 34.05 RCW and chapter 388-02 WAC.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0482, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0484 Process to certify providers of involuntary services. In order to be certified to provide services to consumers on an involuntary basis, the provider must comply with the following process:

(1) Be licensed as a community support provider consistent with this section or licensed as a community hospital by the department of health;

(2) Complete and submit an application for certification to the regional support network;

(3) The regional support network selects providers for certification and makes a request to the mental health division for certification;

(4) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(5) The mental health division grants certification based on compliance with the minimum standards of this section and chapter 71.05 RCW;

(6) The certificate may be renewed annually at the request of the regional support network and the provider's continued compliance with the minimum standards of this section;

(7) The procedures to suspend or revoke a certificate are the same as outlined WAC 388-865-0468;

(8) The appeal process to contest a decision of the mental health decision is the same as outlined in WAC 388-865-0482.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0484, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0500 Inpatient evaluation and treatment facilities. The mental health division certifies facilities to provide involuntary inpatient evaluation and treatment services for more than twenty-four hours. Facilities must be certified in order to provide services to consumers who are authorized by the regional support network or mental health prepaid health plan to receive psychiatric inpatient evaluation and treatment services on an involuntary basis.

(1) The following facilities must be licensed by the department of health:

(a) General hospital;

(b) Psychiatric hospital; or

(c) Residential (nonhospital) inpatient facility such as adult residential rehabilitation centers and psychiatric institutions for children and youth.

(2) The following state psychiatric hospitals for adults or children are not licensed by the state, but certified by the Health Care Financing Administration and accredited by the Joint Commission on Accreditation of Healthcare Organizations:

(a) Eastern state hospital;

(b) Western state hospital; and

(c) Child study and treatment center.

(3) No correctional institution or facility, juvenile court detention facility, or jail may be used as an inpatient evaluation and treatment facility within the meaning of this chapter.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0500, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0501 Certification based on deemed status. (1) The mental health division may deem compliance with state minimum standards and issue an inpatient evaluation and treatment certificate based on the provider being currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division. Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency;

(2) The mental health division will only grant certification based on deemed status to providers that have attained full certification as defined in WAC 388-865-0472;

(3) Specific requirements of state regulation, contract or policy will be waived through a deeming process consistent with the working agreement between the mental health division and the accrediting agency;

(4) Specific requirements of state or federal law or regulation will not be waived through a deeming process.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0501, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0502 Single bed certification. At the discretion of the mental health division, an exception may be granted to allow treatment to an adult on a seventy-two hour detention or fourteen-day commitment in a facility that is not certified under WAC 388-865-0500 or for a maximum of thirty days to allow a community facility to provide treatment to an adult on a ninety- or one hundred eighty-day inpatient involuntary commitment order.

(1) The regional support network or its designee must submit a written request for a single bed certification to the mental health division prior to the commencement of the order;

(2) The facility receiving the single bed certification must meet all requirements of this section unless specifically waived by the mental health division;

(3) The request for single bed certification must describe why the consumer meets at least one of the following criteria:

(a) The consumer requires services that are not available at a state psychiatric hospital; or

(b) The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care.

(4) The mental health division director or the director's designee makes the decision and gives written notification to the requesting regional support network in the form of a single bed certification. The single bed certification must not contradict a specific provision of federal law or state statute;

(5) The mental health division may make site visits at any time to verify that the terms of the single bed certification are being met. Failure to comply with any term of the exception certification may result in corrective action or, if the mental health division determines that the violation places consumers in imminent jeopardy, immediate revocation of the certification;

(6) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding single bed certification decisions by mental health division staff.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0502, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0504 Exception to rule—Long-term certification. (1) At the discretion of the mental health division, a facility may be granted an exception to WAC 388-865-0229 in order to allow the facility to be certified to provide treatment to adults on ninety- or one hundred eighty-day inpatient involuntary commitment orders.

(2) The exception certification may be requested by the facility, the director of the mental health division or his designee, or the RSN for the facility's geographic area.

(3) The facility receiving the exception certification for ninety- or one hundred eighty-day patients must meet all requirements found in chapter 388-865 WAC for the evaluation and treatment facility short-term inpatient component.

(4) The exception certification must be signed by the director of the mental health division. The exception certification may impose additional requirements, such as types of patients allowed and not allowed at the facility, reporting requirements, requirements that the facility immediately report suspected or alleged incidents of abuse, or any other requirements that the director of the mental health division determines are necessary for the best interests of patients.

(5) The mental health division may make unannounced site visits at any time to verify that the terms of the exception certification are being met. Failure to comply with any term of the exception certification may result in corrective action or, if the mental health division determines that the violation places patients in imminent jeopardy, immediate revocation of the certification.

(6) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding the decision to grant or not to grant exception certification.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0504, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0505 Evaluation and treatment facility certification—Minimum standards. To gain and maintain certification to provide inpatient evaluation and treatment services under chapter 71.05 and 71.34 RCW, a facility must meet applicable local, state and federal laws and regulations including department of health licensure requirements and WAC 388-865-500 through 388-865-560:

(1) Designate a physician or other mental health professional as the professional person in charge of that facility. This person must be given the authority and be responsible for:

(a) Making admission and discharge decisions on behalf of that facility;

(b) Supervision of clinical services provided by the facility; and

(c) Explore less restrictive alternatives, in considering the filing of all petitions for involuntary commitments to inpatient treatment including possible community support or residential treatment, to see if the consumer can be as well or better served, preferably within his or her home community.

(2) Have the capability to admit consumers needing inpatient evaluation and treatment services seven days a week, twenty-four hours a day. Psychiatric institutions for children and youth are exempted from this requirement;

(3) Have at least one seclusion room meeting the requirements of WAC 246-320-365 (12)(d)(ii);

(4) Assure access to necessary medical treatment, emergency life-sustaining treatment, and medication.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0505, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0510 Standards for administration. The inpatient evaluation and treatment facility must develop policies to address the following administrative requirements:

(1) Protect clinical records against loss, defacement, tampering, or use by unauthorized persons;

(2) Maintain adequate fiscal accounting records;

(3) Bill and collect payment for services from all private payors and third party payors, including Medicaid and Medicare consumers;

(4) Ensure the protection of consumer and family rights as described in this chapter and chapter 71.05 and 71.34 RCW;

(5) Maintain written protocols to physically and legally detain a consumer who refuses voluntary treatment and meets the legal criteria for involuntary commitment, including the method to contact the county designated mental health professional;

(6) Maintain written procedures for managing assaultive and/or self-injurious consumer behavior;

(7) Maintain written procedures to ensure the safety of children and adults in an inpatient evaluation and treatment facility:

(a) Adults must be separated from children who are not yet thirteen years of age;

(b) Children who have had their thirteenth birthday, but are under the age of eighteen, may be served with adults only if the child's clinical record contains a professional judgment saying that placement in an adult facility will not be harmful to the child or adult.

(8) Develop policies and procedures to inform and provide relevant information on persons who are absent from the facility without leave consistent with RCW 71.05.410 and 71.05.420;

(9) Maintain written procedures to either admit all consumers who have been detained or arrange for transfer to a more appropriate facility only after it is confirmed that the facility will admit the consumer;

(10) Maintain written procedures to ensure the protection of the consumer's property including:

(a) Inventory articles brought to the facility and not kept by the consumer;

(b) Use reasonable precautions to safeguard the property of the consumer.

(11) If the facility treats children, it must maintain written procedures to ensure that:

(a) Whenever a child is conditionally released or discharged before the end of the commitment, the professional person in charge gives the court written notice of the release within three days of the release. If the child is on a one a one hundred and eighty day commitment the children's long-term inpatient placement committee must also be notified.

(b) If the child elopes, the professional person in charge immediately notifies the parents and the appropriate law enforcement agencies.

(12) Maintain written procedures to ensure that upon discharge of a consumer of voluntary services:

(a) The consumer's permission is sought for release of a clinical summary to the community physician, psychiatrist, or therapist of his/her choice, or to the local treatment facility or licensed service provider.

(b) Information sharing complies with RCW 71.05.390.

(c) The consumer is advised of his or her competency and given the following written notice: "No person is presumed incompetent nor does any person lose any civil rights as a consequence of receiving evaluation and treatment services for a mental disorder, whether voluntary or involuntary, as required by RCW 71.05.450."

(13) Maintain written procedures to ensure that the county designated mental health professional who detained a person can not also be one of the two mental health professionals who examines and evaluates a person within twenty-four hours of admission to determine what treatment he or she requires. An exception can be made only by the director or the mental health division and because no other mental health professional is reasonably available to do the necessary examination and evaluation.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0510, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0515 Admission and intake evaluation. The provider must include the following documentation in the intake evaluation:

(1) An initial treatment plan;

(2) A copy of any advance directives, powers of attorney or letters of guardianship provided by the consumer;

(3) That the consumer was advised of his/her rights;

(4) Consideration of a less restrictive treatment alternative for each patient at the time of detention, admission, and discharge;

(5) For consumers who have been involuntarily detained, evaluations to determine the nature of the disorder, the treatment necessary, and whether or not detention is required at least within twenty-four hours of the initial detention of the consumer, including Saturdays, Sundays and holidays. The evaluation must include at least a:

(a) Medical evaluation by a an appropriately licensed medical professional within his/her scope of practice; and

(b) Psychosocial evaluation by a mental health professional.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0515, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0525 Clinical record. The treatment record for each consumer must contain:

(1) A comprehensive plan for treatment developed collaboratively with the consumer;

(2) Copies of advance directives, powers of attorney or letters of guardianship provided by the consumer.

(3) A plan for discharge including a plan for follow-up where appropriate;

(4) Sufficient information to justify the diagnosis;

(5) Documentation that the facility has provided for or arranged for diagnostic and therapeutic services prescribed by the attending professional staff. This may include participation of a multi-disciplinary team or mental health specialists as defined in WAC 388-865-0150, or collaboration with members of the consumer's support system as identified by the consumer;

(6) Documentation of the course of treatment;

(7) Documentation that a mental health professional has contact with each involuntary consumer at least daily for the purpose of:

(a) Observation;

(b) Evaluation; and

(c) Continuity of treatment.

(8) Documentation that a mental health professional and licensed physician are available for consultation and communication with both the consumer and the direct patient care staff twenty-four hours a day, seven days a week;

(9) Documentation of evaluation of each involuntarily committed consumer for release from commitment at least weekly for fourteen-day commitments.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0525, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0530 Competency requirements for staff. In order to gain and maintain certification as an inpa-

tient evaluation and treatment facility, the provider must document that staff are qualified for the position they hold and have the education, experience, or skills to perform the job requirements, including:

(1) All staff have a current Washington state department of health license or certificate or registration as may be required for his/her position;

(2) Washington state patrol background checks are conducted for employees in contact with consumers consistent with RCW 43.43.830;

(3) Clinical supervisors meet the qualifications of mental health professionals or specialists as defined in WAC 388-865-0150;

(4) Staff receive an annual performance evaluation; and

(5) An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for his/her job description and the population they serve. Such training must include at least:

(a) Least restrictive alternative options available in the community and how to access them;

(b) Methods of patient care;

(c) Management of assaultive and self-destructive behavior; and

(d) The requirements of chapter 71.05 and 71.34 RCW, this chapter, and protocols developed by the mental health division.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0530, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0535 The process for gaining certification and renewal of certification. These processes are the same as described in WAC 388-865-0484.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0535, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0540 Fees for evaluation and treatment facility certification. Inpatient facilities certified to provide inpatient evaluation and treatment services are assessed an annual fee of thirty-two dollars per bed.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0540, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0545 Use of seclusion and restraint procedures—Adults. Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) Staff must notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion;

(2) The consumer must be informed of the reasons for use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures;

(3) The clinical record must document staff observation of the consumer at least every fifteen minutes and observation recorded in the consumer's clinical record;

(4) If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician must assess the consumer and write a new order if the intervention will be continued. This procedure is repeated again for each twenty-four hour period that restraint or seclusion is used;

(5) All assessments and justification for the use of seclusion or restraint must be documented in the consumer's medical record.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0545, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0546 Use of seclusion and restraint procedures—Children. Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour and must authorize the restraints or seclusion;

(2) No consumer may be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. Such consumer must be directly observed every fifteen minutes and the observation recorded in the consumer's clinical record;

(3) If the restraint or seclusion exceeds twenty-four hours, the consumer must 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 must be recorded in the consumer'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.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0546, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0550 Rights of all consumers who receive community inpatient services. The rights assured by RCW 71.05.370 and the following rights must be prominently posted within the department or ward of the community or inpatient evaluation and treatment facility. You have the right to:

(1) Adequate care and individualized treatment.

(2) 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, 71.05.420, and 71.34.160.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0550, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0555 Rights of consumers receiving involuntary inpatient services. Consumers who are receiving inpatient services involuntarily have the rights provided in RCW 71.05.370 plus the following rights. The provider must ensure consumers are informed of his or her rights and that all consumer rights are protected, including:

(1) At admission, each consumer must be informed in writing or orally of his or her rights to have a responsible member of the immediate family if possible, guardian or conservator, if any, and such other person as designated by the consumer given written notice of the consumer's inpatient status, and his or her rights as an involuntary consumer;

(2) A medical and psychosocial evaluation within twenty-four hours of admission to determine whether continued detention in the facility is necessary;

(3) A judicial hearing before a superior court if the consumer is not released within seventy-two hours (excluding Saturdays, Sundays, and holidays), to decide if continued detention within the facility is necessary.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0555, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0557 Rights related to antipsychotic medication. All consumers have a right to make an informed decision regarding the use of antipsychotic medication consistent with the provisions of RCW 71.05.370(7) and 71.05.215. The provider must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including the following requirements:

(1) At the time of admission inform the consumer of his or her right to:

(a) Make an informed decision regarding the use of antipsychotic medication;

(b) Refuse all treatment except lifesaving treatment beginning twenty-four hours prior to any hearing;

(c) Refuse antipsychotic medication beginning twenty-four hours before any court proceeding wherein the consumer has the right to attend and is related to his or her continued commitment;

(d) The consumer must be asked if he or she wishes to decline treatment during the twenty-four hour period, and the answer must be in writing and signed when possible. Compliance with this procedure must be documented in the consumer's clinical record.

(2) The clinical record must document:

(a) The physician's attempt to obtain informed consent;

(b) The reasons why any antipsychotic medication is administered over the consumer's objection or lack of consent.

(3) The physician may administer antipsychotic medications over a consumer's objections or lack of consent only when:

(a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists if:

(i) The consumer presents an imminent likelihood of serious harm to self or others;

(ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and

(iii) In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician.

(b) There is an additional concurring opinion by a second physician for treatment up to thirty days;

(c) 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 consumer. Thereafter, antipsychotic medication may be administered involuntarily only upon order of the court. The review must occur at least every sixty days.

(4) The examining physician must sign all one hundred eighty-day petitions for antipsychotic medications files under the authority of RCW 71.05.370(7);

(5) Consumers 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;

(6) In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining physician files a petition for an antipsychotic medication order the next judicial day;

(7) All involuntary medication orders must be consistent with the provisions of RCW 71.05.370 (7)(a) and (b), whether ordered by a physician or the court;

(8) This section does not preclude use of physical restraints and/or seclusion in compliance with WAC 388-865-0545 and 388-865-0546.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0557, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0560 Rights of consumers who receive emergency and inpatient services voluntarily. (1) At admission, each consumer must be informed in writing or orally of his or her right to immediate release, and other rights as defined in this section and in RCW 71.05.050 for adults and chapter 71.34 RCW for children.

(2) The following rights of voluntary consumers must be prominently displayed within the department or ward where the consumer is housed. You have the right to:

(a) Release, unless involuntary commitment proceedings are initiated.

(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 voluntary consumers have the right to:

(a) Adequate care and individualized treatment;

(b) Make an informed decision about the use of antipsychotic medication.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0560, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0565 Petition for the right to possess a firearm. A person is entitled to the immediate restoration of the right to firearm possession when he or she no longer require treatment or medication for a condition related to the involuntary commitment. This is described in RCW 9.41.040 (6)(c).

(1) The person who wants his or her right to possess a firearm restored may petition the court that ordered involuntary treatment or the superior court of the county in which he or she lives for a restoration of the right to possess firearms. At a minimum, the petition must 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 and conclusions of law.

(2) The person must show the court that he/she no longer require treatment or medication for the condition related to the commitment.

(3) If the court requests relevant information about the commitment or release to make a decision, the mental health professionals who participated in the evaluation and treatment must give the court that information.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0565, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0600 Purpose. In order to enhance and facilitate the department of corrections' ability to carry out its responsibility of planning and ensuring community protection, mental health records and information, as defined in this section, that are otherwise confidential shall be released by any mental health service provider to the department of corrections personnel for whom the information is necessary to carry out the responsibilities of their office as authorized in RCW 71.05.445 and 71.34.225. Department of corrections personnel must use records only for the stated purpose and must assure that records remain confidential and subject to the limitations on disclosure outlined in chapter 71.05 RCW, except as provided in RCW 72.09.585.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0600, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0610 Definitions. Relevant records and reports includes written documents obtained from other agencies or sources, often referred to as third-party documents, as well as documents produced by the agency receiving the request. Relevant records and reports do not include the documents restricted by either federal law or federal regulation related to treatment for alcoholism or drug dependency or the Health Insurance Portability and Accountability Act or state law related to sexually transmitted diseases, as outlined in RCW 71.05.445 and 71.34.225.

(1)**"Relevant records and reports"** means:

(a) Records and reports of inpatient treatment:

(i) Inpatient psychosocial assessment - Any initial, interval, or interim assessment usually completed by a person with a master's degree in social work (or equivalent) or equivalent document as established by the holders of the records and reports;

(ii) Inpatient intake assessment - The first assessment completed for an admission, usually completed by a psychiatrist or other physician or equivalent document as established by the holders of the records and reports;

(iii) Inpatient psychiatric assessment - Any initial, interim, or interval assessment usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(iv) Inpatient discharge/release summary - Summary of a hospital stay usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(v) Inpatient treatment plan - A document designed to guide multi-disciplinary inpatient treatment or equivalent document as established by the holders of the records and reports;

(vi) Inpatient discharge and aftercare plan data base - A document designed to establish a plan of treatment and support following discharge from the inpatient setting or equivalent document as established by the holders of the records and reports.

(b) Records and reports of outpatient treatment:

(i) Outpatient intake evaluation - Any initial or intake evaluation or summary done by any mental health practitioner or case manager the purpose of which is to provide an initial clinical assessment in order to guide outpatient service delivery or equivalent document as established by the holders of the records and reports;

(ii) Outpatient periodic review - Any periodic update, summary, or review of treatment done by any mental health practitioner or case manager. This includes, but is not limited to: Documents indicating diagnostic change or update; annual or periodic psychiatric assessment, evaluation, update, summary, or review; annual or periodic treatment summary; concurrent review; individual service plan as required by WAC 388-865-0425 through 388-865-0430, or equivalent document as established by the holders of the records and reports;

(iii) Outpatient crisis plan - A document designed to guide intervention during a mental health crisis or decompensation or equivalent document as established by the holders of the records and reports;

(iv) Outpatient discharge or release summary - Summary of outpatient treatment completed by a mental health professional or case manager at the time of termination of outpatient services or equivalent document as established by the holders of the records and reports;

(v) Outpatient treatment plan - A document designed to guide multi-disciplinary outpatient treatment and support or equivalent document as established by the holders of the records and reports.

(c) Records and reports regarding providers and medications:

(i) Current medications and adverse reactions - A list of all known current medications prescribed by the licensed practitioner to the individual and a list of any known adverse reactions or allergies to medications or to environmental agents;

(ii) Name, address and telephone number of the case manager or primary clinician.

(d) Records and reports of other relevant treatment and evaluation:

(i) Psychological evaluation - A formal report, assessment, or evaluation based on psychological tests conducted by a psychologist;

(ii) Neuropsychological evaluation - A formal neuropsychological report, assessment, or evaluation based on neuropsychological tests conducted by a psychologist;

(iii) Educational assessment - A formal report, assessment, or evaluation of educational needs or equivalent document as established by the holders of the records and reports;

(iv) Functional assessment - A formal report, assessment, or evaluation of degree of functional independence. This may include but is not limited to: Occupational therapy evaluations, rehabilitative services data base activities assessment, residential level of care screening, problem severity scale, instruments used for functional assessment or equivalent document as established by the holders of the records and reports;

(v) Forensic evaluation - An evaluation or report conducted pursuant to chapter 10.77 RCW;

(vi) Offender/violence alert - A any documents pertaining to statutory obligations regarding dangerous or criminal behavior or to dangerous or criminal propensities. This includes, but is not limited to, formal documents specifically designed to track the need to provide or past provision of: Duty to warn, duty to report child/elder abuse, victim/witness notification, violent offender notification, and sexual/kidnaping offender notification per RCW 4.24.550, 10.77.205, 13.40.215, 13.40.217, 26.44.330, 71.05.120, 71.05.330, 71.05.340, 71.05.425, 71.09.140, and 74.34.035;

(vii) Risk assessment - Any tests or formal evaluations administered or conducted as part of a formal violence or criminal risk assessment process that is not specifically addressed in any psychological evaluation or neuropsychological evaluation.

(e) Records and reports of legal status - Legal documents are documents filed with the court or produced by the court indicating current legal status or legal obligations including, but not limited to:

(i) Legal documents pertaining to chapter 71.05 RCW;

(ii) Legal documents pertaining to chapter 71.34;

(iii) Legal documents containing court findings pertaining to chapter 10.77 RCW;

(iv) Legal documents regarding guardianship of the person;

(v) Legal documents regarding durable power of attorney;

(vi) Legal or official documents regarding a protective payee;

(vii) Mental health advance directive.

(2) **"Relevant information"** means descriptions of a consumer's participation in, and response to, mental health treatment and services not available in a relevant record or report, including all statutorily mandated reporting or duty to warn notifications as identified in WAC 388-865-610 (1)(d)(vi), Offender/Violence alert, and all requests for evaluations for involuntary civil commitments under chapter 71.05 RCW. The information may be provided in verbal or written form at the discretion of the mental health service provider.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0610, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0620 Scope. Many records and reports are updated on a regular or as needed basis. The scope of the records and reports to be released to the department of corrections are dependent upon the reason for the request.

(1) For the purpose of a presentence investigation release only the most recently completed or received records of those completed or received within the twenty-four-month period prior to the date of the request; or

(2) For all other purposes release all versions of records and reports that were completed or received within the ten year period prior to the date of the request that are still available.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0620, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0630 Time frame. The mental health service provider shall provide the requested relevant records, reports and information to the authorized department of corrections person in a timely manner, according to the purpose of the request:

(1) Presentence investigation - within seven calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the seven-day-period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(2) All other purposes - within thirty calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0630, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0640 Written requests. The written request for relevant records, reports and information shall include:

(1) Verification that the person for whom records, reports and information are being requested is under the

authority of the department of corrections, per chapter 9.94A RCW, and the expiration date of that authority.

(2) Sufficient information to identify the person for whom records, reports and information are being requested including name and other identifying data.

(3) Specification as to which records and reports are being requested and the purpose for the request.

(4) Specification as to what relevant information is requested and the purpose for the request.

(5) Identification of the department of corrections person to whom the records, reports and information shall be sent, including the person's name, title and address.

(6) Name, title and signature of the requestor and date of the request.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0640, filed 5/31/01, effective 7/1/01.]

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 to be a sexually violent predator.

(2) Beginning July 1, 1990, the department's SPP shall provide:

(a) Custody, supervision, and evaluation of a person court-detained to the SPP to determine if the person meets the definition of a sexually violent predator under chapter 71.09 RCW; and

(b) Treatment, care, and control of a person court-committed as a sexually violent predator.

(3) Secure facilities operated by the department for the sexual predator program include the special commitment center (SCC) total confinement facility, the secure community transition facility, and any community-based facilities established under chapter 71.09 RCW and operated by the secretary or under contract with the secretary.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-005, filed 12/27/01, effective 1/27/02; 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 388-880-007 Purpose. These rules carry out the legislative intent of chapter 71.09 RCW, authorizing the department to provide care, control, and treatment of persons court-detained or committed to the sexual predator program, identified as the special commitment center.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-007, filed 12/27/01, effective 1/27/02.]

WAC 388-880-010 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

"Appropriate facility" means the total confinement facility the department uses to hold and evaluate a person court-detained under chapter 71.09 RCW.

"Care" means a service the department provides during a person's detention or commitment within a secure facility toward adequate health, shelter, and physical sustenance.

"Control" means a restraint, restriction, or confinement the department applies protecting a person from endangering self, others, or property during a period of custody under chapter 71.09 RCW.

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

"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.

"Evaluation" means an examination, report, or recommendation a professionally qualified person makes determining if a person has a personality disorder and/or mental abnormality, as defined in chapter 71.09 RCW, which renders the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

"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.

"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.

"Individual treatment plan (ITP)" means an outline the SCC staff persons develop detailing how control, care, and treatment services are provided to a committed person or to a court-detained person.

"Less restrictive alternative" means court-ordered treatment in a setting less restrictive than total confinement which satisfies the conditions stated in RCW 71.09.092.

"Less restrictive alternative facility" means a secure community transition facility as defined under RCW 71.09.020(1).

"Mental abnormality" means a congenital or acquired condition, including a personality disorder, affecting the person's emotional or volitional capacity, predisposing the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others.

"Oversight" means official direction, guidance, review, inspection, investigation, and information gathering activities conducted for the purposes of program quality assurance by persons or entities within, or external to, the SCC.

"Predatory" means acts a person directs toward:

(1) Strangers;

(2) Individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or

(3) Persons of casual acquaintance with whom no substantial personal relationship exists.

"Professionally qualified person" means:

(1) **"Mental health counselor"** means a person licensed as a mental health counselor under chapter 251, Laws of 2001;

(2) **"Psychiatric nurse"** means a person licensed as a registered nurse under chapter 18.79 RCW and having two or more years supervised clinical experience;

(3) **"Psychiatrist"** means a person licensed as a physician under chapters 18.71 and 18.57 RCW. In addition, the person shall:

(a) Have completed three years of graduate training in a psychiatry program approved by the American Medical Association or the American Osteopathic Association; and

(b) Be certified, or eligible to be certified, by the American Board of Psychiatry and Neurology.

(4) **"Psychologist"** means a person licensed as a doctor of psychology under chapter 18.83 RCW;

(5) **"Social worker"** means a person licensed as an advanced social worker or independent clinical social worker under chapter 251, Laws of 2001; and

(6) **"Clinical practitioner"** means a sex offender treatment provider certified under chapter 18.155 RCW, or a forensic therapist three or forensic therapist supervisor designated to perform annual evaluations.

"Resident" means a person detained or committed pursuant to chapter 71.09 RCW.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"Secure community transition facility" means a residential facility for persons civilly committed and conditionally released to a less restrictive alternative under chapter 71.09 RCW. A secure community transition facility has supervision and security, and either provides or ensures the provision of sex offender treatment services. Secure community transition facilities include, but are not limited to, the facilities established in RCW 71.09.201 and any community-based facilities established under chapter 71.09 RCW and operated by the secretary or under contract with the secretary.

"Secure facility" means a residential facility for persons court-detained or committed under the provisions of chapter 71.09 RCW that includes security measures sufficient to protect the community. Such facilities include total confinement facilities, secure community transition facilities, and any residence used as a court-ordered placement in RCW 71.09.096.

"Sexual predator program" means a department-administered and operated program including the special commitment center (SCC) established for:

(1) A court-detained person's custody and evaluation; or

(2) Control, care, and treatment of a court-committed person defined as a sexually violent predator under chapter 71.09 RCW.

"Sexually violent offense" means an act defined under chapter 9A.28 RCW, RCW 9.94A.030 and 71.09.020.

"Sexually violent predator" means any person 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 if not confined in a secure facility.

"Superintendent" means the person delegated by the secretary of the department to be responsible for the general operation, program, and facilities of the SCC.

"Total confinement facility" means a facility that provides supervision and sex offender treatment services in a total confinement setting. Total confinement facilities include the special commitment center and any similar facility designated as a secure facility by the secretary.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-010, filed 12/27/01, effective 1/27/02; 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 as a sexually violent predator only when:

(1) A court determines probable cause exists and orders the person transferred to an appropriate facility for evaluation;

(2) The person is evaluated by one or more professionally qualified persons;

(3) The person is found to have a personality disorder and/or mental abnormality which makes the person more likely than not to engage in predatory acts of sexual violence unless confined in a secure facility; and

(4) 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.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-020, filed 12/27/01, effective 1/27/02; 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 initial evaluation—Reporting. (1) When a court orders a person transferred to an appropriate facility for evaluation, the department shall, prior to the scheduled commitment hearing or trial, evaluate and provide a recommendation to the court as to whether the person has been convicted of or charged with a crime of sexual violence and suffers from a mental abnormality or personality disorder which makes the person more likely than not to engage in predatory acts of sexual violence if not confined in a secure facility.

(2) If the trial is continued beyond the forty-five day period specified in RCW 71.09.050(1), the evaluation must be completed and provided to attorneys for the prosecution and defense by the date ordered by the trail court or at least thirty days prior to trial.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-030, filed 12/27/01, effective 1/27/02; 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 388-880-031 Sexual predator program annual evaluation—Reporting. (1) Annually or as required by court order, the department shall examine the mental condition of each person committed under chapter 71.09 RCW. The annual report shall include consideration of whether:

(a) The person currently meets the definition of a sexually violent predator; and

(b) Conditional release to a less restrictive alternative is in the best interest of the person and conditions can be imposed that would adequately protect the community.

(2) The report of the department shall be in the form of a declaration or certification in compliance with the requirements of RCW 9A.72.085 and shall be prepared by a professionally qualified person as defined herein.

(3) The department shall file this periodic report with the court that detained or committed the person under chapter 71.09 RCW.

(4) A copy of this report shall be served on the prosecuting agency involved in the initial hearing or commitment and upon the detained or committed person and his or her counsel.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-031, filed 12/27/01, effective 1/27/02.]

WAC 388-880-032 Recommendation for release to a less restrictive alternative (LRA). Upon an evaluation which supports a person's unconditional discharge or release to a less restrictive alternative, the secretary or secretary's designee shall authorize the person to petition the court in accordance with RCW 71.09.090.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-032, filed 12/27/01, effective 1/27/02.]

WAC 388-880-040 Individual treatment. (1) When the court detains a person or commits a person to the SCC, SCC staff persons shall develop an individual treatment plan (ITP) for the person.

(2) The ITP shall be based upon, but not limited to, the following information as may be available:

(a) The person's offense history;

(b) A psycho-social history;

(c) The person's most recent annual evaluation; and

(d) A statement of high risk factors for potential re-offense, as may be ascertained over time.

(3) The ITP shall include, but not be limited to:

(a) A description of the person's specific treatment needs in:

(i) Sex offender specific treatment;

(ii) Substance abuse treatment;

(iii) Supports to promote psychiatric stability;

(iv) Supports for medical conditions and disability;

(v) Social, family, and life skills.

(b) An outline of intermediate and long-range treatment goals, with a cognitive and behavioral measures for achieving the goals;

(c) The treatment strategies for achieving the treatment goals;

(d) A description of SCC staff persons' responsibilities; and

(e) A general plan and criteria, keyed to the resident's achievement of long-range treatment goals, for recommending to the court whether the person should be released to a less restrictive alternative.

(4) SCC staff persons shall review the person's ITP every six months.

(5) A detained person's plan may include access to program services and opportunities available to persons who are court-committed, with the exception that the detained person may be restricted in employment and other activities, depending on program resources and incentives reserved for persons who are court-committed and/or actively involved in treatment.

(6) Nothing in this chapter shall exclude a court-detained person from engaging in the sex offender treatment program and, should the person elect to engage in treatment prior to the person's commitment trial:

(a) The person shall be accorded privileges and access to program services in a like manner as are accorded to a committed person in treatment; and

(b) Shall not, solely by reason of the person's voluntary participation in treatment, be judged nor assumed by staff, administrators or professional persons of the SCC or of the department to meet the definition of a sexually violent predator under chapter 71.09 RCW.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-040, filed 12/27/01, effective 1/27/02; 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 388-880-042 Resident records—Purposes. (1) The SCC shall maintain records for each person court-detained for evaluation or committed for treatment as a sexually violent predator. Such records shall include:

(a) All evaluations, records, reports, and other documents obtained from other agencies relating to the person prior to the person's detention and/or commitment to the SCC;

(b) All evaluations, clinical examinations, forensic measures, charts, files, reports, and other information made for or prepared by SCC personnel, contracted professionals, or others which relate to the person's care, control, and treatment during the person's detention or commitment to, the SCC.

(2) Records made by contracted professional persons providing treatment or residential services may be maintained in their professional files, subject to contractual arrangement for SCC or department access to those records.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-042, filed 12/27/01, effective 1/27/02.]

WAC 388-880-043 Resident clinical records—Location and custody. (1) Records pertaining to residents of the SCC shall be kept in a location accessible only to assigned treatment providers and authorized staff persons.

(2) During the period of a person's residence at the SCC secure facility or LRA facility:

(a) The person's treatment records shall be maintained in the facility wherein the resident is housed.

(b) The person's medical and psychiatric records shall be maintained in the facility wherein the resident is housed and directly available to medical and emergency treatment providers and authorized staff persons.

(3) During the period of a person's residence in a less restrictive alternative facility operated by the department, the person's treatment records shall be maintained in a safe location accessible only by authorized staff.

(4) During a period of a resident's less restrictive alternative placement in a private home or in a facility operated by a contracting agency:

(a) Original behavioral and treatment records and evaluations shall be maintained by the contracted professional person providing treatment and copies thereof shall be made available to the SCC or the department by contract requirement; and

(b) Copies of documents held by the SCC may be made available as necessary to the contracting agency, the contracted treatment provider, and the assigned community corrections officer.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-043, filed 12/27/01, effective 1/27/02.]

WAC 388-880-044 Resident records—Access. (1) Upon request and proper showing, the department shall provide to the following persons access to a detained or committed person for an evaluation and access to all records and reports related to the person's detention, commitment, control, care, and treatment:

(a) The person's attorney;

(b) The 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.

(2) Upon documented request by a resident, the SCC shall provide the resident supervised access to all records and reports, or to redacted copies thereof, related to the person's commitment, control, care, and treatment. The SCC may reasonably limit conditions, frequency and duration of the person's access to the person's records and reports.

(3) A policy on access to resident records shall be maintained and published to residents of the SCC.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-044, filed 12/27/01, effective 1/27/02.]

WAC 388-880-045 Resident records—Retention. (1) The SCC shall create schedules and requirements, consistent with department policy, for the retention, storage, and disposal of records, documents, evaluations, reports, and other material related to SCC residents, to include:

(a) While a person is currently court-detained or committed to the SCC;

(b) Following a court ruling that a person does not meet the definition of a violent sexual predator within chapter 71.09 RCW and upon the person's release from the custody of the department;

(c) Following a resident's unconditional discharge from commitment;

(d) Following a resident's death.

(2) All original records specified herein and held by the SCC shall be retained in the SCC total confinement facility for a period of five years, and in the records center of the Secretary of State for a period consistent with department administrative policy, after a resident's:

(a) Release following a court ruling that the person does not meet the definition of a violent sexual predator within chapter 71.09 RCW;

(b) Unconditional discharge from commitment; or

(c) Death.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-045, filed 12/27/01, effective 1/27/02.]

WAC 388-880-050 Rights of a person court-detained or committed to the special commitment center. (1) During a person's period of detention or commitment, the department shall:

(a) Apprise the person of the person's right to an attorney and to retain a professionally qualified person to perform an evaluation on the person's behalf;

(b) Provide access to the person and the person's records in accordance with RCW 71.09.080 and WAC 388-880-044.

(2) A person the court detains for evaluation or commits to the SCC shall:

(a) Receive adequate care and individualized treatment;

(b) Be permitted to wear the person's own clothing except as may be required during an escorted leave from the secure facility, and to keep and use the person's own 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 SCC;

(c) Be permitted to accumulate and spend a reasonable amount of money in the person's SCC account;

(d) Have access to reasonable personal storage space within SCC 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 SCC limitations; and

(g) Have reasonable access to letter writing material and to:

(i) Receive and send correspondence through the mail within SCC limitations and according to established safeguards against the receipt of contraband material to include, in the resident's presence, opening and inspecting packages and fanning written material; and

(ii) Send written communication regarding the fact of the person's detention or commitment.

(3) A person the court commits to the SCC 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 SCC; 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.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-050, filed 12/27/01, effective 1/27/02; 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 388-880-110 Escort procedures. (1) Only persons approved by the superintendent, or designee, will be authorized to serve as escorts. All escorts from the total confinement facility 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 SCC superintendent, or designee, and be done in accordance with applicable department of corrections policy and procedures. The department of corrections shall be reimbursed, according to rates and procedures established between the department of social and health services and the department of corrections. Correctional officers may wear civilian clothing when escorting a resident for a bedside visit or a funeral.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-110, filed 12/27/01, effective 1/27/02; 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.]

Chapter 388-881 WAC
SEXUAL PREDATOR PROGRAM—EXTERNAL OVERSIGHT
(Formerly chapter 275-155)

WAC

WAC 388-881-010 External oversight of the special commitment center. Independent external oversight of the SCC shall include:

(1) A governing body;

(2) Professional standards to be used as a benchmark for evaluation;

(3) An inspection of care according to accepted professional standards;

(4) An ombudsman service; and

(5) External investigation of incidents.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-010, filed 12/27/01, effective 1/27/02.]

WAC 388-881-015 External oversight—Governing body. The governing body for the special commitment center shall:

(1) Be appointed by the secretary of the department of social and health services (DSHS);

(2) Derive its membership in accordance with department policy established to this purpose;

(3) Operate under by-laws approved by the secretary, DSHS.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-015, filed 12/27/01, effective 1/27/02.]

WAC 388-881-020 External oversight—Professional standards. (1) The department shall develop and governing body approve for use professional practice standards applicable to treatment programs for civilly committed adult sex offenders.

(2) Such standards shall include provisions requiring:

(a) Staff competency, training, and supervision;

(b) Adequacy of treatment components and measures of progress;

(c) A treatment-supportive environment;

(d) Provision of medical services appropriate to a residential treatment setting; and

(e) Program oversight.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-020, filed 12/27/01, effective 1/27/02.]

WAC 388-881-025 External oversight—Annual inspection of care (IOC). (1) An independent, annual, on-site inspection of care, performed according to professional standards approved under this chapter, shall be conducted of the SCC at least annually.

(2) The purpose of the IOC shall be to provide objective measures of service delivery, for internal program use and quality management, to the governing body.

(3) Members of the inspection of care team shall be contracted by the department annually for a specified period during which they shall:

(a) Conduct an on-site and documentary inspection;

(b) Prepare interim and final, and, as requested by the SCC superintendent or governing body, supplementary reports;

(c) Receive and consider SCC program responses to all reports.

(4) The IOC team shall be of no fewer than four and no more than six persons.

(a) At least one member of the IOC team must not be a DSHS employee; and

(b) At least one member must be a sex offender treatment provider.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-025, filed 12/27/01, effective 1/27/02.]

WAC 388-881-030 External oversight—Ombudsman service. (1) The SCC shall retain an ombudsman service for the purpose of conducting independent, neutral reviews of program conformance with internal SCC policies in the care, control and treatment of residents at the SCC.

(2) The ombudsman function shall be outside the supervision of the superintendent of the SCC and of the assistant secretary for health and rehabilitation services.

(3) In performance of the ombudsman function, the individual(s) so employed shall be afforded access to all records and documents normally available to public inspection according to rules and policies of the department and of the state of Washington.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-030, filed 12/27/01, effective 1/27/02.]

WAC 388-881-035 External oversight—Investigation of incidents. (1) The Washington state patrol shall investigate incidents which involve SCC residents in accordance with department policy.

(2) The scope and authority for such investigations shall be determined through an interagency agreement between the department and the Washington state patrol.

(3) Criteria to determine which incidents justify external investigation shall be approved by the secretary, DSHS.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-035, filed 12/27/01, effective 1/27/02.]

Title 390 WAC

PUBLIC DISCLOSURE COMMISSION

Chapters

Chapter 390-05 WAC
GENERAL POLICIES AND DEFINITIONS

WAC

WAC 390-05-400 Changes in dollar amounts. Pursuant to the requirement in RCW 42.17.690 that the commission biennially revise the dollar amounts found in Initiative 134 to reflect changes in economic conditions, the following revisions are made:

Code Section	Subject Matter	Amount Enacted or Last Revised	2001 Revision
.020	Definition of "Independent Expenditure"	$600	$625
.125	Reimbursement of candidate for loan to own campaign	$3,500	$3,800
.180(1)	Report—		
	Applicability of provisions to		
	Persons who made contributions	$12,000	$12,500
	Persons who made independent expenditures	$600	$625
.640(1)	Contribution Limits—		
	Candidates for state leg. office	$600	$625
	Candidates for other state office	$1,200	$1,250
.640(2)	Contribution Limits—		
	State official up for recall or pol comm. supporting recall—		
	State Legislative Office	$600	$625
	Other State Office	$1,200	$1,250
.640(3)	Contribution Limits—		
	Contributions made by political parties and caucus committees		
	State parties and caucus committees	.60 per voter	.64 per voter
	County and leg. district parties	.30 per voter	.32 per voter
	Limit for all county and leg. district parties to a candidate	.30 per voter	.32 per voter