

[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.

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(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.]

## Chapter 388-165 WAC

### CHILDREN'S ADMINISTRATION CHILD CARE SUBSIDY PROGRAMS

#### WAC

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- 388-165-090 Eligibility conditions—Residency and alien status. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-090, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-100 Payment limitations. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-100, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

**Reviser's note:** Chapter 388-165 (Consolidated emergency assistance program—Social services (CEAP-SS)) was repealed by 98-01-125, filed 12/18/98. WSR 99-15-076, filed 7/20/99 reactivated and renamed this chapter.

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

- 388-165-005 Purpose. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-005, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-010 General provisions. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-010, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-020 Application procedure. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-020, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-030 Application form. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-030, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-040 Assistance unit. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-040, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-050 Eligibility conditions—Emergent need. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-050, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

**WAC 388-165-108 What are the types of child care subsidies?** This chapter relates to the following programs:

- (1) Seasonal child care;
- (2) Teen parent child care;
- (3) Child protective services child care;
- (4) Child welfare services child care; and
- (5) Employed foster parent child care.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-108, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-110 Definitions.** The following definitions apply to WAC 388-15-171, 388-15-174, 388-15-175 and 388-15-176.

**"Child"** means a person twelve years of age or younger or a person under nineteen years of age who is physically, mentally, or emotionally incapable of self care as verified by a licensed medical practitioner or masters level or above mental health professional.

**"Co-payment"** means the amount of money the family is responsible to pay the child care provider toward the cost of child care each month.

**"Income"** means the gross earned income minus the average payroll and income tax paid at that income level, plus any unearned income.

**"In-home/relative child care provider"** see definition for **"in-home/relative provider"** under WAC 388-290-020.

**"Parent"** see definition for **"parent"** under WAC 388-290-020.

**"Teen parent"** means a parent twenty-one years of age or younger.

[99-15-076, recodified as § 388-165-110, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and



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

**WAC 388-165-120 Subsidized child care for teen parents.** (1) The department may authorize teen parent child care within available funds for parents who:

- (a) Are twenty-one years of age or younger;
- (b) Are enrolled in an approved secondary education or general equivalency diploma (GED) program;
- (c) Are not receiving a temporary assistance for needy families (TANF) grant; and
- (d) Have an income at or below one hundred seventy-five percent of the Federal Poverty Level (FPL).

(2) All teen parents contribute to the cost of child care by making a monthly co-payment to the child care provider which is:

- (a) Determined by the teen parent's income; and
- (b) Calculated by using the rules under WAC 388-290-090 (2)(a), (b), and (c)(i) and (ii).

(3) The department funds child care only during the portion of the day when the child's parent(s) is unable to provide necessary care and supervision due to the parents participation in DSHS approved activities.

[99-15-076, recodified as § 388-165-120, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-171, filed 10/22/98, effective 11/22/98.]

**WAC 388-165-130 Subsidized child care for seasonal workers.** (1) The department may purchase seasonal child care within available funds for children residing in Washington state where:

(a) Both parents, or the single parent (in the case of the one-parent family), are currently employed or seeking work in agriculturally related work;

(b) Fifty percent or more of the family's annual income is derived from agriculturally related work;

(c) In a two-parent household, the primary wage earner is employed in agricultural work for eleven months or less with any given employer, in the twelve months previous to the time of application;

(d) In a one-parent household, the single parent is employed in agricultural work for eleven months or less with any given employer, in the twelve months previous to the time of application; and

(e) The family's monthly income, averaged for the twelve months prior to the time of application, is at or below one hundred and seventy-five percent of the FPL.

(2) Failure of the parent(s) to meet the requirements of (b) of this subsection due to receipt of TANF within the past twelve months shall not result in ineligibility for seasonal child care.

(3) The parent(s) participates in the cost of child care by making a monthly co-payment to the child care provider which is:

(a) Determined by the parent's income averaged for the twelve months prior to the time of application; and

(b) Calculated by using the rules under WAC 388-290-090 (2)(a), (b), and (c)(i) and (ii).

(4) The department will fund child care during the portion of the day described under WAC 388-15-171(3).

[99-19-087, recodified as § 388-165-130, filed 9/17/99, effective 9/17/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-174, filed 10/22/98, effective 11/22/98.]

**WAC 388-165-140 Child care for child protective services (CPS) and child welfare services (CWS).** The department may purchase CPS/CWS child care within available funds for children of families in need of support as part of a CPS/CWS case plan. This service is short-term and time-limited. Social workers must determine if other resources are available to meet this need before authorizing payment by the department.

[99-15-076, recodified as § 388-165-140, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-175, filed 10/22/98, effective 11/22/98.]

**WAC 388-165-179 When are DSHS child care subsidy rates in this chapter effective?** (1) DSHS child care subsidy rates in this chapter are effective on or after November 1, 1999 when a family:

(a) Has a change that requires their authorization to be updated;

(b) Is newly authorized to receive child care subsidies; or

(c) Is reauthorized to continue receiving child care subsidies.

(2) DSHS child care subsidy rates are authorized at the provider's usual rate or the DSHS maximum child care subsidy rate, whichever is less.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-179, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-180 What are the maximum child care subsidy rates DSHS pays for child care in a licensed or certified child care center?** DSHS pays directly to a licensed or certified child care center, whichever is less:

(1) The provider's usual rate for that child; or

(2) The DSHS maximum child care subsidy rate for that child as listed in the following table.

**DSHS Maximum Child Care Subsidy Rate for Licensed Child Care Centers**

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$22.73	\$19.85	\$18.00	\$16.70
	Half-Day	\$11.36	\$9.93	\$9.00	\$8.35
Region 2	Full-Day	\$23.18	\$20.45	\$17.75	\$16.82
	Half-Day	\$11.59	\$10.23	\$8.88	\$8.41

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 3	Full-Day	\$30.18	\$26.00	\$22.00	\$19.77
	Half-Day	\$15.09	\$13.00	\$11.00	\$9.89
Region 4	Full-Day	\$37.80	\$29.55	\$26.14	\$23.40
	Half-Day	\$18.90	\$14.77	\$13.07	\$11.70
Region 5	Full-Day	\$25.82	\$22.18	\$19.45	\$17.50
	Half-Day	\$12.91	\$11.09	\$9.73	\$8.75
Region 6	Full-Day	\$25.59	\$22.73	\$20.00	\$20.00
	Half-Day	\$12.80	\$11.36	\$10.00	\$10.00

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-180, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-185 What are the maximum child care subsidy rates DSHS pays for child care in a licensed or certified family child care home?** DSHS pays directly to a licensed or certified family child care provider, whichever is less:

(1) The provider's usual rate for that child; or

(2) The DSHS maximum child care subsidy rate for that child as listed in the following table.

**DSHS Maximum Child Care Subsidy Rate for Licensed Family Child Care Homes**

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$19.00	\$17.60	\$17.00	\$15.00
	Half-Day	\$9.50	\$8.80	\$8.50	\$7.50
Region 2	Full-Day	\$18.00	\$18.00	\$16.00	\$15.00
	Half-Day	\$9.00	\$9.00	\$8.00	\$7.50
Region 3	Full-Day	\$28.00	\$24.00	\$22.00	\$20.00
	Half-Day	\$14.00	\$12.00	\$11.00	\$10.00
Region 4	Full-Day	\$30.00	\$27.27	\$25.00	\$22.50
	Half-Day	\$15.00	\$13.64	\$12.50	\$11.25
Region 5	Full-Day	\$21.00	\$20.00	\$19.00	\$17.00
	Half-Day	\$10.50	\$10.00	\$9.50	\$8.50
Region 6	Full-Day	\$20.50	\$20.00	\$18.00	\$17.00
	Half-Day	\$10.25	\$10.00	\$9.00	\$8.50

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-185, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-190 When can DSHS pay in addition to the maximum DSHS child care subsidy rate?** DSHS pays additional subsidies to a licensed or certified family child care home or center when:

(1) Care is for nonstandard hours (see WAC 388-165-195 and 388-165-200);

(2) The infant bonus is authorized (see WAC 388-165-205);

(3) A child has a documented special need(s) (see WAC 388-165-210, 388-165-215, or 388-165-220); or

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(4) Care is not available at the DSHS rate and the provider's usual rate is authorized.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-190, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-195 What is nonstandard hour child care?** DSHS authorizes nonstandard hour child care when fifteen or more hours of care are needed per month, that are:

(1) Before 6:00 a.m. or after 6:00 p.m. Monday through Friday; and/or

(2) Anytime on Saturday or Sunday.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-195, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-200 How does DSHS pay for non-standard hour child care?** DSHS authorizes the nonstandard hour bonus to licensed or certified child care providers, DSHS pays:

(1) The DSHS maximum child care subsidy rate as listed in WAC 388-165-180 or 388-165-185 or the provider's usual rate for that child, whichever is less; and

(2) The monthly nonstandard hour bonus as listed in the table below.

**Monthly Nonstandard Hour Bonus**

Region 1	\$74.00
Region 2	\$73.00
Region 3	\$91.00
Region 4	\$108.00
Region 5	\$80.00
Region 6	\$83.00

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-200, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-205 Does DSHS pay a bonus for infants who receive child care subsidies?** DSHS child care subsidy programs pay a two hundred and fifty dollar infant bonus directly to the licensed or certified family child care home or center if:

(1) The child care facility has not already received a bonus for that infant;

(2) The infant was first enrolled in the child care facility after August 30, 1998;

(3) The infant is less than one year old; and

(4) The provider cares for the infant a total of five or more days before the child's first birthday.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-205, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-210 How does DSHS determine that a child qualifies for a special needs rate?** To qualify for the DSHS child care programs special needs subsidy rate the child must:

(1) Be under nineteen years old;

(2) Have a verified physical, mental, emotional, or behavioral condition that requires a higher level of care; and

(3) Have their condition and need for higher level of care verified by a health, mental health, or education professional with at least a master's degree.

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[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-210, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-215 What is the DSHS child care subsidy rate for children with special needs in a licensed or certified child care center?** DSHS pays child care subsidies for a child with special needs to licensed or certified child care centers as described in WAC 388-165-180 and whichever of the following is greater:

- (1) The provider's documented additional cost associated with the care of that child with special needs; or
- (2) The rate listed in the table below.

**Licensed Child Care Centers Special Needs Rate**

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$6.82	\$5.96	\$5.40	\$5.01
	Half-Day	\$3.41	\$2.98	\$2.70	\$2.51
Region 2	Full-Day	\$6.95	\$6.14	\$5.33	\$5.05
	Half-Day	\$3.48	\$3.07	\$2.66	\$2.52
Region 3	Full-Day	\$9.05	\$7.80	\$6.60	\$5.93
	Half-Day	\$4.53	\$3.90	\$3.30	\$2.97
Region 4	Full-Day	\$11.34	\$8.86	\$7.84	\$7.02
	Half-Day	\$5.67	\$4.43	\$3.92	\$3.51
Region 5	Full-Day	\$7.75	\$6.65	\$5.84	\$5.25
	Half-Day	\$3.87	\$3.33	\$2.92	\$2.63
Region 6	Full-Day	\$7.68	\$6.82	\$6.00	\$6.00
	Half-Day	\$3.84	\$3.41	\$3.00	\$3.00

- (3) The maximum rate paid for a five year old child is:
  - (a) The preschool rate for a child who has not entered kindergarten; or
  - (b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-215, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-220 What is the DSHS child care subsidy rate for children with special needs in a licensed or certified family child care home?** DSHS pays child care subsidies for a child with special needs to licensed or certified family child care homes as described in WAC 388-165-195 and whichever of the following is greater:

- (1) The provider's documented additional cost associated with the care of that child with special needs; or
- (2) The rate listed in the table below.

**Licensed Family Child Care Homes Special Needs Bonus**

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$5.70	\$5.28	\$5.10	\$4.50
	Half-Day	\$2.85	\$2.64	\$2.55	\$2.25
Region 2	Full-Day	\$5.40	\$5.40	\$4.80	\$4.50
	Half-Day	\$2.70	\$2.70	\$2.40	\$2.25
Region 3	Full-Day	\$8.40	\$7.20	\$6.60	\$6.00
	Half-Day	\$4.20	\$3.60	\$3.30	\$3.00
Region 4	Full-Day	\$9.00	\$8.18	\$7.50	\$6.75
	Half-Day	\$4.50	\$4.09	\$3.75	\$3.38
Region 5	Full-Day	\$6.30	\$6.00	\$5.70	\$5.10
	Half-Day	\$3.15	\$3.00	\$2.85	\$2.55
Region 6	Full-Day	\$6.15	\$6.00	\$5.40	\$5.10
	Half-Day	\$3.08	\$3.00	\$2.70	\$2.55

[Title 388 WAC—p. 630]

- (3) The maximum rate paid for a five year old child is:
  - (a) The preschool rate for a child who has not entered kindergarten; or
  - (b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-220, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-225 What is the DSHS in-home/relative child care rate for children with special need?** DSHS subsidy programs pay in-home/relative child care providers for care of a child with special needs (as described in WAC 388-15-185) two dollars per hour plus whichever is greater of the following:

- (1) Sixty-two cents per hour; or
- (2) The provider's documented additional cost associated with the care for that child with special needs.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-225, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-230 What is the maximum child care subsidy rate DSHS pays for in-home/relative child care?**

(1) The DSHS child care subsidy programs pay toward the cost of child care directly to the parent, who is the employer. DSHS pays whichever of the following that is less:

- (a) Two dollars and six cents per hours for the child who needs the greatest amount of care and one dollar and three cents per hour for the care of each additional child in the family; or
- (b) The provider's usual rate for that care.
- (2) DSHS may pay above the maximum rate for children who have special needs as stated in WAC 388-165-225.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-230, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-235 In-home/relative child care.** (1)

When the parent(s) chooses in-home/relative child care, the parent(s) will give the in-home/relative child care provider's name and address to the department and make the following assurances at the time child care is authorized:

- (a) The in-home/relative provider is:
  - (i) Eighteen years of age or older;
  - (ii) Of sufficient physical, emotional, and mental health to meet the needs of the child in care. If requested by the department, the parent(s) must provide written evidence that the in-home child care provider of the parent's choice is of sufficient physical, emotional, and mental health to be a safe child care provider;
  - (iii) Able to work with the child without using corporal punishment or psychological abuse;
  - (iv) Able to accept and follow instructions;
  - (v) Able to maintain personal cleanliness; and
  - (vi) Prompt and regular in job attendance.

(b) The child is current on the immunization schedule as described in the National Immunization Guidelines, developed by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices;

(c) The home where care is provided is safe for the care of the child; and

(d) The in-home/relative child care provider is informed about basic health practices, prevention and control of infectious disease, immunizations, and home and physical premises safety relevant to the care of the child.

(2) The in-home/relative child care provider's primary function while on duty is to provide child care. The in-home/relative child care provider will have the following responsibilities:

(a) Provide constant care and supervision of the child for whom the provider is responsible throughout the arranged time of care in accordance with the needs of the child; and

(b) Provide developmentally appropriate activities for the child who is under the in-home/relative child care provider's care.

(3) The department provides the parent(s) with information about basic health practices, prevention and control of infectious diseases, immunizations, and building and physical premises safety relevant to the care of the child.

[99-15-076, recodified as § 388-165-235, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-176, filed 10/22/98, effective 11/22/98.]

**WAC 388-165-240 What are the parent/guardian payment responsibilities when they choose in-home/relative child care?** The parent is the employer of the in-home/relative provider. The parent:

(1) Pays the provider the entire amount that DSHS gives them toward the cost of care;

(2) Pays the provider the amount that was authorized for a co-payment;

(3) Requires the in-home/relative provider to sign a receipt when they receive payment;

(4) Keeps the receipts for DSHS to review at the next eligibility determination; and

(5) Keeps accurate attendance records.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-240, filed 10/22/99, effective 11/22/99.]

**WAC 388-165-245 What is the responsibility of DSHS regarding child care subsidies for in-home/relative child care?** (1) On all payments DSHS makes toward the cost of in-home/relative child care, DSHS pays the employer's share of:

(a) Social Security taxes;

(b) Medicare taxes;

(c) Federal Unemployment Taxes (FUTA); and

(d) State unemployment taxes (SUTA) when applicable.

(2) On all payments DSHS makes toward the cost of in-home/relative child care DSHS withholds the following taxes:

(a) Social security taxes up to the wage base limit; and

(b) Medicare taxes.

(3) If an in-home/relative child care provider receives less than one thousand one hundred dollars per family in a calendar year, DSHS refunds all withheld taxes to the provider.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-245, filed 10/22/99, effective 11/22/99.]

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**WAC 388-165-250 When can DSHS pay toward the cost of in-home/relative child care provided outside the child's home?** DSHS will pay toward the cost of child care provided in the relative's home by the following adult relative of the child:

(1) Siblings and stepsiblings living outside the child's home;

(2) Grandparents;

(3) Aunts;

(4) Uncles;

(5) First cousins;

(6) Great grandparents;

(7) Great aunts;

(8) Great uncles; and

(9) Extended family members as determined by law or custom of the Indian child's tribe.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-250, filed 10/22/99, effective 11/22/99.]

## Chapter 388-200 WAC

### FINANCIAL AND MEDICAL ASSISTANCE— GENERAL PROVISIONS

#### WAC

388-200-1250 Gifts, bequests by will, and contributions.

#### 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.

388-200-1100 Grievance procedure. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1100, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1100, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-389.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-200-1150 Exception to rule. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1150, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-20-010.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-200-1160 Notification of exception to rule request and decision. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1160, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-23-387.] Repealed by 00-03-035, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035.

388-200-1200 Translation of written communications with a limited English proficient client. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1200, filed 5/3/94, effective 6/3/94. Formerly WAC 388-38-045.] Repealed by 03-01-115, filed 12/18/02, effective 1/18/03. Statutory Authority: RCW 74.04.025 and

- 74.08.090. Later promulgation, see chapter 388-271 WAC.
- 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.
- 388-200-1400 Application of rules—Temporary assistance to needy families. [Statutory Authority: RCW 74.08.090, 74.04.050, 70.04.055 and Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, § 103). 97-07-008, § 388-200-1400, filed 3/10/97, effective 4/10/97.] Repealed by 00-22-063, filed 10/27/00, effective 11/27/00. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.04.055.

**WAC 388-200-1250 Gifts, bequests by will, and contributions.** (1) The department may accept a gift, bequest, or contributions in cash, or otherwise, from an association or corporation.

(2) The department shall not accept a gift or contribution from a person applying for, or receiving, public assistance.

(3) The department shall not advise any person desiring information or assistance regarding the preparation of a will. The department shall advise the person to contact an attorney, or the local legal aid society.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1250, filed 5/3/94, effective 6/3/94.]

### Chapter 388-271 WAC

#### LIMITED ENGLISH PROFICIENT SERVICES

##### WAC

- 388-271-0010 What are limited English proficient (LEP) services?
- 388-271-0020 What are the department's responsibilities in providing me with an interpreter?
- 388-271-0030 What are the department's responsibilities in providing me with written communication in my primary language?

**WAC 388-271-0010 What are limited English proficient (LEP) services?** (1) The department provides limited English proficient (LEP) services to you if you are limited in your ability to read, write and/or speak English. These services provide a way for us to communicate with you even though you are limited in your ability to communicate in English. LEP services are provided in your primary language by authorized bilingual workers or by contracted interpreters and translators. Your primary language is the language you have indicated on your application or your eligibility review as the language you wish to communicate in with the department.

(2) LEP services include:

(a) Interpreter (verbal) services in person and/or over the telephone; and

(b) Translation of department forms, letters and other printed materials.

[Statutory Authority: RCW 74.04.025 and 74.08.090. 03-01-115, § 388-271-0010, filed 12/18/02, effective 1/18/03.]

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**WAC 388-271-0020 What are the department's responsibilities in providing me with an interpreter?** (1) If you have trouble speaking and/or understanding English, and a bilingual worker is not available to assist you, we get a qualified interpreter in your primary language to help you communicate verbally with us. A qualified interpreter is someone who is fluent in English and your primary language and is trained on the Interpreter Code of Professional Conduct.

(2) Interpreter services are provided in-person or over the telephone.

(3) We pay for the interpreter. You do not have to pay anything.

(4) If a worker from our department feels that they are not able to communicate with you well enough to provide adequate services, they may request the services of an interpreter even if you did not ask for help.

(5) We will provide interpreter services to you in a timely manner so that we can process your case within the processing timeframes defined in chapters 388-406, 388-418, and 388-434 WAC.

[Statutory Authority: RCW 74.04.025 and 74.08.090. 03-01-115, § 388-271-0020, filed 12/18/02, effective 1/18/03.]

**WAC 388-271-0030 What are the department's responsibilities in providing me with written communication in my primary language?** (1) We provide fully translated written communication in your primary language. This includes, but is not limited to:

(a) Department pamphlets, brochures and other informational material that describe department services and client rights and responsibilities;

(b) Department forms, including applications and individual responsibility plans, that we ask you to complete and/or sign; and

(c) Department letters as described in chapter 388-458 WAC.

(2) We pay for the written translation. You do not have to pay anything.

(3) We will provide translated documents to you in a timely manner so that we can process your case within the processing timeframes defined in chapters 388-406, 388-418, and 388-434 WAC.

[Statutory Authority: RCW 74.04.025 and 74.08.090. 03-01-115, § 388-271-0030, filed 12/18/02, effective 1/18/03.]

### Chapter 388-273 WAC

#### WASHINGTON TELEPHONE ASSISTANCE PROGRAM

(Formerly chapter 388-31 WAC)

##### WAC

- 388-273-0010 Purpose of the Washington telephone assistance program.
- 388-273-0020 Who may receive WTAP?
- 388-273-0025 Benefits you receive as a WTAP participant.
- 388-273-0030 How you can apply for WTAP.
- 388-273-0035 What we reimburse the local telephone company.

**WAC 388-273-0010 Purpose of the Washington telephone assistance program.** The Washington telephone

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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?** (1) To receive WTAP benefits, you must:

- (a) Be age eighteen or older or, if under eighteen, be the responsible head of household, and either;
- (b) Be receiving one of the following programs from us:
  - (i) Temporary assistance for needy families (TANF);
  - (ii) State family assistance (SFA);
  - (iii) General assistance;
  - (iv) Refugee assistance;
  - (v) Food assistance;
  - (vi) State Supplemental Security Income (SSI);
  - (vii) Medical assistance, including Medicare cost sharing programs;
  - (viii) Community options program entry system (COPEs);
  - (ix) Chore services; or
- (c) Have completed using community service voice mail services, and been identified to the department as eligible for WTAP by the community agency that provided your community service voice mail program; and

(2) Apply to a local exchange company for WTAP and request the lowest available flat rate telephone service at the WTAP rate. In exchange areas where wireline service is not available without service extension, you may apply to a wireless carrier:

(a) "**Local exchange company**" means a telephone company that is required by the Washington utilities and transportation commission to offer WTAP benefits and offers local calling, i.e., calling without long distance charges.

(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; and

(3) You must have the local telephone service billed in your name.

[Statutory Authority: RCW 74.08.090, 80.36.440, 2002 c 104, 02-18-106, § 388-273-0020, filed 9/3/02, effective 10/4/02. 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.

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(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, except if you qualified for telephone assistance through using the community services voice mail programs, you will receive one additional service year of benefits.

(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, 2002 c 104, 02-18-106, § 388-273-0025, filed 9/3/02, effective 10/4/02. 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.]

[Title 388 WAC—p. 633]



## Chapter 388-280 WAC

## UNITED STATES REPATRIATION PROGRAM

## WAC

388-280-0010	What is the United States Repatriation Program?
388-280-0020	How do I apply for repatriation assistance?
388-280-0030	Do I have to repay the repatriation assistance?
388-280-0040	Are there limits to my income and resources?
388-280-0050	How long can I receive repatriation assistance?
388-280-0060	What services are available to me under the repatriation program?

DISPOSITION OF SECTIONS FORMERLY  
CODIFIED IN THIS CHAPTER

388-280-1010	Purpose. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1010, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1020	Definition. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1020, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1030	Application. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1030, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1040	Repaying repatriation assistance. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1040, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1050	Safeguarding information. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1050, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1060	Referral to other agencies. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1060, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1070	Income and resources. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1070, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1080	Eligibility. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1080, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1090	Client responsibilities. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1090, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1100	Department responsibilities as the port of entry state. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1100, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1110	Department responsibilities as the final destination state. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1110, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1120	Unattended minors. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1120, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1130	Scope of services. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1130, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1140	Time limits on benefits. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1140, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-

077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1150 Payment limits. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1150, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1160 Assistance payment—Types of payments. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1160, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

**WAC 388-280-0010 What is the United States Repatriation Program?** The United States Repatriation Program assists a U.S. citizen or dependent who is:

- (1) Without financial resources; and
- (2) Returned or brought back to the U.S. from a foreign country because of:
  - (a) Mental illness; or
  - (b) Destitution, physical illness, or a crisis such as war.

For the purposes of this chapter, "we" and "us" means the department of social and health services.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0010, filed 9/19/00, effective 11/1/00.]

**WAC 388-280-0020 How do I apply for repatriation assistance?** You apply for repatriation assistance by contacting the U.S. State Department or us.

- (1) If you contact the U.S. State Department, we consider a referral from them as an approved application.
- (2) If you contact us directly, we apply for you to the U.S. Department of Health and Human Services (HHS).

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0020, filed 9/19/00, effective 11/1/00.]

**WAC 388-280-0030 Do I have to repay the repatriation assistance?** Repatriation assistance is a loan. You, or your representative if you are mentally ill, must:

- (1) Sign a statement recognizing repatriation assistance as a loan; and
- (2) Agree to repay the funds.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0030, filed 9/19/00, effective 11/1/00.]

**WAC 388-280-0040 Are there limits to my income and resources?** (1) You are ineligible to receive repatriate assistance if you have nonexempt:

- (a) Income, as defined by temporary assistance for needy families (TANF) equal to or greater than the TANF need standards as described in WAC 388-450-0005; or
  - (b) Resources, as defined by TANF under WAC 388-470-0005 that are available to meet your resettlement needs.
- (2) We consider a resource available to you when:
- (a) The value can be determined;
  - (b) It is controlled by you; and
  - (c) You can use the resource to meet your needs.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0040, filed 9/19/00, effective 11/1/00.]

**WAC 388-280-0050 How long can I receive repatriation assistance?** (1) If you are mentally ill, you receive temporary care until you:

(a) Can be released to the care of a relative or state agency; or

(b) Are discharged or granted release from hospitalization.

(2) If you are not mentally ill, you may receive repatriation assistance up to twelve months as follows:

(a) "Temporary assistance" meaning repatriation assistance provided during the first ninety days after you return to the United States.

(b) "Extended assistance" meaning repatriation assistance provided for up to nine months after the end of your temporary assistance. We must have approval in advance from HHS, so you must ask us to apply for extended assistance while receiving temporary assistance and be:

(i) Ineligible for any other assistance program; and

(ii) Unable to support or care for yourself due to age, illness, or lack of job skills.

[Statutory Authority: RCW 74.08.090, 00-19-077, § 388-280-0050, filed 9/19/00, effective 11/1/00.]

**WAC 388-280-0060 What services are available to me under the repatriation program?** (1) The HHS sets limits on how much we pay for repatriation assistance. The limits are:

(a) The temporary assistance for needy families (TANF) payment standards under WAC 388-478-0015 for goods and services to meet basic needs;

(b) Up to five hundred sixty dollars per person to meet resettlement costs, if necessary, and for only one month while you receive temporary assistance.

(2) Within payment limits, repatriation assistance includes:

(a) Travel to your place of residence, limited to:

(i) One domestic trip at the lowest fare and using the most direct means;

(ii) Meals and lodging while you are traveling;

(iii) Money for incidentals; and

(iv) If you are ill or disabled, travel expenses for an escort.

(b) Goods and services necessary for your health and welfare, including:

(i) Transportation for medical treatment, hospitalization or social services;

(ii) Temporary shelter;

(iii) Meals;

(iv) Clothing;

(v) Hospitalization to treat mental or acute illness or other medical care; and

(vi) Guidance, counseling and other social services.

(c) Resettlement costs, including:

(i) Utility or housing deposits; and

(ii) Basic household goods, such as cookware or blankets.

[Statutory Authority: RCW 74.08.090, 00-19-077, § 388-280-0060, filed 9/19/00, effective 11/1/00.]

**Chapter 388-290 WAC**

**WORKING CONNECTIONS CHILD CARE**

**WAC**

388-290-0001	What is the purpose of the working connections child care program?
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388-290-0010	What makes me eligible for WCCC benefits?
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388-290-0035	What responsibilities does the WCCC program staff have?
388-290-0040	If I receive a temporary assistance for needy families (TANF) grant, what activities must I be involved in to be eligible for WCCC benefits?
388-290-0045	If I don't get a temporary assistance for needy families (TANF) grant, what activities must I be involved in to be eligible for WCCC benefits?
388-290-0050	If I am self-employed, can I get WCCC benefits?
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388-290-0060	What income is counted when determining WCCC eligibility and copayments?
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388-290-0070	What income types and deductions are not counted when figuring my income eligibility and for WCCC benefits?
388-290-0075	What are the steps the WCCC program takes to determine my family's WCCC eligibility and copayment amount?
388-290-0080	When does the WCCC program determine and review my eligibility and copayments?
388-290-0085	When might my WCCC copayment change?
388-290-0090	When do I pay the minimum copayment?
388-290-0095	If I receive temporary assistance for needy families (TANF) and I am determined eligible for WCCC, when do my benefits begin?
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?
388-290-0105	What is the process for my WCCC review for reauthorization of my WCCC benefits?
388-290-0110	What circumstances might affect my on-going eligibility for the WCCC benefits and when might I be eligible again?
388-290-0115	When does the WCCC program provide me with advance and adequate notice of payment changes?
388-290-0120	When doesn't advance and adequate notice of payment changes apply to me?
388-290-0125	What child care providers can I choose under the WCCC program?
388-290-0130	What in-home/relative providers can I choose under the WCCC program?
388-290-0135	When I choose an in-home/relative provider, what information must I submit to receive WCCC benefits?
388-290-0140	When does the WCCC program not pay for the cost of in-home/relative child care?
388-290-0143	Who must have a background check for the WCCC program and how often is the check done?
388-290-0145	Why is a background check required and will I be notified of the results?
388-290-0150	What information is included in the background check and where does it come from?
388-290-0155	What happens after we receive the background information?
388-290-0160	What convictions permanently disqualify my in-home/relative provider from being authorized by us?
388-290-0165	Is there other background information or convictions that will disqualify my in-home/relative provider?
388-290-0167	What happens if my in-home/relative provider, who provides care in their home, is disqualified based solely on the disqualifying background of an individual living with that provider?
388-290-0180	When are the WCCC program subsidy rates in this chapter effective?

388-290-0185	How does the WCCC program set rates when my child is five years old?		290-025, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-0190	What does the WCCC program pay for and when can the program pay more?		
388-290-0200	What daily rates does DSHS pay for child care in a licensed or certified child care center or DSHS contracted seasonal day camps?	388-290-030	Responsibilities for the department, the consumer, and the provider under the subsidized child care program. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-030, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-0205	What daily rates does DSHS pay for child care in a licensed or certified family child care home?		
388-290-0210	When can the WCCC program authorize the nonstandard hour child care bonus?		
388-290-0220	How does DSHS determine that my child qualifies for a special needs daily rate?		
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 or DSHS contracted seasonal day camp?	388-290-035	Providers eligible for payment under the subsidized child care program. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-035, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-035, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-0230	What is the DSHS child care subsidy daily rate for children with special needs in a licensed or certified family child care home?		
388-290-0235	What is the DSHS in-home/relative child care daily rate for children with special needs?		
388-290-0240	What is the DSHS child care subsidy rate for in-home/relative child care and how is it paid?		
388-290-0245	When can the WCCC program authorize payment of fees for registration?	388-290-040	Assurances and responsibilities under JOBS, income assistance, and transitional child care. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-040, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
388-290-0250	When can WCCC pay a bonus for enrolling an infant?		
388-290-0255	When can the WCCC program establish a protective payee to pay my in-home/relative provider?		
388-290-0260	Do I have the right to ask for a hearing about my WCCC benefits and how do I ask for one?		
388-290-0265	When can I get WCCC benefits pending the outcome of a hearing?	388-290-050	Eligible children and consumers under the subsidized child care program. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-050, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-050, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-0270	What is a WCCC overpayment and when might I have one?		
<b>DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER</b>			
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).	388-290-055	Payment for subsidized child care. [Statutory Authority: RCW 74.04.050. 98-21-005, § 388-290-055, filed 10/9/98, effective 11/9/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-055, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-015	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).	388-290-060	Adequate notice requirements and effective dates. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-060, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-020	Subsidized child care—Definitions. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-020, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-020, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-020, filed 11/8/95, effective 12/9/95.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.	388-290-070	Self-employment and subsidized child care. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-070, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-025	Subsidy units and copayments. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-025, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-	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).
		388-290-080	Subsidized child care—Fair hearings. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-080, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
		388-290-090	Subsidized child care—Income eligibility, copayments rates, and when to calculate copayments. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-

- 290-090, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-090, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-105 Subsidized child care—Overpayments. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-105, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-110 JOBS, income assistance, and transitional child care programs. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-110, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-115 JOBS, income assistance, and transitional child care programs—Eligible children and recipients. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-115, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-120 JOBS, income assistance, and transitional child care program—Payment. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-120, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-123 JOBS, income assistance, and transitional child care programs—Effective dates. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-123, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-125 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).
- 388-290-130 Income assistance and transitional child care programs—Effect on eligibility and payments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-130, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-135 JOBS, income assistance, and transitional child care—Hearings. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 96-09-058 (Order 3965), § 388-290-135, filed 4/12/96, effective 5/13/96; 95-23-028 (Order 3916), § 388-290-135, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-140 Income assistance child care program—Conversion. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-140, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-150 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).
- 388-290-155 Transitional child care—Purpose and initial eligibility. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-155, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-160 Transitional child care—Co-payment. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-160, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-170 Transitional child care—Ongoing eligibility. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-170, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-180 Child care overpayments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-180, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-200 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).
- 388-290-210 Other supportive services. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-210, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-250 Transitional supportive services. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-250, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-260 Supportive services overpayments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-260, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
- 388-290-270 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).
- 388-290-550 How does the department figure my adjusted earned income? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-550, filed 6/28/99, effective 7/1/99.] Repealed by 00-17-005, filed 8/2/00, effective 9/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule).
- 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 74.15.020. 00-16-100, § 388-290-870, 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).
- 388-290-874 Will I be notified of the results of the criminal background information on my in-home/relative provider? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-874, filed 8/1/00, effective 8/2/00.] 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).

- 388-290-878 Can I still use my chosen in-home/relative provider to care for my child(ren) if the provider has been convicted of a disqualifying crime? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-878, filed 8/1/00, effective 8/2/00.] 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).
- 388-290-882 What convictions permanently disqualify my in-home/relative provider from being authorized by WCCC? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-882, filed 8/1/00, effective 8/2/00.] 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).
- 388-290-886 Are there some crimes that require a set amount of time to pass before my in-home/relative provider may be authorized for WCCC? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-886, filed 8/1/00, effective 8/2/00.] 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).
- 388-290-888 When can I ask the department to review the decision to deny authorization of my in-home/relative provider? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-888, filed 8/1/00, effective 8/2/00.] 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).
- 388-290-900 When can the department establish a protective payee to pay my in-home/relative provider? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-900, 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).
- 388-290-905 What responsibilities does the department have under the WCCC program? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-905, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-905, filed 6/28/99, effective 7/1/99.] 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).
- 388-290-910 What responsibilities do I have under the WCCC program? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-910, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-910, filed 6/28/99, effective 7/1/99.] 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).
- 388-290-915 When do WCCC payments start? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-915, filed 6/28/99, effective 7/1/99.] 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).
- 388-290-920 When does the department provide me with advance and adequate notice of WCCC payment changes? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-920, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-920, filed 6/28/99, effective 7/1/99.] 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).
- 388-290-925 When don't advance and adequate notice rules apply? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-925, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-925, 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).
- 388-290-930 Under what circumstances does my eligibility for WCCC end? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-930, 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).
- 388-290-935 When might I be eligible for WCCC again? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-935, filed 6/28/99, effective 7/1/99.] 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).
- 388-290-940 Do I have the right to request a hearing? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-940, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-940, filed 6/28/99, effective 7/1/99.] 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).
- 388-290-945 Can I receive WCCC pending the outcome of a hearing? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-945, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-945, filed 6/28/99, effective 7/1/99.] 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).
- 388-290-950 When does the department collect overpayments? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-950, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-950, filed 6/28/99, effective 7/1/99.] 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).

**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?** For the purposes of this chapter "we" and "us" refer to the department of social and health services. You may be eligible for WCCC benefits if:

- (1) Your family is described under WAC 388-290-0015;
- (2) You are 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 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, 74.13.085. 02-14-067, § 388-290-0010, filed 6/27/02, effective 8/1/02. 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 for eligibility?** We determine your family size by reviewing those individuals who live together in the same household as follows:

<b>(1) If you are:</b>	<b>We count the following individuals as part of the family for WCCC eligibility:</b>
(a) A single parent, including a minor parent living independently;	You and your children.
(b) Unmarried parents who 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;	Parents and children, documented and undocumented, as long as the child needing care is a U.S. citizen or legally residing in the United States. All other family rules in this section apply.
(f) A consumer as defined in WAC 388-290-0005 (2)(c) through (i) and you are not financially responsible for the children;	Only the children are counted as the WCCC family. The children and their income are counted.
(g) A minor parent with children and live with a parent/guardian;	Only the minor parent and their children.
(h) A family member who is out of the household because of employment requirements, such as the military or training.	The absent individual, the children, and the other parent if it is a two-parent family. All other family rules in this section apply.
<b>(2) If your household includes:</b>	<b>We count the following individuals as part of the family for WCCC eligibility:</b>
(a) Eighteen year old siblings of the children requiring care who are enrolled in secondary education or general equivalency diploma (GED) program.	The eighteen year olds (unless they are a parent themselves), until they turn nineteen or complete high school/GED, whichever comes first. All other family rules in this section apply.
(b) Siblings of the children requiring care who are up to twenty-one years of age and who are participating in 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). All other family rules in this section apply.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0015, filed 5/31/02, effective 7/1/02. 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 Are there special circumstances that might affect my WCCC eligibility?** (1) You might be eligible for WCCC if you are:

- (a) An employee of the same child care facility where your children are receiving care and you do not provide direct care to your own children 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 children while the other is working, looking for work, or preparing for work;
- (i) "Able" means physically and mentally capable of caring for a child in a responsible manner.

(ii) "Available" means able to provide care when not participating in an approved work activity under WAC 388-290-0040, 388-290-0045, or 388-290-0050 during the time child care is needed.

(d) A married consumer described under WAC 388-290-0005 (1)(d) through (i). Only you or the other parent 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 children are legally residing in the country and are:

- (a) Less than thirteen years of age; or
- (b) Less than age nineteen, and:

(i) Have a verified special need, according to WAC 388-290-0220; or

(ii) Are under court supervision.

[Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0020, filed 5/31/02, effective 7/1/02. 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:

(2003 Ed.)

(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.

(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).

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(6) Respond to you within ten days if you report a change of circumstance that affects your WCCC eligibility or copayment; and

(7) Provide prompt child care payments to your child care provider.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0035, filed 5/31/02, effective 7/1/02. 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, what activities must I be involved in to 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) An approved WorkFirst activity under WAC 388-310-0200;

(2) Employment or self-employment. We consider "employment" or "work" to mean engaging in any legal, income generating activity that is taxable under the United States Tax Code or that would be taxable with or without a treaty between an Indian Nation and the United States;

(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 approved classes; 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, 74.13.085. 02-12-069, § 388-290-0040, filed 5/31/02, effective 7/1/02. 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, what activities must I be involved in to 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. We consider "employment" or "work" to mean engaging in any legal, income generating activity that is taxable under the United States Tax Code or that would be taxable with or without a treaty between an Indian Nation and the United States;

(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, 388-310-1050, 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, 74.13.085. 02-12-069, § 388-290-0045, filed 5/31/02, effective 7/1/02. 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 If I am self-employed, can I get WCCC benefits?** 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 WAC 388-310-1700; 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, 74.13.085. 02-12-069, § 388-290-0050, filed 5/31/02, effective 7/1/02. 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 If I am not working or in an approved activity right now, can I get WCCC benefits?**

(1) We can authorize WCCC payments for a child's attendance in child care 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 a child's attendance in child care 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, 74.13.085. 02-12-069, § 388-290-0055, filed 5/31/02, effective 7/1/02. 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.]

(2003 Ed.)

**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 determine my family's WCCC eligibility and copayment amount?** The WCCC program takes the following steps to determine 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	\$15
Above 82% of the FPL up to 137.5% of the FPL	\$25
Above 137.5% of the FPL - 200% of the FPL	The dollar amount equal to subtracting 137.5% of FPL from countable income, multiplying by 44%, then adding \$25
Income above 200% of the FPL, you are not eligible for WCCC benefits.	

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-067, § 388-290-0075, filed 6/27/02, effective 8/1/02. 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

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(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 percent of the FPL, and:

- (a) Your monthly countable income increases; or
- (b) Your family size decreases.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-067, § 388-290-0085, filed 6/27/02, effective 8/1/02. 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 If 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 are participating in an approved activity under WAC 388-290-0040.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0095, filed 5/31/02, effective 7/1/02. 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 388-290-0100 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

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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. We determine 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 begins when:

- (i) You are participating in 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 you:

(i) Application is date stamped as received or entered into our automated system as received;

(ii) Eligible provider (under WAC 388-290-0125) is caring for your child;; and

(iii) Participation in an approved activity has started.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0105, filed 5/31/02, effective 7/1/02. 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?** We do not give you advance and adequate notice in the following circumstances:

(1) You tell us you no longer want WCCC;

(2) Your whereabouts are unknown to us;

(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) We determine your in-home/relative provider:

(a) Is not of suitable character and competence;

(b) May cause a risk of harm to your children based on the provider's physical 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, 74.13.085. 02-12-069, § 388-290-0120, filed 5/31/02, effective 7/1/02. 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.]

(2003 Ed.)

**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. We pay the lesser of the following to qualified 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 us, such as:

(a) Tribal child care facilities that meet the requirements of tribal law;

(b) Child care facilities on a military installation; and

(c) Child care facilities operated on public school property by a school district.

(4) Seasonal day camps that have a contract with us to provide subsidized child care and are:

(a) Of a duration of three months or less;

(b) Engaged primarily in recreational or educational activities; and

(c) Accredited by the American Camping Association (ACA).

(5) An in-home/relative provider meeting the requirements in WAC 388-290-0130.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0125, filed 5/31/02, effective 7/1/02. 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:

(a) Be a U.S. citizen or legally residing in the country;

(b) Meet the requirements in WAC 388-290-0135;

(c) Complete and submit a criminal background inquiry form prescribed by us; and

(d) Be one of the following adult relatives providing care in the home of either the child or the relative:

(i) An adult sibling living outside the child's home;

(ii) An extended tribal family member under chapter 74.15 RCW; or

(iii) A grandparent, aunt, uncle, or great-grandparent, great-aunt or great-uncle.

(2) A nonrelative provider may be an adult friend or neighbor and must provide care in the child's own home.

(3) The in-home/relative provider may not be:

(a) The child's biological, adoptive or step-parent;

(b) The child's legal guardian or the guardian's spouse; or

(c) Another adult acting in loco parentis or that adult's spouse.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0130, filed 5/31/02, effective 7/1/02. 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.]

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**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;

(2) A copy of the provider's valid Social Security card and photo identification to us;

(3) A completed background inquiry application; and

(4) A completed form that makes the following assurances:

(a) The provider is:

(i) Of suitable character and competence;

(ii) Of sufficient physical and mental health to meet the needs of the children in care. If requested by us, you must provide written evidence that the in-home child care provider of your choice is of sufficient physical and mental health to be a safe child care provider;

(iii) Able to work with the children 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 children are 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 children;

(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 children; and

(e) You have instructed the in-home/relative child care provider that they will have the following responsibilities:

(i) Provide constant care and supervision of the children throughout the arranged time of care in accordance with the needs of the children; and

(ii) Provide developmentally appropriate activities for the children.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0135, filed 5/31/02, effective 7/1/02. 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 pro-

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vider, 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 388-290-0143 Who must have a background check for the WCCC program and how often is the check done?** (1) A background check must be completed for:

(a) All in-home/relative providers who apply to care for a WCCC consumer's child; and

(b) Any individual sixteen years of age or older who is residing with a provider when care occurs outside of the WCCC child's home.

(2) A new background check must be completed:

(a) At least every two years;

(b) Any time an in-home/relative provider applies to provide care for a WCCC family;

(c) For any individual sixteen years of age or older newly residing with a provider when care occurs outside of the WCCC child's home; or

(d) When we have a valid reason to do a check more frequently.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-066, § 388-290-0143, filed 6/27/02, effective 7/1/02.]

**WAC 388-290-0145 Why is a background check required and will I be notified of the results?** (1) We require the background check to:

(a) Help safeguard the health, safety, and well-being of children;

(b) Reduce the possible risk of harm from persons having access to WCCC children that have been convicted of certain crimes; and

(c) Help you make informed, safe and responsible decisions about individuals who have access to your children.

(2) As a WCCC consumer, you will be notified:

(a) Whether we can approve the provider for the WCCC program; and

(b) Of the following results from the background check:

(i) No background information is found given current sources of information;

(ii) Background information is found, but the information will not disqualify the individual being checked; or

(iii) Background information is found that disqualifies the individual being checked.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-066, § 388-290-0145, filed 6/27/02, effective 7/1/02. 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 388-290-0150 What information is included in the background check and where does it come from?** (1) The background information will include, at a minimum, criminal convictions and pending charges.

(2) Additional sources may include:

(a) Child/adult protective service case information; and

(2003 Ed.)

(b) Civil judgments, determinations, or disciplinary board final decisions of abuse or neglect.

(3) The background information may be obtained from sources such as:

(a) The Washington state patrol under chapter 10.97 RCW;

(b) Child/adult protective service case files;

(c) Other states and federally recognized Indian tribes;

(d) The department of corrections and the courts;

(e) Law enforcement records of convictions and pending charges in other states or locations if:

(i) The individual being checked has lived in another state; and

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

(e) Self-disclosure by the individual being checked.

[Statutory Authority: RCW 74.04.050, 74.13.085, 02-14-066, § 388-290-0150, filed 6/27/02, effective 7/1/02. 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 we receive the background information?** After we receive the background information we:

(1) Compare the background information with convictions listed in WAC 388-06-0170 and 388-06-0180.

(2) Review the background information 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;

(c) Convictions whose titles are preceded with the word "attempted" are given the same weight as those titles without the word "attempted"; and

(d) 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, dismiss, or vacate the conviction record.

(3) Notify you whether or not we are able to approve the provider for WCCC.

(4) Allow you to decide character and suitability of the provider given an individual's not automatically disqualifying background information from the record of arrests and prosecutions (RAP) sheet.

(5) Deny or stop payment when the background information disqualifies the individual being checked.

(6) Assist you in finding other child care arrangements.

[Statutory Authority: RCW 74.04.050, 74.13.085, 02-14-066, § 388-290-0155, filed 6/27/02, effective 7/1/02. 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 us?** (1) If your provider or an individual listed in WAC 388-290-0143 (1)(b) has a background containing the following felony convictions, the provider is permanently disqualified as an in-home/relative child care provider for WCCC:

(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 vulnerable adults in any home or facility.

(2) The disqualifying background of an individual sixteen years of age or over living with the provider may not permanently disqualify the provider if conditions in WAC 388-290-0167 (1)(a) and (b) are met.

[Statutory Authority: RCW 74.04.050, 74.13.085, 02-14-066, § 388-290-0160, filed 6/27/02, effective 7/1/02. 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 Is there other background information or convictions that will disqualify my in-home/relative provider?** (1) Your in-home/relative provider can be disqualified if the individual being checked has a background containing information other than conviction information that we determine:

(a) Makes the individual not of suitable character and competence or of sufficient physical or mental health to meet the needs of the child in care; or

(b) Puts the household at risk for harm.

(2) If an individual being checked as a background containing the following crimes within the last five years, your provider is disqualified as an in-home/relative child care provider for WCCC:

(a) Any physical assault not included in WAC 388-290-0160;

(b) Any sex offense not included in WAC 388-290-0160;

(c) Any felony conviction not included in WAC 388-290-0160;

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

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

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

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

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

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

(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 vulnerable adults in your home or facility not less than five years from a conviction listed in this section.

(3) If an individual being checked has:

(a) A conviction listed in subsection (2)(a) through (e) of this section, and it has been more than five years; or

(b) A conviction other than those listed in WAC 388-290-0160 or subsection (2)(a) through (e) of this section, we will allow you to determine the provider's character, suitability, and competence by reviewing:

- (i) The amount of time that has passed since the conviction;
- (ii) The seriousness of the crime that led to the conviction;
- (iii) The individual's age at the time of conviction;
- (iv) The individual's behavior since the conviction;
- (v) The number and types of convictions in the individual's background; and
- (vi) Documentation indicating the individual has successfully completed all court-ordered programs and restitution.

(4) The disqualifying background of an individual sixteen years of age or over living with the provider may not disqualify the provider if conditions in WAC 388-290-0167 (1)(a) and (b) are met.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-066, § 388-290-0165, filed 6/27/02, effective 7/1/02. 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 388-290-0167 What happens if my in-home/relative provider, who provides care in their home, is disqualified based solely on the disqualifying background of an individual living with that provider? (1) If your provider is disqualified based solely on the disqualifying background of an individual living with that provider, we will require that:**

(a) Child care occurs in the child's home away from the disqualified individual, if you wish to continue using that provider; and

(b) The parent and provider sign an agreement with us indicating that:

- (i) Care will occur in the child's home; and
- (ii) There will be no contact between the child and disqualified individual during child care hours.

(2) The parent may choose a licensed provider or submit an application for a different in-home/relative provider.

(3) If we become aware that the parent and provider are not meeting the conditions in subsection (1)(a) and (b) of this section:

- (a) We will terminate care without advance and adequate notice;
- (b) You will need to find a different provider; and
- (c) You may be subject to an overpayment.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-066, § 388-290-0167, filed 6/27/02, effective 7/1/02.]

**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

[Title 388 WAC—p. 648]

(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) We pay 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 and seasonal day camps that have contracted with us to provide subsidized child care when care is needed for five or more hours per day;

(ii) A half day of child care is authorized to licensed/certified facilities and seasonal day camps that have contracted with us to provide subsidized child care 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 care 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 our 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, 74.13.085. 02-12-069, § 388-290-0190, filed 5/31/02, effective 7/1/02. 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 or DSHS contracted seasonal day camps? We pay the lesser of the following to a licensed or certified child care center or a seasonal day camp that has a contract with us to provide subsidized child care:**

- (1) The provider's usual daily rate for that child; or

(2003 Ed.)

(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, 74.13.085, 02-12-069, § 388-290-0200, filed 5/31/02, effective 7/1/02. 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?** (1) We pay the lesser of the following to a licensed or certified family child care home:

- (a) The provider's usual daily rate for that child; or
- (b) 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

(2) The family child care home WAC 388-155-010 allows providers to provide care to children within a birth through eleven years of age range exclusively. In order for a family home provider to provide care for a twelve-year-old or older child, the provider must obtain a child specific and time-limited waiver from their child care licensor.

[Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0205, filed 5/31/02, effective 7/1/02. 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:

(2003 Ed.)

(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 or DSHS contracted seasonal day camp?** We authorize special needs daily rates to licensed or certified child care centers or seasonal day camps that have contracts with us to provide subsidized child care 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

[Title 388 WAC—p. 649]

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 12 yrs)
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, 74.13.085. 02-12-069, § 388-290-0225, filed 5/31/02, effective 7/1/02. 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?** (1) We authorize special needs daily rates to licensed or certified family child care homes under WAC 388-290-0205 and whichever of the following is greater:

- (a) The provider's reasonable documented additional cost associated with the care of the child; or
- (b) 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

(2) The family child care home WAC 388-155-010 allows providers to provide care to children within a birth through eleven years of age range exclusively. In order for a family home provider to provide care for a twelve-year-old or older child, the provider must obtain a child specific and time-limited waiver from their child care licensor.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0230, filed 5/31/02, effective 7/1/02. 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) When you employ an in-home/relative provider, the maximum we pay for child care 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 hourly rate for that care.

(2) We may pay above the maximum hourly rate for children who have special needs under WAC 388-290-0235.

(3) When care is provided by an in-home/relative provider, we pay benefits directly to you, defined as the consumer in WAC 388-290-0005.

(4) On all payments we make toward the cost of in-home/relative child care, when appropriate we pay the employer's share, on behalf of the client, of:

- (a) Social Security and Medicare taxes (FICA);
- (b) Federal Unemployment Taxes (FUTA); and
- (c) State unemployment taxes (SUTA) when applicable.

(5) On all payments we make toward the cost of in-home/relative child care we withhold Medicare taxes and Social Security taxes (FICA) up to the wage base limit.

(6) If an in-home/relative child care provider receives less than the wage base limit per family in a calendar year, we refund all withheld taxes to the provider.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0240, filed 5/31/02, effective 7/1/02. 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?** (1) We pay licensed or certified child care providers and seasonal day camps that have contracts with us to provide subsidized child care 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 children are in care with that provider; and
- (b) Needed to maintain the child care arrangement.

(2) The registration fee may be authorized more than once per calendar year when:

- (a) There is a break in your child care services for 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
- (b) The children change child care providers and the new provider meets subsection (1)(a) and (b) of this section.

(3) 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 subsection (1)(a) and (b) of this section.

[Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0245, filed 5/31/02, effective 7/1/02. 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 or for a Child SafetyNet Payment.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-290-0255, filed 6/28/02, effective 7/1/02. 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.]

(2003 Ed.)

**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 you or a provider has received benefits or payment that you or they are not eligible to receive;
- (b) Is written by us and expected to be paid back by you or the provider.

(2) We establish 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;
- (b) You knowingly fail to report information to us that affects the amount of WCCC you are eligible for; or
- (c) You do not have attendance records and payment receipts to support the amount you billed us for in-home/relative care.

(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, you 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) We establish WCCC overpayments for licensed/certified child care providers and contracted seasonal day camps, 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 us and the provider is not eligible based on WAC 388-290-0125.

[Title 388 WAC—p. 651]



[Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0270, filed 5/31/02, effective 7/1/02. 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.]

## Chapter 388-310 WAC WORKFIRST

### WAC

388-310-0100	WorkFirst—Purpose.
388-310-0200	WorkFirst—Activities.
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388-310-0400	WorkFirst—Entering the WorkFirst program as a mandatory participant.
388-310-0500	WorkFirst—Individual responsibility plan.
388-310-0600	WorkFirst—Job search.
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388-310-1450	Pregnancy to employment.
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388-310-1650	WorkFirst—Child SafetyNet Payments.
388-310-1700	WorkFirst—Self-employment.
388-310-1800	WorkFirst—Post employment services.
388-310-1900	WorkFirst—Services for American Indian tribal members and other American Indians.
388-310-2000	Individual development accounts (IDA).

### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-310-1850	Re-employ Washington Workers (RWW). [Statutory Authority: RCW 74.08.090 and 74.04.050, 00-08-021, § 388-310-1850, filed 3/24/00, effective 4/24/00; 99-14-044, § 388-310-1850, filed 6/30/99, effective 7/31/99.] Repealed by 00-24-040, filed 11/29/00, effective 12/30/00. Statutory Authority: RCW 74.08.090 and 74.04.050.
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### WAC 388-310-0100 WorkFirst—Purpose. (1) What is the WorkFirst program?

The WorkFirst program offers services and activities to help people in low-income families find jobs, keep their jobs, find better jobs and become self-sufficient. The program links families to a variety of state, federal and community resources to meet this goal. When you enter the WorkFirst program, you will be asked to work, look for work and/or prepare for work.

#### (2) Who does the WorkFirst program serve?

The WorkFirst program serves three groups:

- Parents and children age sixteen or older who receive cash assistance under the temporary assistance for needy families (TANF), general assistance for pregnant women (GA-S) or state family assistance (SFA) programs; and
- Parents who no longer receive cash assistance and need some continuing support to remain self-sufficient; and
- Low income parents who support their family without applying for or relying on cash assistance.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-08-051, § 388-310-0100, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0100, filed 10/1/97, effective 11/1/97.]

[Title 388 WAC—p. 652]

### WAC 388-310-0200 WorkFirst—Activities. (1) Who is required to participate in WorkFirst activities?

(a) You are required to participate in WorkFirst activities, and become what is called a "mandatory participant," if you:

- Receive TANF or SFA cash assistance; and
- Are a custodial parent or age sixteen or older; and
- Are not exempt. For exemptions see WAC 388-310-0300 and 388-310-0350.

(b) Participation is voluntary for all other WorkFirst participants (those who no longer receive or have never received TANF or SFA cash assistance).

### (2) What activities do I participate in when I enter the WorkFirst program?

When you enter the WorkFirst program, you will participate in one or more of the following activities (which are described in more detail in other sections of this chapter):

- Paid employment (see WAC 388-310-0400 (2)(a) and 388-310-1500);
- Self employment (see WAC 388-310-1700);
- Job search (see WAC 388-310-0600);
- Community jobs (see WAC 388-310-1300)
- Work experience (see WAC 388-310-1100);
- On-the-job training (see WAC 388-310-1200);
- Vocational educational training (see WAC 388-310-1000);
- Basic education activities (see WAC 388-310-0900);
- Job skills training (see WAC 388-310-1050);
- Community service (see WAC 388-310-1400);
- Activities provided by tribal governments for tribal members and other American Indians (see WAC 388-310-1400(1) and 388-310-1900);
- Other activities identified by your case manager on your individual responsibility plan that will help you with situations such as drug and/or alcohol abuse, homelessness, or mental health issues; and/or
- Activities identified by your case manager on your individual responsibility plan to help you cope with family violence as defined in WAC 388-61-001.

### (3) If I am a mandatory participant, how much time must I spend doing WorkFirst activities?

If you are a mandatory participant, you will be required to participate full time, working, looking for work or preparing for work. You might be required to participate in more than one part-time activity at the same time that add up to full time participation. You will have an individual responsibility plan (described in WAC 388-310-0500) that includes the specific activities and requirements of your participation.

### (4) What activities do I participate in after I get a job?

You will participate in other activities, such as job search or training once you are working twenty hours or more a week in a paid unsubsidized job, to bring your participation up to full time.

You may also engage in activities if you are working full time and want to get a better job.

Post employment services (described in WAC 388-310-1800) include:

(2003 Ed.)

(a) Activities that help you keep a job (called an "employment retention" service); and/or

(b) Activities that help you get a better job or better wages (called a "wage and skill progression" service).

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0200, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-0200, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0200, filed 3/1/00, effective 3/1/00; 99-08-051, § 388-310-0200, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0200, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-0300 WorkFirst—Infant care exemptions for mandatory participants. (1) If I am a mandatory participant, when can I be exempted from participating in WorkFirst activities?**

(a) You can claim an exemption from participating in WorkFirst activities during months that you are needed in the home to personally provide care for your child under four months of age.

(b) You or the other parent of your child, living in your household can claim a one-time exemption from full-time participation, for one child only, if that child is between the age of four months and up to twelve months old. This means the parent who claims this exemption will only be required to participate part-time, up to twenty hours in certain activities described in WAC 388-310-1450.

**(2) Can I participate in WorkFirst while I am exempt?**

(a) You may choose to participate in WorkFirst while you are exempt with a child under four months old. If you decide later to stop participating, and you still qualify for an exemption, you will be put back into exempt status with no financial penalty. For a description of participation activities see WAC 388-310-1450.

(b) You may choose to participate full time while you are taking your one-time/part-time exemption. If you decide later to stop participating full-time, and you still qualify for the part-time exemption, you will be put back into part-time exempt status with no financial penalty. For a description of participation activities see WAC 388-310-1450.

**(3) Does an exemption from participation affect my sixty-month time limit for receiving TANF or SFA benefits?**

An exemption from participation does not affect your sixty-month time limit for receiving TANF or SFA benefits (described in WAC 388-484-0005). Even if exempt from participation, each month you receive a TANF/SFA grant counts toward your sixty-month limit.

[Statutory Authority: RCW 74.08.090, 74.04.050. 02-14-087, § 388-310-0300, filed 6/28/02, effective 7/29/02; 00-06-062, § 388-310-0300, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0300, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0300, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-0350 WorkFirst—Other exemptions from mandatory participation. (1) When am I exempt from mandatory participation?**

You are exempt from mandatory participation if you are:

(a) An older needy caretaker relative:

(i) You are fifty-five years of age or older and caring for a child and you are not the child's parent; and

(ii) Your age is verified by any reliable documentation (such as a birth certificate or a driver's license).

(b) An adult with a severe and chronic disability:

(i) The disability must be a severe and chronic mental, physical, emotional, or cognitive impairment that prevents you from participating in work activities and is expected to last at least twelve months; or

(ii) You have been assessed by a DSHS SSI facilitator as likely to be approved for SSI or other benefits and are applying for SSI or another type of federal disability benefit (such as Railroad Retirement or Social Security Disability); and

(iii) Your disability is verified by documentation from the division of developmental disabilities (DDD), division of vocational rehabilitation (DVR), home and community services division (HCS), division of mental health (MHD), and/or regional support network (RSN), or evidence from another medical or mental health professional; and

(iv) Your SSI application status may be verified through the SSI facilitator and/or state data exchange.

(c) Required in the home to care for a child with special needs when:

(i) The child has a special medical, developmental, mental, or behavioral condition; and

(ii) The child is determined by a public health nurse, physician, mental health provider, school professional, other medical professional, HCS, MHD, and/or a RSN to require specialized care or treatment that significantly interferes with your ability to look for work or work.

(d) Required to be in the home to care for another adult with disabilities when:

(i) The adult with disabilities cannot be left alone for significant periods of time; and

(ii) No adult other than yourself is available and able to provide the care; and

(iii) The adult with the disability is related to you; and

(iv) The disability is verified by documentation from DDD, DVR, HCS, MHD, and/or a RSN, or evidence from another medical or mental health professional.

**(2) Who reviews and approves an exemption?**

(a) If it appears that you may qualify for an exemption or you ask for an exemption, your case manager or social worker will review the information and we will use the case staffing process to determine whether the exemption will be approved. Case staffing is a process to bring together a team of multidisciplinary experts including relevant professionals and the client to identify participant issues, review case history and information, and recommend solutions.

(b) If additional medical or other documentation is needed to determine if you are exempt, your IRP will allow between thirty days and up to ninety if approved to gather the necessary documentation.

(c) Information needed to verify your exemption should meet the standards for verification described in WAC 388-490-0005. If you need help gathering information to verify your exemption, you can ask us for help. If you have been identified as needing NSA services, under chapter 388-472 WAC, your accommodation plan should include information

on how we will assist you with getting the verification needed.

(d) After the case staffing, we will send you a notice that tells you whether your exemption was approved, how to request a fair hearing if you disagree with the decision, and any changes to your IRP that were made as a result of the case staffing.

**(3) Can I participate in WorkFirst while I am exempt?**

(a) You may choose to participate in WorkFirst while you are exempt.

(b) Your WorkFirst case manager may refer you to other service providers who may help you improve your skills and move into employment.

(c) If you decide later to stop participating, and you still qualify for an exemption, you will be put back into exempt status with no financial penalty.

**(4) Does an exemption from participation affect my sixty-month time limit for receiving TANF/SFA benefits?**

An exemption from participation does not affect your sixty-month time limit (described in WAC 388-484-0005) for receiving TANF/SFA benefits. Even if exempt from participation, each month you receive a TANF/SFA grant counts toward your sixty-month limit.

**(5) How long will my exemption last?**

Unless you are an older caretaker relative, your exemption will be reviewed at least every twelve months to make sure that you still meet the criteria for an exemption. Your exemption will continue as long as you continue to meet the criteria for an exemption.

**(6) What happens when I am no longer exempt?**

If you are no longer exempt, then:

(a) You will become a mandatory participant under WAC 388-310-0400; and

(b) If you have received sixty or more months of TANF/SFA, your case will be reviewed for an extension. (See WAC 388-484-0006 for a description of TANF/SFA time limit extensions.)

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-310-0350, filed 5/31/02, effective 6/1/02.]

**WAC 388-310-0400 WorkFirst—Entering the WorkFirst program as a mandatory participant. (1) What happens when I enter the WorkFirst program as a mandatory participant?**

If you are a mandatory participant, you must follow instructions as written in your individual responsibility plan (see WAC 388-310-0500), which is written after the case manager asks you a series of questions about your situation to evaluate your employability. If you have been identified as someone who needs necessary supplemental accommodation (NSA) services (defined in chapter 388-472 WAC) your case manager will first develop an accommodation plan to help you access WorkFirst services. The case manager will use the accommodation plan to help develop your IRP with you. If you have been identified as a victim of family violence (defined in WAC 388-61-001), you and your case manager will develop an IRP to help you with your situation, including referrals to appropriate services.

[Title 388 WAC—p. 654]

If you are a mandatory participant, your case manager will refer you to job search activities unless any of the following applies to you:

(a) You work thirty-two or more hours a week. "Work" means to engage in any legal, income generating activity which is taxable under the United States Tax Code or which would be taxable with or without a treaty between an Indian Nation and the United States;

(b) You work sixteen or more hours a week in the federal or state work study program and you attend a Washington state community or technical college at least half time;

(c) You work twenty or more hours a week in unsubsidized employment and attend a Washington state community or technical college at least half time;

(d) You are under the age of eighteen, have not completed high school, GED or its equivalent and are in school full time;

(e) You are eighteen or nineteen years of age and are attending high school or an equivalent full time;

(f) You are pregnant or have a child under the age of twelve months, and are participating in other pregnancy to employment activities. See WAC 388-310-1450;

(g) Your situation prevents you from looking for a job and you are conducting activities identified on your IRP to help you with your situation. (For example, you may be unable to look for a job while you have health problems or you are homeless; or

(h) Your situation prevents you from looking for work because you are a victim of family violence and you are conducting activities on your IRP to help you with your situation.

**(2) What are my requirements if I am not required to participate in job search activities?**

(a) If and when you are not required to participate in job search activities, you may be required to take part in an employability evaluation. Your individual responsibility plan will describe what you need to do to be able to enter job search and then find a job (see WAC 388-310-0500 and 0700).

(b) If you enter the pregnancy to employment pathway (described in WAC 388-310-1450(2)), you must take part in an assessment.

**(3) What happens if I do not follow my WorkFirst requirements?**

If you do not participate in job search, or in the activities listed in your individual responsibility plan, and you do not have a good reason, the department will reduce your WorkFirst grant (sanction, see WAC 388-310-1600).

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0400, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0400, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0400, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0400, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0400, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-0500 WorkFirst—Individual responsibility plan. (1) What is the purpose of my individual responsibility plan?**

The purpose of your individual responsibility plan is to give you a written statement that describes:

(a) What your responsibilities are; and

(2003 Ed.)

(b) Which WorkFirst activities you are required to participate in; and

(c) What services you will receive so you are able to participate.

**(2) What is included in my individual responsibility plan?**

Your individual responsibility plan includes the following:

(a) What WorkFirst activities you must do and the participation requirements for those activities including the amount of time you will spend doing the activities, a start and end date for each activity and the requirement to participate fully.

(b) Any other specific requirements that are tied to the WorkFirst work activity. For example, you might be required to learn English as part of your work experience activity.

(c) What services we will provide to help you participate in the activity. For example, you may require support services (such as help with paying for transportation) or help with paying childcare.

(d) Your statement that you recognize the need to become and remain employed as quickly as possible.

**(3) How is my individual responsibility plan developed?**

You and your case manager will work together and use information gathered from your employability evaluation (see WAC 388-310-0700) to develop your individual responsibility plan and decide what activities will be included in it. Then, your case manager will assign you to specific WorkFirst activities that will help you find employment as quickly as possible.

**(4) What happens after my individual responsibility plan is completed?**

Once your individual responsibility plan is completed:

(a) You will sign and get a copy of your individual responsibility plan.

(b) You and your case manager will review your plan as necessary over the coming months to make sure your plan continues to meet your employment needs. You will sign and get a copy of your individual responsibility plan every time it is reviewed and changed.

**(5) What should I do if I cannot go to a required WorkFirst appointment or activity because of a temporary situation outside of my control?**

If you cannot participate because of a temporary situation outside of your control, you must call the telephone number shown on your individual responsibility plan on the same day you were to report to explain your situation. You will be given an excused absence. Some examples of excused absences include:

(a) You, your children or other family members are ill;

(b) Your transportation or child care arrangements break down and you cannot make new arrangements in time to comply;

(c) A significant person in your life died; or

(d) A family violence situation arose or worsened.

**(6) What happens if I don't call in on the same day I am unable to attend to get an excused absence?**

If you do not call in on the same day you are unable to attend to get an excused absence, it will be considered an unexcused absence.

If you exceed the number of unexcused absences allowed on your individual responsibility plan, without good cause, your case manager will begin the sanction process. (See WAC 388-310-1600 for more details.)

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0500, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0500, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0500, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0500, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-0600 WorkFirst—Job search. (1) What is job search?**

Job search is an opportunity to learn and use skills you need to find and keep a job. Job search may include:

(a) Classroom instruction; and/or

(b) Structured job search that helps you find job openings, complete applications, practice interviews and apply other skills and abilities with a job search specialist or a group of fellow job-seekers; and/or

(c) Preemployment training; and/or

(d) High-wage/high-demand training.

**(2) What is preemployment training?**

Preemployment training helps you learn skills you need for an identified entry level job that pays more than average entry level wages.

(a) Preemployment training is an acceptable job search activity when an employer or industry commits to hiring or giving hiring preference to WorkFirst participants who successfully complete preemployment training.

(b) You can find out about current preemployment training opportunities by asking your job service specialist, your case manager or staff at your local community and technical college.

**(3) What is high-wage/high-demand training?**

(a) There are two types of high-wage/high-demand (HWHD) full-time training options for TANF recipients to complete a certificate or degree that will lead to employment in a high-wage/high-demand occupation:

(i) Information technology & health care: This option allows you to start and finish a one-year community or technical college training program in the information technology or health care fields; and/or

(ii) Certificate/degree completion: This option allows you to finish up the last year of a two- or four-year certificate or degree in a high-wage/high-demand field on an exception basis. The high-wage/high-demand criteria for this option is based on median income and high-demand occupations within the local labor market as determined by employment security department.

(b) For both types of HWHD training, the training can be approved one-time only (barring an approved exception to policy). There is no work requirement with either option for the twelve months of training time.

(c) To qualify for HWHD training, you must also:

(i) Meet all of the prerequisites for the course;

- (ii) Obtain the certificate or degree within twelve calendar months;
- (iii) Participate full time in the training program and make satisfactory progress;
- (iv) Work with co-located ESD staff during the last quarter of training for job placement; and
- (v) Return to job search once you completes the educational program if still unemployed.

**(4) Who provides me with job search?**

You get job search from the employment security department or another organization under contract with WorkFirst to provide these services.

**(5) How long do I stay in job search?**

Periods of job search may last up to twelve continuous weeks. Job search specialists will monitor your progress. By the end of the first four weeks, a job search specialist will determine whether you should continue in job search. Job search will end when:

- (a) You find a full-time job; or
- (b) You become exempt from WorkFirst requirements (see WAC 388-310-0300); or
- (c) Your situation changes and the case manager changes the activities on your IRP to fit your new circumstances (see WAC 388-310-0400); or
- (d) After fully participating in job search, and based on your experience in looking for work in the local labor market, it is determined that you need additional skills and/or experience to find a job; or
- (e) You have not found a job at the end of the job search period.

**(6) What happens at the end of job search if I have not found a job?**

At the end of each job search period, you will be referred back to your case manager who will conduct a new employability evaluation if you have not found a job. You and your case manager will also modify your individual responsibility plan.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0600, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090, 74.04.050. 02-04-058, § 388-310-0600, filed 1/30/02, effective 3/2/02. Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-0600, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0600, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0600, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-0700 WorkFirst—Employability evaluation. (1) Why do I receive an employability evaluation?**

You receive an employability evaluation from your case manager to determine:

- (a) Why you are unable to look for work (if you are temporarily deferred from job search) or why you have been unable to find work in your local labor market; and
- (b) Which WorkFirst activities you need to become employed in the shortest time possible.

**(2) What is the employability evaluation and when will it be used?**

[Title 388 WAC—p. 656]

(a) The employability evaluation is a series of questions and answers used to determine your ability to find and keep a job in your local labor market.

(b) You and your case manager and/or social worker use the information from this evaluation to create or modify your individual responsibility plan, adding activities that help you become employable.

(c) Your case manager evaluates your ability to find employment when you are a mandatory WorkFirst participant and have:

- (i) Gone through a period of job search without finding a job;
  - (ii) Been referred back early from job search; or
  - (iii) Been temporarily deferred from job search.
- (d) After your employability evaluation, you may receive more assessments to find out if you need additional services.

[Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0700, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0700, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0700, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-0800 WorkFirst—Support services.**

**(1) Who can get support services?**

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.)

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**(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		
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 per program year	x		
Car repair needed to restore car to operable condition	\$500 per program year	x	x	
License/fees/liability insurance	\$600 per program year	x	x	
Mileage, transportation, and/or public transportation	Same rate as established by OFM for state employees	x	x	
Transportation allotment	Up to: \$10 for immediate need, or \$20 twice a month if you live within 40 miles of your local WorkFirst office, or \$30 twice a month if you live more than 40 miles from your local WorkFirst office.	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.

(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.

(c) To qualify for the second payment of five hundred dollars you must meet the following conditions:

(i) Have not received a TANF/SFA grant or diversion cash assistance (DCA) for three months after you stopped your TANF/SFA grant; and

(ii) Are still employed.

**(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, and [WSR] 99-14-043, 02-11-130, § 388-310-0800, filed 5/21/02, effective 7/1/02; 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 general equivalency diploma (GED) and testing to acquire GED certification. It may include 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; or
- (c) You have fully participated in job search without finding a job.

**(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) 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 your case manager may add basic education to your IRP as part of your full-time participation.
- (b) You may attend full-time basic education classes if you have fully participated in job search without finding a job, and it has been determined that you need this training to become employed.
- (c) 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.
- (d) 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.
- (e) Employment security department (ESD) has determined that you are a seasonal worker (that is, your usual pattern of employment 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 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-15-067, § 388-310-0900, filed 7/11/02, effective 8/1/02. 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 for up to twelve months if:

- (a) You are working twenty or more hours a week in paid unsubsidized work; or

- (b) You are working sixteen or more hours per week in a federal or state work-study position; or

- (c) You are working in a subsidized job, like a community jobs position, at least twenty hours per week; or

- (d) Employment security department (ESD) has determined that you are a seasonal worker (that is, your usual pattern of employment 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

- (e) 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

- (f) You have limited English proficiency and 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 may pay for the costs of your vocational education, such as tuition or books, for up to twelve months, if vocational education is in your individual responsibility plan and there is no other way to pay them. You may 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 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-15-067, § 388-310-1000, filed 7/11/02, effective 8/1/02. 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 are generally short term, but differ in what skills are taught and who provides the training. The training may be offered by the following types of organizations that meet the WorkFirst program's standards for service providers:

- (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 if:

- (a) You are working twenty or more hours a week in paid unsubsidized work; or
- (b) You are working sixteen or more hours per week in a federal or state work-study position; or
- (c) You are working in a subsidized job, like a community jobs position, at least twenty hours per week; or

(d) Employment security department (ESD) has determined that you are a seasonal worker (that is, your usual pattern of employment 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

(e) You lack job skills that are in demand for entry level jobs in your area, and the job skills training is short term and is combined with job search.

**(3) Can I get help with paying the costs of job skills training?**

WorkFirst may 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 may 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 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-15-067, § 388-310-1050, filed 7/11/02, effective 8/1/02. 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 388-310-1100 WorkFirst—Work experience.**

**(1) What is work experience?**

Work experience (sometimes called WEX) is an activity for mandatory participants that will teach you the basics of holding down a job and give you a chance to practice or expand your work skills. Work experience teaches you these skills by assigning you to unpaid work with:

- (a) A private, nonprofit organization;
- (b) A community or technical college; or
- (c) A federal, state, local or tribal government or district.

**(2) What happens when I am enrolled in a work experience activity?**

When you are enrolled in a work experience activity:

(a) The organization, government or district that is supervising your work experience position must comply with all applicable state and federal health and safety standards while you are working there.

(b) You may be required to look for work on your own and must accept any paid employment you find that meets the criteria in WAC 388-310-1500.

**(3) How long does a work experience assignment last?**

Your case manager must review your work experience assignment if it lasts longer than six months. This review will determine whether you need more time to learn the skills and abilities that the work experience assignment was set up to teach you.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1100, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1100, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-1200 WorkFirst—On-the-job training. (1) What is on-the-job training?**

On-the-job training (sometimes called OJT) is skills training provided by an employer at the their place of business. You are paid to both work and spend some time learning new skills to help you do your job better. You may receive the training at your job site or be sent to a classroom

(using "release time" from your job) to get some of this training.

**(2) When do I qualify for on-the-job training?**

You may qualify for on-the-job employment if:

(a) You lack skills which are in demand in the local labor market; and

(b) There are employers in your area who can and will provide the training.

**(3) Is my employer reimbursed for giving me on-the-job training?**

Your employer may be reimbursed for giving you on-the-job training for up to fifty percent of your total gross wages for regular hours of work and pre-approved release time for training.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1200, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1200, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-1300 Community jobs. (1) What is the community jobs program?**

Community jobs is a paid work experience that assists you to gain work skills and experience. You are placed in a community job (up to twenty hours per week) where your wages are paid by the community jobs program. If you participate in the program, you are eligible for support services that assist you in moving into a job where your employer pays all your wages.

**(2) What is career jump?**

Career jump offers job-ready community jobs participants an opportunity to gain paid work experience that leads to a permanent job. This program is a subset of community jobs and will be referred to as such. Career jump places you in a part time (up to twenty hours per week), community job where your earnings are paid by the community jobs program, for up to five months, at which time you will transition to the employer's payroll. You will be provided with support services to assist you in retaining your job through the ninth month of the program. At or before the fifth month, the employment opportunity will be above minimum wage, thirty-two or more hours per week and include wage progression and benefits comparable to other employees.

**(3) Who administers the community jobs program?**

The state department of community, trade, and economic development (DCTED) administers the community jobs program. DCTED contract with local agencies throughout the state, known as community jobs contractors who develop and manage the community jobs positions, pay the wages, provide support services and act as the "employer of record" while you are enrolled in a community job.

**(4) What types of work sites are used to provide community jobs?**

The following work sites may be used to provide community jobs:

(a) Federal, state or local governmental agencies and tribal governments;

(b) Private and tribal nonprofit businesses, organizations and educational institutions;

(c) Private for profit businesses for career jump placements.

**(5) What are the requirements for the work sites?**

Work sites for community jobs and career jump:

(a) Must assist in strengthening work ethics, improve workplace skills and help you gain skills to move into a job where the employer pays all your wages. If they do not meet this requirement, they will not be considered for additional community jobs/career jump placements.

(b) We will follow the employment rules described in WAC 388-310-1500. In any situation where training is inconsistent with the terms of a collective bargaining agreement, your community jobs contractor will obtain written approval from the labor organization concerned. Career jump employers will remain neutral with regard to neutralization in the worksite.

(c) You will not be required to do work related to religious, electoral or partisan political activities.

**(6) What are the benefits of community jobs?**

You benefit from community jobs by:

(a) Learning work skills;

(b) Getting work experience;

(c) Working twenty hours per week, while being paid federal or state minimum wage, whichever is higher; and

(d) Earning paid personal leave as determined by DCTED.

**(7) How do I get into community jobs?**

You will be placed into community jobs after you and your DSHS case manager decide:

(a) You would benefit from community jobs after you have participated in job search without finding a job; and/or

(b) You need a supportive work environment to help you become more employable.

**(8) What happens after I am placed in the community jobs program?**

When you are placed in the community jobs program by DSHS:

(a) You will be assigned to a community job by the community jobs contractor for no more than nine months. You will work twenty hours a week and participate in other unpaid activities for twelve to twenty additional hours per week;

(b) Your placement in community jobs will be reviewed by your DSHS case manager every three months during your nine-month placement for the following:

(i) To ensure you are TANF/SFA eligible; and

(ii) To verify any earned or unearned income received by you or another member of your assistance unit (that is, you and other people in your household who are included on your cash grant).

(c) Your community jobs contractor will review your case each month to ensure you are following your IRP and IDP, participating full time, and becoming more employable because of your community job;

(d) If you request a different community jobs placement, we do not consider your request a refusal to participate without good cause under WAC 388-310-1600. You may be asked to explain why you want a different placement;

(e) Grievance policies are in place for your protection. You will be required to sign an acknowledgment that you received a copy of this policy at the time of placement with the employer.

**(9) How does community jobs affect my TANF benefits?**

The amount of your TANF/SFA monthly grant will be determined by following the rules in WAC 388-450-0050 and 388-450-0215 (1), (3), (4), (5) and (6). WAC 388-450-0215(2), does not apply to your community jobs wages.

**(10) What can I expect from my career jump placement?**

(a) You cannot represent more than ten percent of the total labor force for an employer that has ten or more employees.

(b) No more than one community jobs participant shall be allowed per private for profit worksite supervisor.

(c) You will participate in developing a career progression plan that will include health care benefits comparable to other employees.

(d) You may be eligible for unemployment benefits if you have participated in community jobs' career jump and have worked at least six hundred eighty hours in a base year. You will gain unemployment insurance credits for all hours worked under your career jump placement.

(e) Your employer and your community jobs contractor will be required to follow DCTED's contractual agreements for career jump.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.330, and 74.08A.320. 02-20-073, § 388-310-1300, filed 9/30/02, effective 10/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-08-051, § 388-310-1300, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.08.090, 74.04.050 and 74.08A.320. 98-10-054, § 388-310-1300, filed 4/30/98, effective 5/31/98.]

**WAC 388-310-1400 WorkFirst—Community service. (1) What is community service?**

Community service includes two types of activities for mandatory participants:

(a) Unpaid work (such as the work performed by volunteer workers) that you perform for a charitable nonprofit organization, federal, state, local or tribal government or district; or

(b) An activity approved by your case manager which benefits you, your family, your community or your tribe. These activities may include traditional activities that perpetuate tribal culture and customs.

**(2) What type of community service[s] activities benefit me, my family, my community or my tribe and might be included in my individual responsibility plan?**

The following types of community service activities benefit you, your family, your community or your tribe and might be included in your individual responsibility plan:

(a) Caring for a disabled family member;

(b) Caring for a child, if you are fifty-five years old or older and receiving TANF or SFA assistance for the child as a relative (instead of as the child's parent);

(c) Providing childcare for another WorkFirst participant who is doing community service;

(d) Actively participating in a drug or alcohol assessment or treatment program which is certified or contracted by the state under chapter 70.96A RCW;

(e) Participating in family violence counseling or drug or alcohol treatment that will help you become employable or

keep your job (this is called "specialized services" in state law); and/or

(f) Participating in the pregnancy to employment pathway.

[Statutory Authority: RCW 74.08.090, 74.04.050, 00-06-062, § 388-310-1400, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-1400, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1400, filed 10/1/97, effective 11/1/97.]

**Reviser's note:** RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

**WAC 388-310-1450 Pregnancy to employment. (1) How do I know if I am eligible to participate in pregnancy to employment?**

If you are on TANF and are pregnant or have a child under the age of twelve months, you are a participant in the pregnancy to employment pathway.

**(2) What am I required to do while I am in pregnancy to employment?**

You will receive an assessment from a DSHS social worker. Based on the results of the assessment you receive as a pregnancy to employment participant, you and your case manager/social worker will decide how you will be required to participate and which activities best meet your needs. The activities you are required to do will depend on where you are in the pregnancy or the age of your child.

**(3) What am I required to do while I am pregnant?**

(a) In the first and second trimester of pregnancy: Your participation is based upon the results of the assessment you receive and includes work, looking for work or a combination of pregnancy to employment services. You will be required to participate full-time during the first two trimesters of pregnancy unless you have a good reason to participate fewer hours (see WAC 388-310-1600).

(b) In the third trimester of pregnancy: Your participation is voluntary and may include meeting your medical needs.

**(4) What am I required to do after my child is born?**

You are exempt from participation after the birth of your child and until your child reaches the age of four months. You may volunteer to participate in WorkFirst activities while you are exempt (see WAC 388-310-0300).

**(5) Do I have to participate full time once my child reaches age four months?**

Once your child reaches four months old, you are required to participate full time unless you qualify for the one-time exemption from full-time participation. This exemption is called a part-time exemption and you can only receive it once for one child who is between four and up to twelve months old.

**(6) How do I qualify for the part-time exemption?**

Effective June 13, 2002, you can be exempt one-time only, from full-time participation, if you have a child age four months to twelve months old.

**(7) If I qualify for the part-time exemption, what will I be required to do?**

You will have to participate part-time for up to twenty hours per week (per state law) until your child is reaches

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twelve months old. During this time, you will be required, based upon the results of your assessment, to participate in one or more of the following:

(a) Instruction or training to improve your parenting skills or child well-being (if available);

(b) Pre-employment or job readiness training;

(c) High school completion or GED program;

(d) Volunteer in a child care facility licensed under chapter 74.15 RCW. The child care facility has to agree to accept you as a volunteer; or

(e) Volunteer to participate in job search or work activities full-time or part-time. If you change your mind about job search or work activities you will be required to participate up to twenty hours in one of the required activities listed above.

**(8) What if I have used my one-time part-time exemption from full-time participation?**

If you have used your one-time, part-time exemption and you have another child, when that child is between four months and twelve months old, you will be required to participate full-time in one or more of the following activities:

(a) Work;

(b) Looking for work; or

(c) Preparing for work by participating in a combination of activities based upon the results of your assessment.

**(9) What services are provided in the pregnancy to employment?**

This pathway provides you with services, as available within your community, to help you learn how to work while still meeting your child's needs. You and your case manager will decide which of the variety of services you need, such as help finding:

(a) Parenting classes;

(b) Safe and appropriate child care;

(c) Good health care for yourself and your child; and/or

(d) Employment services.

(e) If you are currently employed you will receive the assessment at your next individual responsibility plan review.

**(10) What determines which services I will receive and what my participation will be?**

(a) Your assessment results (see WAC 388-310-0700) determine the services, as available within your community, that you will receive;

(b) An individual responsibility plan will be developed jointly that reflects participation and services available to meet your needs and the needs of your child; and

(c) Follow up contact every three months to jointly reassess your needs and the services and activities you are participating in, until your child reaches age twelve months.

**(11) Will I be sanctioned if I refuse to participate in pregnancy to employment pathway?**

(a) If you are a pregnant woman in your third trimester of pregnancy or if you have an infant less than three months old you will not be sanctioned for not participating.

(b) If you are in the first two trimesters of your pregnancy or have a child four months of age or older, you are required to participate and are subject to the WorkFirst sanction rules (see WAC 388-310-1600).

**(12) What if I have a child between the ages of four months and twelve months but I have a good reason not to participate?**

If you have a good reason not to participate and you claim good cause (WAC 388-310-1600(3)), your needs will be assessed as soon as possible, but no later than ninety days from your request. A good cause determination will establish if you will be required to participate and the types of services that will best meet your needs.

[Statutory Authority: RCW 74.08.090, 74.04.050, 02-14-087, § 388-310-1450, filed 6/28/02, effective 7/29/02; 00-06-062, § 388-310-1450, filed 3/1/00, effective 3/1/00.]

**WAC 388-310-1500 WorkFirst—Employment conditions. (1) If I am a mandatory participant, are there any limitations on the type of paid or unpaid employment I must accept?**

If you are a mandatory participant, you must accept paid or unpaid employment (including any activity in which an employer-employee relationship exists) unless the employment:

- (a) Is not covered by industrial insurance (described in state law under Title 51 RCW) unless you are employed by a tribal government or a tribal private for-profit business;
- (b) Is available because of a labor dispute;
- (c) Has working hours or conditions that interfere with your religious beliefs or practices (and a reasonable accommodation cannot be made);
- (d) Does not meet federal, state or tribal health and safety standards; or
- (e) Has unreasonable work demands or conditions, such as working for an employer who does not pay you on schedule.

**(2) Are there any additional limitations on when I can be required to accept paid employment?**

You must accept paid employment unless the job or the employer:

- (a) Pays less than the federal, state, or tribe minimum wage, whichever is higher;
- (b) Does not provide unemployment compensation coverage (described in state law under Title 50 RCW) unless you:
  - (i) Work for a tribal government or tribal for-profit business; or
  - (ii) Are a treaty fishing rights related worker (and exempt under section 7873 of the internal revenue code);
- (c) Requires you to resign or refrain from joining a legitimate labor organization; or
- (d) Does not provide you benefits that are equal to those provided to other workers employed in similar jobs.

**(3) How many hours of unpaid employment can I be required to perform?**

You can be required to work a set number of hours of unpaid employment each month. The number of hours required will not be more than your TANF, SFA or GA-S cash grant divided by the state or federal minimum wage, whichever is higher.

**(4) What safeguards are in place to make sure I am not used to displace currently employed workers?**

The following safeguards are in place to make sure you are not used to displace currently employed workers:

(a) You cannot be required to accept paid or unpaid employment which:

(i) Results in another employee's job loss, reduced wages, reduced hours of employment or overtime or lost employment benefits;

(ii) Impairs existing contracts for services or collective bargaining agreements;

(iii) Puts you in a job or assignment, or uses you to fill a vacancy, when:

(A) Any other person is on lay off from the same (or very similar) job within the same organizational unit; or

(B) An employer ends the job of a regular employee (or otherwise reduces its workforce) so you can be hired.

(iv) Reduces current employees' opportunities for promotions.

(b) If a regular employee believes your subsidized or unpaid work activity (such as a community jobs or work experience position) violates any of the rules described above, this employee (or his or her representative) has the right to:

(i) A grievance procedure (described in WAC 388-200-1100); and

(ii) A fair hearing (described in chapter 388-08 WAC).

**(5) What other rules apply specifically to subsidized or on-the-job training positions?**

If you are in a subsidized or on-the-job training position:

(a) WorkFirst state agencies must stop paying your wage or on-the-job training subsidy to your employer if your employer's worksite or operation becomes involved in a strike, lockout or bona fide labor dispute.

(b) If your wage subsidy or on-the-job training agreement is ended (and we stop paying any subsidies to your employer) because you were used to displace another employee, it will be up to you and the employer to decide whether you can (or want to) keep working there.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1500, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1500, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-1600 WorkFirst—Sanctions. (1) What WorkFirst requirements do I have to meet?**

You must do the following when you are a mandatory WorkFirst participant:

(a) Give the department the information we need to develop your individual responsibility plan (see WAC 388-310-0500);

(b) Show that you are participating fully to meet all of the requirements listed on your individual responsibility plan;

(c) Go to scheduled appointments listed in your individual responsibility plan;

(d) Follow the participation and attendance rules of the people who provide your assigned WorkFirst services or activities; and

(e) Accept available paid employment when it meets the criteria in WAC 388-310-1500.

**(2) What happens if I don't meet WorkFirst requirements?**

(a) If you do not meet WorkFirst requirements, we will send you a letter telling you what you did not do.

(b) You will have ten days to contact us so we can talk with you about the situation. You can contact us in writing, by phone, by going to the appointment described in the letter, or by asking for an individual appointment.

(c) If you do not contact us within ten days, we will make sure you have been screened for family violence and use existing information to decide whether:

- (i) You were unable to do what was required; or
- (ii) You were able, but refused, to do what was required.

(d) If you had a good reason not to do a required activity we will work with you and, if needed, change the requirements in your individual responsibility plan. If you have been unable to meet your WorkFirst requirements because of family violence, you and your case manager will develop an IRP to help you with your situation, including referrals to appropriate services.

**(3) What is considered a good reason for not being able to do what WorkFirst requires?**

You have a good reason if it was not possible to do what WorkFirst requires due to a significant problem or event outside your control. Some examples of good reasons include:

(a) You had an emergent physical, mental or emotional condition, confirmed by a licensed health care professional that interfered with your ability to participate;

(b) You were threatened with or subjected to family violence;

(c) You could not locate child care for your children under thirteen years that was:

(i) Affordable (did not cost you more than your co-payment would under the working connections child care program in chapter 388-290 WAC);

(ii) Appropriate (licensed, certified or approved under federal, state or tribal law and regulations for the type of care you use and you were able to choose, within locally available options, who would provide it); and

(iii) Within a reasonable distance (within reach without traveling farther than is normally expected in your community).

(iv) You could not locate other care services for an incapacitated person who lives with you and your children.

(d) You had an immediate legal problem, such as an eviction notice; or

(e) You are a person who gets necessary supplemental accommodation (NSA) services under chapter 388-472 WAC and your limitation kept you from participating. If you have a good reason because you need NSA services, we will review your accommodation plan.

**(4) What if we decide that you did not have a good reason for failing to meet WorkFirst requirements?**

If we decide that you did not have a good reason for failing to meet WorkFirst requirements, we will send you a letter that tells you:

- (a) What you failed to do;
- (b) That you are in sanction status;
- (c) Penalties that will be applied to your grant;
- (d) When the penalties will be applied;

(e) How to request a fair hearing if you disagree with this decision; and

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(f) How to end the penalties and get out of sanction status.

**(5) What is sanction status?**

When you are a mandatory WorkFirst participant, you must follow WorkFirst requirements to qualify for your full grant. If you or someone else on your grant doesn't comply and you can't prove that you had a good reason, you do not qualify for your full grant. This is called being in WorkFirst sanction status.

**(6) Are there penalties when you or someone in my household goes into sanction status?**

(a) When someone in your household is in sanction status, we impose penalties. The penalties last until you or the household member meet WorkFirst requirements.

(b) There are three penalty levels:

(i) Level one: We calculate your family's grant and then remove the noncompliant person(s) share of the grant;

(ii) Level two: Your reduced grant (removing the non-compliant person's share) will be sent to a protective payee every month until you get out of sanction status. (WAC 388-460-0001 describes the protective payee rules.)

(iii) Level three: Your grant is reduced by the person(s) share or forty percent, whichever is more and your reduced grant will be sent to a protective payee until you get out of sanction status.

(c) The penalties change depending on how long you have been in sanction status and how many times you have been in sanction status:

(i) The first time you go into sanction your penalties will start at level one. If you are still in sanction after three months, you will go to level two. If you are still in sanction after another three months, you will go to level three.

(ii) The second time you are in sanction, your penalties start at level two and changes to level three after three months.

(iii) After three or more times in sanction, you start at level three.

(d) If you are in sanction status on August 1, 2002, your penalties will start at level one, two, or three depending on how long you have been in sanction status. This will be considered your first sanction.

**(7) How do I end the penalties and get out of sanction status?**

To stop the penalties and get out of sanction status:

(a) You must provide the information we requested to develop your individual responsibility plan; and/or

(b) Start and continue to do your required WorkFirst activities, as follows:

(i) For two weeks in a row if you are in level one of sanction;

(ii) For four weeks in a row if you are in level two or three of sanction.

(c) When you leave sanction status, your grant will be restored beginning with the day you began doing your required activities.

**(8) What if I reapply for TANF or SFA and I was in sanction status when my case closed?**



(a) If your case closes while you are in sanction status and is reopened in six months or less, you will start out in sanction where you were when the case was closed.

(b) If your case has been closed for more than six months, you will not be in sanction status if your case is reopened.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-1600, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1600, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1600, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1600, filed 10/1/97, effective 11/1/97.]

### **WAC 388-310-1650 WorkFirst—Child SafetyNet Payments. (1) What is a Child SafetyNet Payment?**

A Child SafetyNet Payment (CSNP) is a TANF/SFA time limit extension to maintain housing and basic utilities and other verified needs of the children in your household. (See WAC 388-484-0006.) Your family will get a Child SafetyNet Payment extension instead of a regular TANF/SFA time limit extension if:

(a) You or another adult in your household has been getting TANF/SFA for more than sixty months; and

(b) Someone in your household is in sanction status because they are not exempt (see WAC 388-310-0300 and 388-310-0350) and have refused to do WorkFirst requirements without a good reason. We will not place you into CSNP status unless we first offered you the opportunity to talk about the proposed sanction as required by WAC 388-310-1600(2) and gave you notice that we did not think you had a good reason for failing to meet WorkFirst requirements as required by WAC 388-310-1600(4).

### **(2) How will I know if my family will be getting a Child SafetyNet Payment?**

We will send you a letter that tells:

(a) What caused your household to go into sanction status;

(b) When your Child SafetyNet Payments will start;

(c) How to request a fair hearing if you disagree with the decision; and

(d) How to become qualified for regular TANF/SFA time limit extension benefits.

### **(3) Are there penalties when my household gets a Child SafetyNet Payment?**

(a) When your household gets a Child SafetyNet Payment:

(i) We reduce your grant by forty percent or the noncompliant person's share, whichever is more; and

(ii) Send your family's CSNP to a protective payee.

(b) The protective payee can only pay your verified rent and utility costs with your CSNP and will spend anything left over to pay your children's expenses (like clothing, diapers, toiletries, school supplies or other school-related costs).

(c) The Child SafetyNet Payment is cash assistance and if you get more than you are eligible to get, then we can recover the amount we overpaid you under chapter 388-410 WAC.

### **(4) How do I end the penalties and get out of CSNP status?**

To stop the penalties and get out of CSNP status, you must:

(a) Prove that you have been doing your WorkFirst requirements for one full month; or

(b) Prove that you had a good reason not to do your required activities (see WAC 388-310-1600(3)); or

(c) Become exempt from WorkFirst requirements (see WAC 388-310-0350).

### **(5) What happens when I leave CSNP status?**

Once you leave CSNP status:

(a) All your penalties will end if you proved that you had a good reason not to do your WorkFirst requirements or you became exempt; or

(b) You will go into level three of sanction status described in WAC 388-310-1600(6). Your grant will be sent to a protective payee and reduced by forty percent or the non-compliant person's share, whichever is more.

(c) The level three sanction penalties will end after you do all your WorkFirst requirements for four weeks in a row.

### **(6) What if I reapply for TANF or SFA and my family was in CSNP status a when my case closed?**

If your case closes while you are in CSNP status, you will go back into CSNP status when your grant is reopened.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-084, § 388-310-1650, filed 6/28/02, effective 7/29/02.]

### **WAC 388-310-1700 WorkFirst—Self-employment.**

#### **(1) What is self-employment?**

When you work for yourself and do not have an employer, you are self-employed.

#### **(2) When can I be deferred from job search to pursue self-employment?**

(a) To be deferred from job search for self-employment, you must meet all the conditions below:

(i) You must be working at least thirty-two hours a week at your business;

(ii) Your business must generate income for you that is equal to the minimum wage (state or federal, whichever is higher) times thirty-two hours per week after your business expenses are subtracted.

(iii) Your case manager will refer you to a local business resource center, and they must approve your self-employment plan;

(b) If you do not meet all these conditions, you can still be self-employed, but you will also need to participate in job search or other WorkFirst activities.

#### **(3) What self-employment services can I get?**

If you are a mandatory participant and have an approved self-employment plan in your individual responsibility plan, you may get the following self-employment services:

(a) A referral to community resources for technical assistance with your business plan.

(b) Small business training courses through local community organizations or technical and community colleges.

(c) Information on affordable credit, business training and ongoing technical support.

#### **(4) What support services may I receive?**

If you have an approved self-employment plan in your individual responsibility plan all support services are available.

**(5) Can I get childcare?**

Childcare is available if you have an approved self-employment plan in your individual responsibility plan. (See chapter 388-290 WAC for working connections child care rules.)

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-1700, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1700, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1700, filed 10/1/97, effective 11/1/97.]

**WAC 388-310-1800 WorkFirst—Post employment services. (1) What is the purpose of post employment services?**

Post employment services help low-income parents who are working twenty hours or more a week keep and cope with their current jobs, look for better jobs, gain work skills for a career and become self sufficient.

**(2) How do I obtain post employment services?**

(a) You can obtain post employment services by:

(i) Asking for a referral from the local community service office;

(ii) Contacting community or technical colleges; or

(iii) Contacting the employment security department.

Employment security department staff may also telephone you if you got a job while you were on TANF or SFA to see if you are interested in receiving these services.

(b) You may qualify for different services (from various state or federal programs) depending on whether you:

(i) Are a mandatory participant (that is, you currently receive TANF or SFA benefits);

(ii) Used to receive TANF or SFA benefits; or

(iii) Have never been on TANF or SFA.

**(3) Who provides post employment services and what kind of services do they provide?**

(a) The employment security department can help you increase your wages, increase your job skills or find a better job by providing you with:

(i) Employment and career counseling;

(ii) Labor market information;

(iii) Job leads for a better job (sometimes called job development);

(iv) On the job training;

(v) Help with finding a job that matches your interests, abilities and skills (sometimes called job matching); and

(vi) Help with finding a new job after job loss (sometimes called reemployment).

(b) Any Washington state technical and community college can approve a skill-training program for you that will help you advance up the career ladder. Their staff will talk to you, help you decide what training would work best for you and then help you get enrolled in these programs. The college may approve the following types of training for you at any certified institution:

(i) High school/GED,

(ii) Vocational education training,

(iii) Job skills training,

(iv) Adult basic education,

(v) English as a second language training, or

(vi) Preemployment training.

**(4) What other services are available while you receive post employment services?**

While you receive post employment services, you may qualify for:

(a) Working connections childcare if you meet the criteria for this program (described in chapter 388-290 WAC).

(b) Other support services, such as help in paying for transportation or work expenses.

(c) Other types of assistance for low-income families such as food stamps, medical assistance or help with getting child support that is due to you and your children.

**(5) Who is eligible for post employment service, support services and childcare?**

You may qualify for post employment services, support services and child care if you are working twenty hours or more a week, and:

(a) You are current TANF or SFA recipient. You qualify for:

(i) All types of post employment services, unless you are in sanction status;

(ii) Tuition assistance from the community and technical college system;

(iii) WorkFirst support services; and

(iv) Working connections childcare.

(b) You are a former TANF or SFA recipient. You qualify for:

(i) Employment retention services (help with keeping a job) for up to twenty-four months after exiting TANF or SFA.

(ii) Wage and skill progression services (help with finding a better job and/or obtaining better wages) for up to twenty four months after exiting TANF or SFA.

(iii) Tuition assistance or preemployment training from the community and technical college system;

(iv) Working connections childcare assistance; and/or

(v) WorkFirst support services for up to twelve months after exiting TANF or SFA.

(c) You are a low wage earner (that is, your family income does not exceed one hundred seventy-five percent of the federal poverty level) who has never received TANF or SFA benefits, and are in a community or technical college-approved skill training program. You may qualify for:

(i) Tuition assistance or preemployment training from the community and technical college system; or

(ii) Working connections child care while you are in training or school for up to a total of thirty six months.

**(6) What if I lose my job while I am receiving post employment services?**

If you now receive or used to receive TANF or SFA, help is available to you for up to four weeks so that you can find another job and continue in your approved post employment.

(a) The employment security department will provide you with reemployment services.

(b) At the same time, your case manager can approve up to four weeks of support services and childcare for you.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-15-067, § 388-310-1800, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-1800, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1800, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1800, filed 10/1/97, effective 11/1/97.]

### **WAC 388-310-1900 WorkFirst—Services for American Indian tribal members and other American Indians.**

#### **(1) When might I be referred to a tribal government?**

Your case manager may refer you to a tribal government when you are an American Indian who applies for or receives TANF assistance, and:

(a) You are in the population and service area identified in a tribal government's federally-approved tribal TANF program; or

(b) The tribal government does not operate its own TANF program, but it works with the local community service office to provide WorkFirst services and activities to meet your needs.

#### **(2) What if I am an American Indian and am not referred to a tribal TANF program or tribal government to receive services?**

WorkFirst state agencies and their community partners must give you equitable access to all WorkFirst activities and services.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1900, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1900, filed 10/1/97, effective 11/1/97.]

### **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 388-400 WAC PROGRAM SUMMARY**

### **WAC**

388-400-0005	Who is eligible for temporary assistance for needy families?
388-400-0010	Who is eligible for state family assistance?
388-400-0025	General assistance unemployable—General eligibility requirements.

- 388-400-0030 Refugee cash assistance—Summary of eligibility requirements.
- 388-400-0035 Refugee medical assistance—Summary of eligibility requirements.
- 388-400-0040 General eligibility requirements for the federal food assistance program.
- 388-400-0045 Food assistance program for legal immigrants (FAP)—General eligibility requirements.

**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 388-400-0010 Who is eligible for state family assistance?** (1) To be eligible for state family assistance (SFA), certain aliens must meet Washington state residency requirements as listed in WAC 388-424-0015.

(2) You are eligible for SFA if you are not eligible for temporary assistance for needy families for the following reasons:

(a) You are a qualified alien and have been in the United States for less than five years as described in WAC 388-424-0010;

(b) You are a alien who is permanently residing in the United States under color ow law (PRUCOL) as defined in WAC 388-424-0005;

(c) You are a nineteen or twenty-year-old student that meets the education requirements of WAC 388-404-0005;

(d) You are a caretaker relative of a nineteen or twenty-year-old student that meets the education requirements of WAC 388-404-0005; or

(e) You are a pregnant woman who has been convicted of:

(i) Misrepresenting their residence in order to receive benefits from two or more states at the same time; or

(ii) A drug-related felony as described in WAC 388-442-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-400-0010, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-400-0025 General assistance unemployable—General eligibility requirements.** (1) You can get general assistance unemployable (GAU) benefits if:

(a) You are incapacitated as required under WAC 388-448-0010 through 388-448-0120;

(b) You are at least eighteen years old or, if under eighteen, a member of a married couple;

(c) You are in financial need according to GAU income and resource rules in chapters 388-450, 388-470 and 388-488 WAC;

(d) You meet the general assistance citizenship/alien status requirements under WAC 388-424-0005(3);

(e) You provide a Social Security number as required under WAC 388-476-0005;

(f) You reside in the state of Washington as required under WAC 388-468-0005;

(g) You undergo a treatment and referral assessment as provided under WAC 388-448-0130 through 388-448-0150;

(h) You assign interim assistance as provided under WAC 388-448-0210.

(2) You cannot get GAU benefits if:

(a) You are eligible for temporary assistance for needy families (TANF) benefits;

(b) You are eligible for state family assistance (SFA) benefits unless you are not eligible under WAC 388-400-0010;

(c) You have the ability to, but refuse to meet a TANF or SFA eligibility rule;

(d) You are eligible for supplemental security income (SSI) benefits;

(e) You are an ineligible spouse of an SSI recipient; or

(f) You were denied benefits or your benefits were terminated by the Social Security Administration (SSA) for failing to follow a SSI program rule or application requirement.

(3) The assistance unit will be established according to WAC 388-408-0010.

(4) You may be eligible for GAU if you reside in a public institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it. Your eligibility will depend upon the type of institution you are in.

(a) If you reside in a public institution and are otherwise eligible for GAU, you may be eligible for general assistance if you are:

(i) A patient in a public medical institution; or

(ii) A patient in a public mental institution and are:

(A) Sixty-five years of age or older; or

(B) Twenty years of age or younger.

(b) You are not eligible for GAU when you are in the custody of or confined in a public institution such as a state penitentiary or county jail including placement:

(i) In a work release program; or

(ii) Outside of the institution.

[Statutory Authority: RCW 74.04.057, 74.08.090. 00-15-017, § 388-400-0025, filed 7/10/00, effective 9/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0025, filed 7/31/98, effective 9/1/98.]

**WAC 388-400-0030 Refugee cash assistance—Summary of eligibility requirements.** (1) To be eligible for refugee cash assistance (RCA), 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 employment and training requirements of WAC 388-466-0150; and

(d) Meet income and resource requirements of WAC 388-466-0140.

(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) We determine your eligibility and benefit level for RCA using the TANF payment standards under WAC 388-478-0020.

(4) If you are eligible for RCA you may also be eligible for additional requirements for emergent needs under WAC 388-436-0002.

(5) If you meet the requirements of this section you are eligible for refugee cash assistance only during the eight-month period beginning in the first month you entered the United States (WAC 388-466-0120).

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.320, and 7 C.F.R. § 400.65, § 400.66, § 400.67, § 400.68, and § 400.69. 02-09-051, § 388-400-0030, filed 4/12/02, effective 5/13/02. 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.]

**WAC 388-400-0040 General eligibility requirements for the federal food assistance program.** (1) Persons applying for benefits for the federal food assistance program must meet certain eligibility criteria established under the Food Stamp Act of 1977 as amended.

(2) When a person applies for benefits, a decision is made about who must be included in the assistance unit as specified under WAC 388-408-0035.

(3) After the assistance unit is determined, all members must:

(a) Be U.S. citizens or nationals as specified under WAC 388-424-0005(1); or

(b) Be qualified aliens as specified under WAC 388-424-0020;

(c) Be residents of the state of Washington as specified under chapter 388-468 WAC; and

(d) Provide Social Security numbers as specified under chapter 388-476 WAC.

(4) To be eligible, an assistance unit must:

(a) Have income at or below gross and net income standards unless excluded from these standards as specified under WAC 388-478-0060;

(b) Own resources at or below the applicable resource limits as specified in WAC 388-470-0005;

(c) Provide identity as specified under WAC 388-406-0015;

(d) Participate in the food stamp employment and training program (FSE&T) as specified under chapter 388-444 WAC;

(e) Meet the eligibility criteria for strikers as specified in chapter 388-480 WAC;

(f) Return a completed monthly report as required under chapter 388-456 WAC.

(5) Assistance units are allowed deductions from their income as specified under WAC 388-450-0200.

(6) Persons with disabilities may be allowed special consideration as explained in subsection (7) of this section, when the person:

(a) Receives SSI;

(b) Receives disability payments:

(i) Under Titles I, II, XIV, or XVI of the Social Security Act;

(ii) From a local, state or federal government agency that considers the disability as permanent under section 221(i) of the Social Security Act;

(iii) From the Railroad Retirement Act under sections 2(a)(1)(iv) and (v) and meets Title XIX disability elements or is eligible for Medicare.

(c) Receives disability-related medical assistance under Title XIX of the Social Security Act;

(d) Is a veteran and receives disability payments rated at one hundred percent;

(e) Is a spouse of a veteran and:

(i) Is in need of an attendant or permanently housebound;

or

(ii) Has a disability as described under section 221(i) of the Social Security Act and entitled to death or pension payments under Title 38 of the USC.

(7) A person with disabilities described in subsection (6) of this section:

(a) Does not have to have income at or below the gross income standard, only the net income standard;

(b) May be entitled to a medical deduction as described under chapter 388-450 WAC; or

(c) Is not required to count the value of a vehicle when the vehicle is needed to transport them as specified under WAC 388-470-0070 and 388-470-0075.

(8) The following persons applying for food assistance are denied benefits:

(a) Students attending an institution of higher education when the student does not meet the eligibility factors as specified under WAC 388-482-0005;

(b) Able-bodied adults without dependents who are no longer eligible under WAC 388-444-0030; and

(c) Assistance units who participate in the food distribution program. This program is available to assistance units living on or near an Indian reservation. The program is administered by tribal organizations approved by the federal Food and Nutrition Service (FNS).

(9) The following persons applying for food assistance are denied benefits but some of their income and all of their resources are considered available to the eligible assistance unit members:

(a) Fugitive felons including probation and parole violators and felons convicted of drug-related felonies as specified under chapter 388-442 WAC;

(b) Persons failing to attest to citizenship or alien status under WAC 388-408-0035(9);

(c) Persons disqualified for:

(i) An intentional program violation as specified under WAC 388-446-0015;

(ii) Failure to provide a Social Security number under chapter 388-476 WAC; or

(iii) Not participating with work requirements as specified under chapter 388-444 WAC; or

(d) Persons who are ineligible aliens under WAC 388-424-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0040, filed 7/31/98, effective 9/1/98.]

**WAC 388-400-0045 Food assistance program for legal immigrants (FAP)—General eligibility requirements.** (1) A legal immigrant meets alien status eligibility for the state-funded food assistance program if the immigrant:

(a) Meets those alien status requirements of the Food Stamp Act of 1977 in effect prior to August 22, 1996;

(b) Is not eligible for federal food stamps solely due to the immigrant provisions of the Personal Responsibility and



Work Opportunity Reconciliation Act of 1996, P.L. 104-193, as amended. The immigrant must meet alien status rules under WAC 388-424-0025.

(2) FAP provides the same amount of benefits as the federal food stamp program. Some assistance units may receive a combined benefit of both state and federal food stamps. Food assistance benefit levels are found in WAC 388-478-0060.

(3) FAP follows the same eligibility rules, except for alien status, as the federal food stamp program. The federal food stamp program summary is found in WAC 388-400-0040.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0045, filed 7/31/98, effective 9/1/98.]

### Chapter 388-404 WAC AGE REQUIREMENTS

#### WAC

388-404-0005	How does a child's age and attendance in school affect their eligibility for TANF and SFA?
388-404-0010	Age requirement for GA-U and ADATSA.
388-404-0015	Definition of elderly person for food and cash assistance programs.

**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.]

**WAC 388-404-0010 Age requirement for GA-U and ADATSA.** To be eligible for general assistance - unemployable (GA-U) or the ADATSA program a person must be:

(1) At least eighteen years of age or older; or

(2) For GA-U only, if under eighteen years of age, a member of a married couple:

(a) Residing together, or

(b) Residing apart solely because a spouse is:

(i) On a visit of ninety days or less;

(ii) In a public or private institution;

(iii) Receiving care in a hospital, long-term care facility, or chemical dependency treatment facility; or

(iv) On active duty in the uniformed military services of the United States.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-404-0015 Definition of elderly person for food and cash assistance programs.** For food and cash assistance, "elderly person" means a person sixty years of age or older.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0015, filed 7/31/98, effective 9/1/98.]

### Chapter 388-406 WAC APPLICATIONS

#### WAC

388-406-0005	Can I apply for cash, medical, or food assistance?
388-406-0010	How do I apply for benefits?
388-406-0012	What is the date of my application and how does it affect my benefits?
388-406-0015	Can I get food assistance right away?
388-406-0021	How the department decides if you are a migrant or seasonal farmworker and if you are destitute.
388-406-0030	Do I need to submit other information after I apply for benefits?
388-406-0035	How long does the department have to process my application?
388-406-0040	What happens if the processing of my application is delayed?
388-406-0045	Is there a good reason my application for cash or medical assistance has not been processed?
388-406-0050	How do I know when my application is processed?
388-406-0055	When do my benefits start?
388-406-0060	What happens when my application is denied?
388-406-0065	Can I still get benefits even after my application is denied?

### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-406-0020	Destitute household definition. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0020, filed 7/31/98, effective 9/1/98.] Repealed by 99-24-008, filed 11/19/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-406-0025	Applicant to provide information needed to determine eligibility. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0025, filed 7/31/98, effective 9/1/98.] Repealed by 02-11-137, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.

**WAC 388-406-0005 Can I apply for cash, medical, or food assistance?** (1) You can apply for any program benefit the department offers, including cash, medical, or food assistance.

(2) You must meet certain eligibility requirements in order to receive a program benefit.

(3) You can apply for someone else if you are:

(a) A legal guardian, caretaker, or authorized representative applying on behalf of a dependent child, an incapacitated person, or someone who is deceased; or

(b) Acting on behalf of the applicant when the applicant can not apply for some other reason. We may ask why the applicant is unable to apply on their own behalf.

(4) You do not need to apply for medical benefits if you get Supplemental Security Income (SSI) as we automatically open medical benefits for you.

(5) A person or agency may apply for GAU or medical assistance on your behalf if:

(a) You are temporarily living out of state; and

(b) You are a Washington state resident.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-11-137, § 388-406-0005, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0405 and 388-504-0410.]

**WAC 388-406-0010 How do I apply for benefits?** (1) You can apply for cash, food, or medical assistance by giving us an application form in person, by mail, by fax, or by completing an online application.

(2) If your entire household gets or is applying for Supplemental Security Income (SSI), then your household can file an application for food assistance at the local Social Security Administration District Office (SSADO).

(3) A legal guardian, caretaker, or authorized representative can apply for a dependent child or incapacitated person or someone unable to apply on their own behalf for some other reason.

(4) You can apply for cash, food, and medical assistance with just one application form.

(5) If you apply for benefits at a local office, we accept your application on the same day you come in. If you apply at the wrong office, we send your application to the appropriate office no later than the next business day so that office receives your application on the same day we send it.

(6) We accept your application for benefits if it has at least:

(a) For cash or medical assistance, the name, address, and signatures of the responsible adult household members or person applying on your behalf. A minor child may sign if there is no adult in the household. Signatures must be either handwritten, electronic or digital as defined by the department, or a mark if witnessed by another person; or

(b) For food assistance, the name, address, and signature of a responsible household member or person applying on your behalf.

(7) As a part of the application process, you may be required to:

(a) Complete an interview if one is required under WAC 388-452-0005;

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(b) Give us the information we need to decide if you are eligible as required under WAC 388-406-0030; and

(c) Give us proof of information as required under WAC 388-490-0005 so we can determine if you are eligible.

(8) If you are eligible for necessary supplemental accommodation (NSA) services under chapter 388-472 WAC, we help you comply with the requirements of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-11-137, § 388-406-0010, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0405.]

**WAC 388-406-0012 What is the date of my application and how does it affect my benefits?** The date of your application affects when your benefits start. The date of your application is the date any field office receives your application unless:

(1) Your entire household gets or applies for Supplemental Security Income (SSI) and requests food assistance at the local Social Security office, then the date of application is the date Social Security gets your application; or

(2) You apply outside of normal business hours, including online, dropped off, or by fax, then the date of your application is the next business day.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-11-137, § 388-406-0012, filed 5/21/02, effective 7/1/02.]

**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 appropriate utility allowance under WAC 388-450-0195, if you have heating or cooling costs and the appropriate utility allowance is greater than the amount you pay; or

(b) The amount you pay, if it is greater than the appropriate utility allowance.

(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

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(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; 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 and are found eligible for food assistance, we give you benefits for no more than two months. If we give you benefits and we need additional information to decide if you are eligible for continued benefits, you have up to thirty days from the date you applied 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 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 20 C.F.R. 416.2130. 02-20-068, § 388-406-0015, filed 9/30/02, effective 10/31/02. 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.]

**WAC 388-406-0021 How the department decides if you are a migrant or seasonal farmworker and if you are destitute.** The rules in this section apply to food assistance.

(1) A migrant is a person who travels away from home on a regular basis, usually with a group of other workers, to seek employment in an agriculturally-related activity. A migrant assistance unit is an assistance unit that travels for this purpose.

(2) A seasonal farmworker is a person who:

(a) Does agricultural work on a farm for edible crops; and

(b) Is not required to be away from their permanent place of residence overnight in order to perform this work.

(3) For seasonal farmworkers, agricultural work is field work in which the person:

(a) Plants;

(b) Cultivates; or

(c) Harvests the crop.

(4) An assistance unit is considered a seasonal farmworker assistance unit if it receives its only countable income from:

(a) Seasonal farmwork;

(b) Unemployment compensation between seasons; or

(c) Interest earned on a checking or savings account.

(5) A migrant or seasonal farmworker is considered destitute when:

(a) The assistance unit's income for the month of application was received before the date of application and was from a source no longer providing income; or

(b) The assistance unit's income of the month of application is from a new source and the assistance unit will not receive more than twenty-five dollars during the ten calendar days from the date of application.

(6) A household member changing jobs but continuing to work for the same employer is considered to be receiving income from the same source.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-406-0021, filed 11/19/99, effective 1/1/00.]

**WAC 388-406-0030 Do I need to submit other information after I apply for benefits?** (1) When we get your application for benefits, we decide if other information is needed to determine your eligibility for benefits. If so, we give you:

(a) A written request for what is needed and for proof if required under WAC 388-490-0005; and

(b) At least ten calendar days to give us the information.

(2) If you ask orally or in writing for additional time to give us requested information, then we give you at least ten additional calendar days.

(3) If you give us some of the information we requested, we give you:

(a) A written request for what is needed to determine eligibility; and

(b) At least ten additional calendar days to give us the information.

(4) If you are eligible for necessary supplemental accommodation (NSA) services under chapter 388-472 WAC, we help you comply with the requirements of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-11-137, § 388-406-0030, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0030, filed 7/31/98, effective 9/1/98.]

**WAC 388-406-0035 How long does the department have to process my application?** (1) We must process your application as quickly as possible. We must respond promptly to your application and to any information you give us. We can not delay processing your request by using the time limits stated in this section as a waiting period for determining eligibility.

(2) Unless your application is delayed under WAC 388-406-0040, we process your application for benefits within thirty calendar days, except:

(a) If you are pregnant, your medical must be processed within fifteen working days;

(b) General assistance (GAU), alcohol or drug addiction treatment (ADATSA), or medical assistance must take no more than forty-five calendar days; and

(c) Medical assistance requiring a disability decision must take no more than sixty calendar days.

(3) For calculating time limits, "day one" is the date following the date:

(a) An application for benefits is received by the department as specified under WAC 388-406-0010;

(b) Social Security gets a request for food assistance from a household in which all members either get or are applying for Supplemental Security Income (SSI);

(c) You are released from an institution if you get or are authorized to get SSI and request food assistance through Social Security prior to your release.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-11-137, § 388-406-0035, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0470.]

**WAC 388-406-0040 What happens if the processing of my application is delayed?** (1) We process your application for benefits as soon as possible. We do not intentionally delay processing your application for benefits for any reason. If we have enough information to decide eligibility for:

(a) Food assistance, then we promptly process your request for food assistance even if we need more information to determine eligibility for cash or medical;

(b) Medical assistance, then we promptly process your request for medical even if we need more information to determine eligibility for cash or food assistance.

(2) If your application for food assistance is not processed within the first thirty days and we have enough information to determine eligibility, then we promptly process your application. If additional information is needed to determine eligibility, we give you:

(a) A written request for the additional information; and

(b) An additional thirty days to provide the information.

(3) If your application for food assistance has not been processed by the sixtieth day and you are responsible for the delay, then we deny your request for benefits. If we are responsible for the delay, then we:

(a) Promptly process your request if we have the information needed to determine eligibility; or

(b) Deny your request if we don't have enough information to determine eligibility. If we deny your request we notify you of your right to file a new application and that you may be entitled to benefits lost. If you reapply by the sixtieth day of your first application and are eligible, we give you benefits lost from:

(i) The date of your first application if we caused the delay in the first thirty days; or

(ii) The month following the month of your first application if you caused the delay in the first thirty days.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0040, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0040, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050,

74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

**WAC 388-406-0045 Is there a good reason my application for cash or medical assistance has not been processed?** If your application for cash or medical assistance is not processed within the time limits under WAC 388-406-0035, the department must decide if there is a good reason for the delay. This good reason is also called "good cause."

(1) We do not have a good reason for not processing your application for TANF or SFA within thirty days if:

(a) We did not give or send you a notice of what information we needed to determine your eligibility within twenty days from the date of your application;

(b) We did not give or send you a notice that we needed additional information or action within five calendar days of the date we learned that more information was needed to determine eligibility;

(c) We did not process your application within five calendar days from getting the information needed to decide eligibility; and

(d) We decide good cause exists but do not document our decision in the case record on or before the time limit for processing the application ends.

(2) We do have a good reason for not processing your application timely if:

(a) You do not give us the information or take an action needed for us to determine eligibility;

(b) We have an emergency beyond our control; or

(c) There is no other available verification for us to determine eligibility and the eligibility decision depends on information that has been delayed such as:

(i) Medical documentation;

(ii) For cash assistance, extensive property appraisals; or

(iii) Out-of-state documents or correspondence.

(3) For medical assistance, good cause exists only when the department otherwise acted promptly at all stages of the application process.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0045, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0045, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

**WAC 388-406-0050 How do I know when my application is processed?** (1) Your application is processed when:

(a) We approve or deny benefits; and

(b) We give or send you a letter telling you if you are eligible to get benefits.

(2) Any letters we send you must meet the requirements under chapter 388-458 WAC.

(3) We send you a letter of withdrawal under WAC 388-458-0006 if you voluntarily withdraw an application verbally, in sign language, or in writing.

(4) We send you a letter of denial according to the requirements of WAC 388-406-0060.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0050, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0050, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050,

74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2505.]

**WAC 388-406-0055 When do my benefits start?** The date we approve your application affects the amount of benefits you get. If you are eligible for:

(1) Cash assistance, your benefits start:

(a) The date we have enough information to make an eligibility decision; or

(b) No later than the thirtieth day for TANF, SFA, or RCA; or

(c) No later than the forty-fifth day for general assistance (GAU).

(2) Food assistance, your benefits start from the date you applied unless:

(a) You are recertified for food assistance, then the date we start your benefits is under WAC 388-434-0020;

(b) We were unable to process your application within thirty days because of a delay on your part. If you caused the delay, then we approve your benefits starting the first day of the month following the month of application if you submit required verification by the end of the second thirty-day period, even if we denied your application; or

(c) We denied your application for food assistance and your assistance unit becomes categorically eligible (CE) within sixty days from the date you applied, then the date we approve food assistance is the date you become CE. You are CE if you meet the criteria specified in WAC 388-414-0001.

(3) Medical assistance, the date your benefits start is stated in chapter 388-416 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0055, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0055, filed 7/31/98, effective 9/1/98.]

**WAC 388-406-0060 What happens when my application is denied?** (1) We (the department) deny your application for cash, medical, or food assistance benefits if:

(a) You do not show for your interview appointment for cash or food assistance if required under WAC 388-452-0005 and have not rescheduled and your application is over thirty days old; or

(b) We do not have the information we need to determine your eligibility within ten days of request and you did not ask for additional time to give us the information; or

(c) Your entire assistance unit does not meet certain eligibility criteria to get benefits; or

(d) For food assistance, your application has not been processed by the sixtieth day because of a delay on your part.

(2) If we deny your application, you do not get benefits unless:

(a) You mistakenly apply for benefits you already get; or

(b) We reconsider your eligibility under WAC 388-406-0065 and you are eligible to get benefits.

(3) We can reconsider if you are eligible for benefits under the requirements of WAC 388-406-0065 even after your application is denied.

(4) We give or send a letter to you explaining why your application was denied as required under WAC 388-458-0011.

(5) If you disagree with our decision about your application, you can ask for a fair hearing. If we deny your application because we do not have enough information to decide that you are eligible, the hearing issue is whether you are eligible using:

(a) Information we already have; and

(b) Any more information you can give us.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0060, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.057 and C.F.R. 273.2(h1d), waiver October 10, 1984. 00-13-076, § 388-406-0060, filed 6/19/00, effective 7/20/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0060, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0485.]

**WAC 388-406-0065 Can I still get benefits even after my application is denied?** (1) If we (the department) deny your application for benefits, we can redetermine your eligibility for benefits without a new application if:

(a) For cash or medical assistance, you give us the information we need within thirty days from the date we denied your application;

(b) For food assistance:

(i) You give us the information we need by the end of the month following the month you applied; or

(ii) You become categorically eligible for food assistance under WAC 388-414-0001 within sixty days of the date you applied for benefits.

(2) For medical assistance, if the thirty days to reconsider your application under subsection (1) of this section has ended you can still get benefits without a new application if:

(a) You timely request a fair hearing; and

(b) You give us the information needed to determine eligibility and you are eligible.

(3) If you are eligible for cash or food assistance, we decide the date your benefits start according to WAC 388-406-0055. If you are eligible for medical assistance, we decide the date your benefits start according to chapter 388-416 WAC. For all programs the eligibility date is based on the date of your original application that was denied.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0065, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0065, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0485.]

## Chapter 388-408 WAC ASSISTANCE UNITS

### WAC

388-408-0005	What is a cash assistance unit?
388-408-0010	Who is in my assistance unit for general assistance?
388-408-0015	Who must be in my assistance unit for temporary assistance for needy families (TANF) or state family assistance (SFA)?
388-408-0020	When am I not allowed to be in a TANF or SFA assistance unit?
388-408-0025	When can I choose who is in my TANF or SFA assistance unit?
388-408-0030	What children must be in the same TANF or SFA assistance unit?
388-408-0034	What is an assistance unit for food assistance?
388-408-0035	Who is in my assistance unit for food assistance?
388-408-0040	How does living in an institution affect my eligibility for food assistance?

- 388-408-0045 Am I eligible for food assistance if I live in a shelter for battered women and children?  
 388-408-0050 Does the department consider me homeless for food assistance benefits?  
 388-408-0055 Medical assistance units.

### 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 incapacitated 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

(2003 Ed.)

(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-

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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

(2003 Ed.)

(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.]

**WAC 388-408-0055 Medical assistance units.** (1) A medical assistance unit (MAU) is determined on the basis of relationship and financial responsibility.

(a) Married persons, living together are financially responsible for each other;

(b) Parents are financially responsible for their unmarried, minor children living in the same household;

(c) A parent's financial responsibility is limited when their minor child is receiving inpatient chemical dependency or mental health treatment. Only the income a parent chooses to contribute to the child is considered available when:

[Title 388 WAC—p. 677]

(i) The treatment is expected to last ninety days or more;  
 (ii) The child is in court-ordered out-of-home care in accordance with chapter 13.34 RCW; or

(iii) The department determines the parents are not exercising responsibility for the care and control of the child.

(d) Minor children are not financially responsible for their parents or for their siblings.

(2) Certain situations require the establishment of separate MAUs for some family members living in the same household. Separate MAUs are established for:

(a) A pregnant minor, regardless of whether she lives with her parent(s);

(b) A child with income;

(c) A child with resources which makes another family member ineligible for medical assistance;

(d) A child of unmarried parents when both parents reside with the child;

(e) Each unmarried parent of a child in common, plus any of their children who are not in separate MAUs;

(f) A caretaker relative that is not financially responsible for the support of the child;

(g) SSI recipients or SSI-related persons from the non-SSI related family members;

(h) The purpose of applying medical income standards for an:

(i) SSI-related applicant whose spouse is not related to SSI or is not applying for SSI-related medical; and

(ii) Ineligible spouse of an SSI-recipient.

(3) Only the parent's income actually contributed to a pregnant minor is considered income to the minor.

(4) A parent's income up to one hundred percent of the Federal Poverty Level (FPL) is allocated to the parent and other members of the parent's MAU. The excess is allocated among their children in separate MAUs.

(5) A parent's resources are allocated equally among the parent and all persons in the parent's household for whom the parent is financially responsible. This includes family members in separate MAUs.

(6) Countable income for medical programs is described in WAC 388-450-0150 and 388-450-0210.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-408-0055, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610, 388-506-0630 and 388-507-0730.]

## Chapter 388-410 WAC BENEFIT ERROR

### WAC

388-410-0001	What is a cash/medical assistance overpayment?
388-410-0005	Cash and medical assistance overpayment amount and liability.
388-410-0010	Repayment of grant overpayment occurring prior to April 3, 1982, and resulting department error.
388-410-0015	Recovery of cash assistance overpayments by mandatory grant deduction.
388-410-0020	What happens if I get more food assistance benefits than I am supposed to get?
388-410-0025	Am I responsible for an overpayment in my assistance unit?
388-410-0030	How does the department calculate and set up my food assistance overpayment?
388-410-0033	How and when does the department collect a food assistance overpayment?

388-410-0035 Alien and alien sponsor cash, and food assistance overpayments.

388-410-0040 Cash and food assistance underpayments.

**WAC 388-410-0001 What is a cash/medical assistance overpayment?** (1) An overpayment is any cash or medical assistance paid that is more than the assistance unit was eligible to receive.

(2) There are two types of cash/medical overpayments:

(a) Intentional overpayments, presumed to exist when the client willfully or knowingly:

(i) Fails to report within twenty days a change in circumstances that affects eligibility; or

(ii) Misstates or fails to reveal a fact affecting eligibility as specified in WAC 388-446-0001.

(b) Unintentional overpayments, which includes all other client-caused and all department-caused overpayments.

(3) If you request a fair hearing and the fair hearing decision is in favor of the department, then:

(a) Some or all of the continued assistance you get before the fair hearing decision must be paid back to the department (see WAC 388-418-0030); and

(b) The amount of assistance you must pay back will be limited to sixty days of assistance, starting with the day after the department receives your hearing request.

(4) If you receive child support payments directly from the noncustodial parent, you must turn these payments over to the division of child support (DCS). These payments are not cash assistance overpayments.

[Statutory Authority: RCW 74.04.510 and 7 C.F.R. 273.9 (d)(6). 99-24-131, § 388-410-0001, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0001, filed 7/31/98, effective 9/1/98.]

**WAC 388-410-0005 Cash and medical assistance overpayment amount and liability.** (1) The amount of overpayment for cash and medical assistance households is determined by the amount of assistance received to which the assistance unit was not entitled.

(2) Cash and medical assistance overpayments are recovered from:

(a) Any individual member of an overpaid assistance unit, whether or not the member is currently a recipient; or

(b) Any assistance unit of which a member of the overpaid assistance unit has subsequently become a member.

(3) A cash or medical assistance overpayment is not recovered from:

(a) A nonneedy caretaker relative or guardian who received no financial benefit from the payment of assistance; or

(b) A person not receiving assistance when an unintentional overpayment of less than thirty-five dollars is discovered and/or computed.

(4) Overpayments resulting from incorrectly received cash assistance are reduced by:

(a) Cash assistance a household would have been eligible to receive from any other category of cash assistance during the period of ineligibility; and

(b) Child support the department collected for the month of overpayment in excess of the amount specified in (a) of this subsection; or

- (c) Any existing grant underpayments.
- (5) A cash assistance overpayment cannot be reduced by a medical or food assistance underpayment.
- (6) A medical assistance overpayment cannot be reduced by a cash or food assistance underpayment.
- (7) An underpayment from one assistance unit cannot be credited to another assistance unit to offset an overpayment.
- (8) All overpayments occurring after January 1, 1982 are required to be repaid by mandatory grant deduction except where recovery is inequitable as specified in WAC 388-410-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0005, filed 7/31/98, effective 9/1/98.]

**WAC 388-410-0010 Repayment of grant overpayment occurring prior to April 3, 1982, and resulting department error.** (1) An assistance unit will not be held liable for an overpayment occurring prior to April 3, 1982, which was caused by departmental error, until the department determines recovery would not be inequitable. Recovery is considered inequitable if:

- (a) The department informed the recipient or the recipient's authorized representative that the recipient was entitled to part or all of the financial assistance or services overpaid; or
- (b) The department acted in a manner which would reasonably lead the recipient to believe he/she was eligible to receive the assistance or services overpaid; and
- (c) The recipient retained or accepted the assistance with the understanding that he/she had the right to rely upon the information received from the department; and
- (d) The recipient would suffer an injury if the department were allowed to refuse to recognize the department's admission, statement, act or omission; and
- (e) Injury as used in this section includes liability for repayment of a debt due the state.

(2) If the department determines recovery would be inequitable:

- (a) The recipient is not liable for repayment;
  - (b) The overpayment is not a debt due the state; and
  - (c) The recipient is so informed.
- (3) If recovery would not be inequitable, the recipient will be notified:
- (a) Of the specific reason why recovery is not inequitable;
  - (b) That the recipient is liable for repayment of the debt;
  - (c) Whether the overpayment is subject to a mandatory deduction from the current grant; and
  - (d) Of the right to contest the decision.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-410-0015 Recovery of cash assistance overpayments by mandatory grant deduction.** (1) All overpayments of cash assistance are recovered by means of a mandatory deduction from future continuing assistance grants except as specified by WAC 388-410-0010.

(2003 Ed.)

(2) All members of an overpaid assistance unit are responsible for repayment of an overpayment. Repayment may be from:

- (a) Resources and/or income; or
  - (b) Deductions from subsequent grants; and
  - (c) An assistance unit member's estate.
- (3) The mandatory grant deduction of an intentional overpayment is ten percent of the monthly grant payment standard.
- (4) A monthly grant deduction of up to one hundred percent of the grant can be established when:
- (a) The overpayment is intentional;
  - (b) The client has liquid resources available but refuses to use these resources in full or partial satisfaction of the overpayment; and
  - (c) The amount of income and resources remaining available to the assistance unit is not less than ninety percent of the grant payment standard.

(5) An unintentional overpayment is recovered by grant deduction of five percent of the monthly grant payment standard unless the client voluntarily requests a larger deduction in writing.

(6) A monthly deduction for overpayment recovery can be established against the clothing and incidental grant of a recipient in a nursing facility, intermediate care facility, or hospital. A monthly deduction cannot be established against the vendor payment to the nursing facility, intermediate care facility or hospital.

(7) When the monthly grant deduction is equal to or more than the current grant for which the client is eligible had no overpayment occurred, the grant is suspended.

(8) No more than the total amount of an overpayment may be collected by mandatory deduction from a client's public assistance grant. The client will receive compensation for an underpayment resulting from any erroneous monthly deduction.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0015, filed 7/31/98, effective 9/1/98.]

**WAC 388-410-0020 What happens if I get more food assistance benefits than I am supposed to get?** (1) If you get more assistance benefits than you were supposed to get, your assistance unit (AU) has a food assistance overpayment. There are three types of food assistance overpayments:

(a) **Administrative error overpayment:** When you received too many benefits because the department made a mistake.

(b) **Inadvertent household error overpayment:** When you received too many benefits because you made a mistake or didn't understand what you were supposed to do.

(c) **Intentional program violation (IPV) overpayment:** When you received too many benefits because you broke a food stamp rule on purpose. If you have an IPV, you could be disqualified from receiving food assistance benefits under chapter 388-446 WAC.

(2) The department must set up and start collecting an overpayment within certain timeframes. If we do not meet both of the timeframes below based on the type of overpayment your AU has, we will not set up an overpayment:

[Title 388 WAC—p. 679]

(a) Administrative error overpayment:	(b) Inadvertent household error overpayment:	(c) Intentional program violation overpayment:
We must discover the overpayment within twelve months of the date you were overpaid; and	We must discover the overpayment within twenty-four months of the date you were overpaid; and	We must discover the overpayment within seventy-two months of the date you were overpaid; and
We must mail your household a recovery demand letter and overpayment calculation within twenty-four months of the date that we discovered you were overpaid.	We must mail your household a recovery demand letter and overpayment calculation within twenty-four months of the date that we discovered you were overpaid.	We must mail your household a recovery demand letter and overpayment calculation within twenty-four months of the date that were discovered you were overpaid.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 7 C.F.R. 273.18. 02-06-090, § 388-410-0020, filed 3/1/02, effective 4/1/02. 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 Am I responsible for an overpayment in my assistance unit?** If your assistance unit (AU) gets more food assistance benefits than it was supposed to get, your AU has an overpayment. If you have an overpayment, the department determines the amount you were overpaid and sets up a claim to recover this overpayment.

(1) We set up an overpayment for the full amount your AU was overpaid for every adult AU member at the time your AU was overpaid.

(2) Each adult member is responsible for the whole overpayment until we recover the entire amount of the overpayment. We do not collect more than the amount your AU was overpaid.

(3) If we determine you are responsible for an overpayment, you are responsible for the overpayment even if you are now in a different AU than you were when you had the overpayment.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 7 C.F.R. 273.18. 02-06-090, § 388-410-0025, filed 3/1/02, effective 4/1/02. 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 set up my food assistance overpayment?** (1) The department calculates the amount of your food assistance overpayment by counting the difference between:

- (a) The benefits your assistance unit (AU) received; and
- (b) The benefits your AU should have received.

(2) To calculate the benefits your AU should have received, we determine what we would have authorized if we:

- (a) Had correct and complete information; and
- (b) Followed all the necessary procedures to determine your AU's eligibility and benefits.

(3) If you did not report your earned income as required under WAC 388-468-0007, you do not get the earned income disregard under WAC 388-450-0185 when we calculate your overpayment amount.

(4) If you were underpaid food assistance benefits for a period of time, we will use these benefits to reduce your overpayment if:

(a) We have **not** already issued you benefits to replace what you were underpaid; and

(b) We have **not** used this amount to reduce another overpayment.

(5) We set up an inadvertent household error or administrative error overpayment if:

(a) We discovered the overpayment through the quality control process;

(b) You currently get food assistance benefits; or

(c) The overpayment is over one hundred twenty-five dollars and you do not currently get food assistance benefits.

(6) We do not set up inadvertent household error or administrative error overpayment if:

(a) We cannot find the responsible AU members; or

(b) We have referred your inadvertent household error for prosecution or an administrative disqualification hearing and collecting the overpayment could negatively impact this process.

(7) We set up an intentional program violation overpayment based on the results of an administrative hearing (chapter 388-02 WAC) unless:

(a) Your AU has repaid the overpayment;

(b) We cannot find the responsible AU members; or

(c) We have referred your inadvertent household error for prosecution and collecting the overpayment could negatively impact this process.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 03-01-005, § 388-410-0030, filed 12/4/02, effective 2/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 7 C.F.R. 273.18. 02-06-090, § 388-410-0030, filed 3/1/02, effective 4/1/02. 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.]

**WAC 388-410-0033 How and when does the department collect a food assistance overpayment?** (1) You can repay your overpayment by:

(a) Paying the entire amount at once;

(b) Having us take the amount of your overpayment out of your EBT account;

(c) Making regular installments under a payment schedule as specified in subsection (3) of this section; or

(d) Having your current food assistance benefits reduced.

(2) If you have an inactive EBT account and we cancelled food assistance benefits in the account under WAC 388-412-0025, we use the cancelled funds to reduce the amount of your overpayment.

(3) If your AU currently gets food assistance, you can repay your overpayment by monthly installments that you

agree on with the department. The agreement must be more than we would recover through us reducing your benefits. Your AU or the department can request a change to the agreement if necessary.

(4) If you are responsible for repaying an administrative or inadvertent household error overpayment, we automatically reduce your monthly benefits if you do not:

- (a) Pay the overpayment all at once;
- (b) Set up a repayment agreement with us; or
- (c) Request a fair hearing and continued benefits within ninety days of the date you received your collection action notice.

(5) If you are responsible for an intentional program violation (IPV) overpayment, you must tell us how you want to repay this overpayment within ten days of the date you get your collection action notice. If you do not do this, we will reduce your current monthly benefits.

(6) If you get ongoing food assistance benefits we can reduce your monthly benefits to repay the overpayment. We do not reduce your first food assistance allotment when we approve your application for food assistance benefits.

(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 IPV overpayment, we reduce your benefits by the greater of:

- (i) Twenty percent of your monthly benefits; or
- (ii) Twenty dollars per month.

(7) If you do not meet the terms of a repayment agreement with the department, we automatically reduce your current food assistance benefits unless you:

- (a) Catch up with all overdue payments; or
- (b) Ask us to consider a change to the repayment schedule.

(8) If you no longer get food assistance, we will refer your overpayment for federal collection if the claim is past due for one hundred eighty or more days. A federal collection includes reducing your income tax refund, social security benefits, or federal wages. We do not count your overpayment as past due if you:

- (a) Repay the entire overpayment by the due date; or
- (b) Meet the requirements of your scheduled repayment agreement.

(9) If you no longer get food assistance benefits, we can garnish your wages, file a lien against your personal or real property, attach other benefits, or otherwise access your property to collect the overpayment amount.

(10) We suspend collection on an overpayment if:

- (a) We cannot find the responsible AU members; or
- (b) The cost of collecting the overpayment would likely be more than the amount we would recover.

(11) We can negotiate the amount of an overpayment if the amount you offer is close to what we could expect to get from you before we can no longer legally collect the overpayment from you.

(12) We write off unpaid overpayments and release any related liens when:

- (a) We can not possibly collect any more funds;

(b) We agreed to accept a partial payment that left an unpaid balance after this payment; or

(c) There is an unpaid balance left after an overpayment case has been suspended for three consecutive years unless a collection may be possible through the Treasury Offset Program.

(13) If your AU has an overpayment from another state, we can collect this overpayment if the state where you were overpaid does not plan to collect it and they give us the following:

(a) A copy of the overpayment calculation and overpayment notice made for the client; and

(b) Proof that you received the overpayment notice.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 7 C.F.R. 273.18.02-06-090, § 388-410-0033, filed 3/1/02, effective 4/1/02.]

**WAC 388-410-0035 Alien and alien sponsor cash, and food assistance overpayments.** (1) An alien and their sponsor are jointly and individually liable for any overpayment of cash or food assistance made to the alien during the three years after the alien's entry into the United States.

(2) When an overpayment to a sponsored alien results from incorrect information provided by the alien's sponsor, both the alien and the sponsor are liable for repayment.

(3) When the alien's sponsor had good cause for reporting the incorrect information, the sponsored alien is solely liable for an inadvertent household error overpayment.

(4) When good cause does not exist, collection action is initiated against:

- (a) The alien's sponsor; or
- (b) The sponsored alien's assistance unit; or
- (c) Of the two, the one considered most likely to repay first.

(5) Collection action is initiated against an alien's sponsor for an inadvertent household error when:

(a) A department representative contacts the sponsor in person or by phone; and

(b) The sponsor is informed in writing there will be no responsibility for repayment if good cause for reporting incorrect information causing the overpayment can be demonstrated.

(6) Collection action is initiated against the sponsored alien's assistance unit for an inadvertent household error when:

(a) Collection action is taken first against the alien's sponsor; and

(b) The alien's sponsor does not respond within thirty days; or

(c) The sponsored alien provides incorrect information concerning the sponsor or sponsor's spouse through misunderstanding or unintended error.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-410-0035, filed 7/31/98, effective 9/1/98.]

**WAC 388-410-0040 Cash and food assistance underpayments.** (1) All cash assistance underpayments not credited against an overpayment are repaid upon discovery to any current or former recipient.

(2) All food assistance benefits underpaid are restored when:



- (a) An underpayment was caused by department error;
  - (b) An administrative disqualification for intentional program violation was reversed;
  - (c) A rule or instruction specifies restoration of unpaid benefits; or
  - (d) A court action finds benefits were wrongfully withheld.
- (3) A client is eligible for restoration of underpaid benefits for any of the twelve months prior to:
- (a) The month the client requests restoration;
  - (b) The month the department discovers an underpayment;
  - (c) The date the household makes a fair hearing request when a request for restoration of benefits was not received; or
  - (d) The date court action was started when the client has taken no other action to obtain restoration of benefits.
- (4) The client may request a fair hearing if they disagree with the amount of benefits the department determines were underpaid.
- (5) If household composition changes prior to the department's restoration of an underpayment, the underpayment is paid to:
- (a) First, the household containing a majority of the persons who were household members at the time of the underpayment; or
  - (b) Second, the household containing the head of the household at the time of the underpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0040, filed 7/31/98, effective 9/1/98.]

### Chapter 388-412 WAC BENEFIT ISSUANCES

#### WAC

388-412-0005	General information about your cash benefits.
388-412-0010	Endorsing the warrant.
388-412-0015	General information about your food assistance allotments.
388-412-0020	When do I get my benefits?
388-412-0025	How do I get my benefits?
388-412-0030	Returning a warrant.
388-412-0035	Loss, theft, destruction or nonreceipt of a warrant issued to clients and vendors.
388-412-0040	Can I get my benefits replaced?

#### 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.
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**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 388-412-0010 Endorsing the warrant.** (1) Clients must endorse their warrants unless they have executed a power of attorney. If a client has given someone else a power of attorney, the client must give the department a copy.

(2) If a client is unable to sign the warrant, it must be endorsed by the client's mark or thumb print witnessed by two people. The witnesses must give their names and addresses to the person that cashes the warrant.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-412-0015 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) If you get your cash benefits on an electronic benefits card (EBT), you get your cash benefits deposited on the first of each month.

(2) If you get your cash benefits deposited directly to your bank account, electronic funds transfer (EFT), your money is deposited on the first working day of the month. When the first of the month is a federal holiday or a Sunday, the benefits are deposited the following day.

(3) If you get food assistance your benefits are issued by the tenth day of each month. The day you get your benefits is the same as the last number of your food assistance AU number. If the last number of your assistance unit (AU) number is zero, you get your benefits on the tenth.

[Statutory Authority: RCW 74.04.510 and 74.08.090. 02-18-105, § 388-412-0020, filed 9/3/02, effective 10/4/02; 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 either:

(a) Electronic benefit transfer (EBT), electronic benefits card which is a direct deposit into a DSHS account that you access with a debit card called Quest;

(b) Electronic funds transfer (EFT), which is a direct deposit into your own bank account; or

(c) A check to:

(i) A payee who is not approved for direct deposit [or]; or

(ii) You, if you get diversion, additional requirements for emergent needs or clothing and personal incidentals (CPI) payments.

(2) You use a debit 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 under time frames in WAC 388-412-0020.

(4) We establish an EBT account for each AU that receives their benefits by EBT.

(5) Your cash and food assistance are canceled when you do not use your EBT benefits for three hundred sixty-five days.

(a) Food benefits that have not been used for three hundred sixty-five days cannot be replaced.

(b) You have two years to contact department of revenue in order to replace cash benefits that were canceled because you did not use them for three hundred sixty-five days. You can contact department of revenue at 1-800-435-2429. After that time, you must contact the state treasurer to claim any canceled funds.

(6) When you move to a state where you cannot use your EBT account we convert your food assistance to coupons. There may be up to one dollar and ninety-nine cents left in your EBT account after conversion. You must use the remaining balance in your EBT account within seven days

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after we convert your benefits from EBT to coupons. We cancel these benefits if you do not use them within the seven days.

(7) EBT benefits cannot be converted into checks. You must use your cash benefits from your EBT account.

[Statutory Authority: RCW 74.04.510 and 74.08.090. 02-18-105, § 388-412-0025, filed 9/3/02, effective 10/4/02; 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.]

**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 388-412-0030 Returning a warrant.** (1) A person who has possession of a warrant payable to a deceased payee must return the warrant to the department for cancellation.

(2) A person who has possession of a warrant payable to an assistance unit payee who has left the home and is not likely to return during the month to endorse the warrant, must return the warrant to the CSO. The warrant may be reissued to another eligible payee for the assistance unit.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0030, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0030, filed 7/31/98, effective 9/1/98.]

**WAC 388-412-0035 Loss, theft, destruction or non-receipt of a warrant issued to clients and vendors.** The following applies to replacements of warrants issued to clients and to vendors.

(1) The department does not replace a warrant or the cash proceeds from a warrant which was endorsed by a client or vendor.

(2) Clients or vendors asking for a replacement of a warrant which was not endorsed by them must:

(a) Complete a notarized affidavit;

(b) Provide all facts surrounding the loss, theft, destruction or nonreceipt of the warrant; and

(c) File a report with the police or the post office, as appropriate.

(3) If a client is eligible to receive a replacement, the warrant is issued:

(a) On or before the tenth of the month in which the warrant was due; or

(b) Within five working days of the date the decision is made to replace the warrant, whichever is later.

(4) A client or vendor is issued the full amount of the original warrant if the warrant is replaced.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0035, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0035, filed 7/31/98, effective 9/1/98.]

**WAC 388-412-0040 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 your 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.]

**Chapter 388-414 WAC****CATEGORICAL ELIGIBILITY FOR FOOD ASSISTANCE****WAC**

388-414-0001 Some food assistance units do not have to meet all eligibility requirements.

[Title 388 WAC—p. 684]

**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;

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- (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**

- 388-416-0005 How long can I get food assistance?
- 388-416-0010 Medical certification periods for recipients of cash assistance programs.
- 388-416-0015 Certification periods for categorically needy (CN) medical and children's health insurance program (CHIP).
- 388-416-0020 Certification periods for noninstitutionalized medically needy (MN) program.
- 388-416-0030 Certification periods for the medically indigent (MI) program.
- 388-416-0035 Certification periods for Medicare cost sharing programs.

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

- 388-416-0025 Certification period for children's health program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-416-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0970, 388-519-1905, 388-521-2106 and 388-522-2210.] Repealed by 02-17-030, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415.

**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.

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(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.]

**WAC 388-416-0010 Medical certification periods for recipients of cash assistance programs.** (1) The certification period for medical services begins on the first day of the month of application when the client is determined eligible for cash assistance for one of the following programs:

- (a) Temporary assistance for needy families (TANF);
  - (b) Supplemental Security Income (SSI); or
  - (c) Refugee assistance.
- (2) The certification period for the medical programs associated with the cash programs in subsection (1) of this section continues as long as eligibility for these programs lasts. When a client's cash assistance is terminated, eligibility for medical assistance is continued until eligibility is redetermined as described in WAC 388-418-0025.

(3) The certification period for medical can begin up to three months prior to the month of application for clients described in subsection (1) of this section if the conditions in WAC 388-416-0015(6) apply.

(4) The certification period for medical care services begins on the date eligibility begins for the following cash assistance programs:

- (a) General assistance for unemployable persons (GA-U); or
- (b) Alcohol and drug abuse treatment and support act (ADATSA) programs, when the client is either receiving a grant or waiting for treatment to begin.

(5) The certification period for medical care services for clients in subsection (4) of this section runs concurrently with the period of eligibility for the client's cash assistance program.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-416-0010, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-416-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2110, 388-521-2120, 388-522-2210 and 388-524-2420.]

**WAC 388-416-0015 Certification periods for categorically needy (CN) medical and children's health insurance program (CHIP).** (1) A certification period is the period of time a person is determined eligible for a categorically needy (CN) medical program. Unless otherwise stated in this section, the certification period begins on the first day of the month of application and continues to the last day of the last month of the certification period.

(2) For a child eligible for the newborn medical program, the certification period begins on the child's date of birth and continues through the end of the month of the child's first birthday.

(3) For a woman eligible for a medical program based on pregnancy, the certification period ends the last day of the month that includes the sixtieth day from the day the pregnancy ends.

(4) For families, children, and SSI-related persons, the certification period is twelve months. When the medical assistance unit is also receiving benefits under a cash or food assistance program, the medical certification period is updated to begin anew at each:

- (a) Approved application for cash or food assistance; or
- (b) Completed eligibility review.

(5) When the child turns nineteen the certification period ends even if the twelve-month period is not over. The certification period may be extended past the end of the month the child turns nineteen when:

- (a) The child is receiving inpatient services on the last day of the month the child turns nineteen;
- (b) The inpatient stay continues into the following month or months; and
- (c) The child remains eligible except for exceeding age nineteen.

(6) A retroactive certification period can begin up to three months immediately before the month of application when:

- (a) The client would have been eligible for medical assistance if the client had applied; and
- (b) The client received covered medical services as described in WAC 388-529-0100.

(7) If the client is eligible only during the three-month retroactive period, that period is the only period of certification.

(8) Any months of a retroactive certification period are added to the designated certification periods described in this section.

(9) For a child determined eligible for CHIP medical benefits as described in chapter 388-542 WAC:

- (a) The certification periods are described in subsections (1), (4), and (5) of this section;
- (b) There is not a retroactive eligibility period as described in subsections (6), (7), and (8); and
- (c) For a child who has creditable coverage at the time of application, the certification period begins on the first of the month after the child's creditable coverage is no longer in effect, if:

- (i) All other CHIP eligibility factors are met; and
- (ii) An eligibility decision is made per WAC 388-406-0035.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.09.450. 00-08-002, § 388-416-0015, filed 3/22/00, effective 5/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0015, filed 7/31/98, effective 9/1/98. Formerly 388-509-0970, 388-521-2105, 388-522-2210 and 388-522-2230.]

**WAC 388-416-0020 Certification periods for noninstitutionalized medically needy (MN) program.** (1) The

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certification period for the noninstitutionalized medically needy (MN) program begins:

(a) On the first day of the month in which hospital expenses equal the spenddown amount; or

(b) On the day that spenddown is met, when hospital expenses are less than the spenddown amount or no hospital expenses are involved.

(2) The certification period continues through the last day of the final month of the base period as described in chapter 388-519 WAC.

(3) The certification period can begin up to three months immediately prior to the month of application as described in chapter 388-519 WAC.

(4) The certification period for MN clients with income below the medically needy income level (MNIL) is twelve months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2105 and 388-521-2130.]

**WAC 388-416-0030 Certification periods for the medically indigent (MI) program.** (1) A client must meet the emergency medical expense requirement (EMER), before eligibility can be determined for the medically indigent (MI) program.

(2) If the client is not required to spenddown excess income or resources, the certification period for MI begins on the date that the EMER was met.

(3) When an MI applicant must satisfy a spenddown amount, the certification period begins:

(a) On the first day of the month in which hospital expenses (excluding the EMER) equal the spenddown amount; or

(b) On the day that spenddown is met, when hospital expenses are less than the spenddown amount.

(4) The certification period cannot exceed three calendar months in a twelve month period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2140.]

**WAC 388-416-0035 Certification periods for Medicare cost sharing programs.** (1) The certification period for the qualified Medicare beneficiary (QMB) program:

(a) Is for twelve months; and

(b) Begins the first day of the month following the month of QMB eligibility determination; and

(2) The certification period for the qualified disabled working individual (QDWI) program:

(a) Is twelve months; and

(b) May begin up to three months prior to the month of application if on the first day of the first month of the certification period the person:

(i) Is or had been enrolled in Medicare Part A; and

(ii) Meets or has met the department's eligibility requirements for QDWI.

(3) The certification period for the:

(a) Special low income medicare beneficiary (SLMB) program is twelve months in duration;

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(b) Expanded special low income medicare beneficiary (ESLMB) program extends to the end of the calendar year.

(4) The certification periods for SLMB and ESLMB may begin up to three months prior to the month of application if on the first day of the first month of the certification period the person:

(a) Is or has been enrolled in Medicare Part B; and

(b) Meets or has met the department's eligibility requirements for SLMB or ESLMB.

(5) The certification period for SLMB coverage is twelve months in duration.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2150, 388-521-2155 and 388-521-2160.]

**Chapter 388-418 WAC  
CHANGE OF CIRCUMSTANCE**

**WAC**

- 388-418-0005 What type of changes must I report for cash, food, and medical assistance?
- 388-418-0007 When do I have to report changes in my circumstances?
- 388-418-0020 How does the department determine the date a change affects my benefits?
- 388-418-0025 Effect of changes on medical program eligibility.

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

- 388-418-0010 Requesting information or action needed. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0010, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-418-0012 Prospective eligibility for food assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-418-0012, filed 7/26/99, effective 9/1/99.] Repealed by 00-07-077, filed 3/14/00, effective 5/1/00. Statutory Authority: RCW 74.08.090.
- 388-418-0015 Recipient fails to provide requested information or take requested action. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0015, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-418-0030 Notifying a recipient of intent to reduce, suspend or terminate assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-418-0030, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2205 and 388-525-2570.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

**WAC 388-418-0005 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

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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
(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 new-borns 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



<b>Table 1 - Cash Assistance and Food Assistance</b>		
<b>Type of change to report when you or anyone in your assistance unit AU):</b>	<b>Do I have to report this change for cash assistance?</b>	<b>Do I have to report this change for food assistance?</b>
(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
(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.

<b>Table 2 - Medical Assistance</b>		
<b>Type of change to report when you or anyone in your assistance unit (AU):</b>	<b>Do I have to report this change for family medical assistance (i.e., TANF/SFA-related)?</b>	<b>Do I have to report this change for children's medical and/or pregnancy medical?</b>
(16) Starts to get money from a new source;	Yes	No
(17) Has unearned income that changed;	Yes	No

<b>Table 2 - Medical Assistance</b>		
<b>Type of change to report when you or anyone in your assistance unit (AU):</b>	<b>Do I have to report this change for family medical assistance (i.e., TANF/SFA-related)?</b>	<b>Do I have to report this change for children's medical and/or pregnancy medical?</b>
(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
(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 spenddown.

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
(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.]

(2003 Ed.)

**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.]

**WAC 388-418-0020 How does the department determine the date a change affects my benefits?** (1) Unless otherwise specified, the rules in this chapter refer to cash, food and medical assistance benefits.

(2) When a change causes an increase in benefits, the client must provide proof of the change before we adjust the benefit amount.

(a) If you give us the proof within ten days from the date we requested it, we increase your benefits starting the month after the month you reported the change.

(b) If you give us the proof more than ten days after the date we requested it, we increase your benefits starting the month after the month we got the proof.

(c) If you are entitled to get more benefits and we have already sent you benefits for that month, we must send them to you within ten days of the day we got the proof.

(3) When a change causes a decrease in benefits, we change your benefit amount before we ask for proof:

(a) If you report the change within the time limits in WAC 388-418-0007, we decrease your benefits starting the first month following the advance notice period. The advance notice period:

(i) Begins on the day we send you a letter about the change, and

(ii) Is determined according to the rules in WAC 388-458-0010.

(b) If you do not report the change within the time limits in WAC 388-418-0007:

(i) We figure out the effective date as if you had reported it on time. This includes:

(A) Ten days for you to report the change, and  
 (B) Ten days for the advance notice period to begin, if required under chapter 388-458 WAC.

(ii) If the effective date should have been a past month:

(A) We establish an overpayment claim according to the rules in chapter 388-410 WAC for all the appropriate months; and

(B) Decrease your benefits starting the following month.

(iii) We establish an overpayment claim and decrease your benefits starting the month after next when:

(A) The effective date should have been next month; and

(B) It is less than ten days away; and

(C) We were supposed to give you ten days notice.

(iv) If the effective date should have been next month or the following month and we have time to give you ten-days notice, we decrease your benefits starting that month.

(c) We have until your next recertification/eligibility review to ask for proof.

(4) If we are not sure how the change will affect your benefits, we send you a letter as described in WAC 388-458-0020 requesting information from you.

(a) We give you ten days to provide the information. If you need more time, you can ask for it.

(b) If you do not give us the information in time, we will stop your benefits after giving you advance notice, if required, as described in WAC 388-458-0030.

(5) Within ten days of the day we learn about a change, we:

(a) Send advance notice according to the rules in chapter 388-458 WAC; and

(b) Take necessary action to correct the benefit. We wait to take action on a change if you request a hearing about a proposed decrease in benefits before the effective date or within the advance notice period as described in WAC 388-458-0040.

(6) When you request a hearing and get continued benefits:

(a) We keep giving you the same benefits you got before the advance notice of reduction until the earliest of the following events occur:

(i) For food assistance only, your certification period expires;

(ii) The end of the month the fair hearing decision is mailed;

(iii) You state in writing that you do not want continued benefits;

(iv) You withdraw your fair hearing request in writing; or

(v) You abandon your fair hearing request; or

(vi) An administrative law judge issues a written order that ends continued benefits prior to the fair hearing.

(b) We establish an overpayment claim according to the rules in chapter 388-410 WAC when the hearing decision agrees with the action we took.

(7) Some changes have a specific effective date as follows:

(a) When cash assistance benefits increase because a person is added to your assistance unit, we use the effective date rules for applications in WAC 388-406-0055.

(b) When cash assistance benefits increase because you start paying shelter costs, we use the date the change occurred.

(c) When a change in law or regulation changes the benefit amount, we use the date specified by the law or regulation.

(d) When institutional medical assistance participation changes, we calculate the new participation amount beginning with the month your income or allowable expense changes.

[Statutory Authority: RCW 74.08.090, 74.04.057, and 74.04.510. 02-14-086, § 388-418-0020, filed 6/28/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-418-0020, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0020, filed 7/31/98, effective 9/1/98.]

**WAC 388-418-0025 Effect of changes on medical program eligibility.** (1) A client continues to be eligible for Medicaid until the department determines the client's ineligibility or eligibility for another medical program. This applies to a client who, during a certification period, becomes ineligible for, is terminated from, or requests termination from:

(a) A CN Medicaid program; or

(b) Any of the following cash grants:

(i) TANF;

(ii) SSI; or

(iii) GA-X. See WAC 388-434-0005 for changes reported during eligibility review.

(2) A child remains continuously eligible for CN Medicaid for a period of twelve months from the date of certification for medical benefits or last review, whichever is later. This applies unless the child:

(a) Moves out of state;

(b) Loses contact with the department or the department does not know the child's whereabouts;

(c) Becomes an inmate of a public institution, including a correctional facility (refer to WAC 388-505-0210(5) for exceptions);

(d) Turns nineteen years of age;

(e) Dies; or

(f) Receives benefits under the state children's health insurance program (SCHIP) and:

(i) Does not pay health insurance premiums for four consecutive months; or

(ii) Is determined to have had creditable coverage at the time of application. Refer to chapter 388-542 WAC.

(3) When a client becomes ineligible for refugee cash assistance, refugee medical assistance can be continued only through the eight-month limit, as described in WAC 388-400-0035(4).

(4) A client receiving medical benefits with a TANF cash grant or family medical program is eligible for a medical extension, as described under WAC 388-523-0100, when the client's cash grant or family medical program is terminated as a result of:

(a) Earned income; or

(b) Collection of child or spousal support.

(5) A change in income during a certification period does not affect eligibility for:

(a) Pregnant women's medical programs; or

(b) The first six months of the medical extension benefits.

(6) For a child receiving benefits under SCHIP as described in chapter 388-542 WAC, the department must redetermine eligibility for a Medicaid program when the family reports:

- (a) Family income has decreased to less than two hundred percent FPL;
- (b) The child becomes pregnant;
- (c) A change in family size; or
- (d) The child receives SSI.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-418-0025, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.09.450. 00-08-002, § 388-418-0025, filed 3/22/00, effective 5/1/00. Statutory Authority: RCW 74.04.050, 74.04.057 and Section 4731 of the BBA (Public Law 105-33). 99-10-064, § 388-418-0025, filed 5/3/99, effective 6/3/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0840, 388-509-0920, 388-509-0960, 388-522-2205 and 388-522-2210.]

**Chapter 388-420 WAC**

**CHEMICAL DEPENDENCY FOOD ASSISTANCE**

**WAC**

388-420-010 Alcohol and drug treatment centers.

**WAC 388-420-010 Alcohol and drug treatment centers.** (1) Food assistance is only available to a resident of a drug or alcohol treatment center when the treatment center is:

- (a) Administered by a public or private nonprofit agency; and
- (b) Certified by the division of alcohol and substance abuse (DASA).

(2) A resident is considered a one person assistance unit. However if the resident's spouse or child is also living in the treatment center, the spouse or child is included in the resident's assistance unit.

(3) The resident must have a designated employee of the treatment center act as an authorized representative as specified in chapter 388-460 WAC.

(4) The authorized representative receives and uses the food assistance benefits for meals the resident is served in the treatment center.

(5) The authorized representative also has responsibilities as specified in chapter 388-460 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-420-010, filed 7/31/98, effective 9/1/98.]

**Chapter 388-422 WAC**

**CHILD SUPPORT**

**WAC**

- 388-422-0005 What happens to my child, spousal and medical support when I get public assistance?
- 388-422-0010 Do I have to cooperate with the division of child support (DCS)?
- 388-422-0020 What if you are afraid that cooperating with the division of child support (DCS) may be dangerous for you or the child in your care?
- 388-422-0030 What happens if my support is more than my TANF or SFA cash benefit?

(2003 Ed.)

**WAC 388-422-0005 What happens to my child, spousal and medical support when I get public assistance? (1)**

The following definitions apply to this chapter:

- (a) "We" means the department of social and health services.
- (b) "You" means a person applying for or getting benefits from us.
- (c) "Benefits" mean family medical and related alien emergency medical (AEM), TANF or SFA cash assistance.
- (d) "Support" means the money paid to meet a support order whether it is called child support, spousal support, alimony, maintenance, or medical support.
- (e) "Medical support" means either or both:
  - (i) The set dollar amount for health care costs in a support order; or
  - (ii) Health insurance coverage for a dependent child.
- (f) "Assistance unit" or "AU" means the group of people who live together and whose income and resources we count to decide your eligibility for benefits and the amount of those benefits.

(2) When you apply for TANF or SFA cash benefits, you assign your rights to current support and back support (also called "arrears") under WAC 388-14A-2036. You permanently assign to the state your current support for the months you get assistance. Support for months before you begin receiving assistance is temporarily assigned to the state. For more information about permanently and temporarily assigned support see:

- (a) Permanently assigned arrears, WAC 388-14A-2037.
- (b) Temporarily assigned arrears, WAC 388-14A-2038.
- (3) You assign your rights to medical support under WAC 388-505-0540 when you apply for or get benefits from the following:
  - (a) Family medical; or
  - (b) Children's medical.
- (4) You assign your rights to support when you sign the application for benefits, or when you get cash or medical benefits.

(5) If you have a good reason (WAC 388-422-0020) DCS may not be able to establish or collect child support (WAC 388-14A-2060).

(6) If you receive any support payments before you assign your rights to support, we count this as unearned income to your AU (WAC 388-450-0025).

(7) If you receive any direct support payments after you assign your rights to support, you must send the support payments to the division of child support (DCS) under WAC 388-14A-2040(3).

(8) If you keep any support payments you receive after you assign your rights to support, DCS may collect this money from you (WAC 388-14A-5505).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-19-041, § 388-422-0005, filed 9/11/02, effective 10/12/02; 98-16-044, § 388-422-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0560.]

**WAC 388-422-0010 Do I have to cooperate with the division of child support (DCS)?** (1) When you get benefits, you must cooperate with DCS as required to establish or col-

lect child support, unless you have a good reason for not cooperating.

(2) DCS defines what cooperating with them to establish or collect child support means in WAC 388-14A-2040.

(3) If you are a two-parent household, you and the other parent must help DCS establish paternity for each child in your AU, if necessary.

(4) DCS determines whether you are cooperating with them. See WAC 388-14A-2041(1) for reasons why DCS might determine that you are not cooperating.

(5) If you get TANF or SFA and do not have a good reason for not cooperating with DCS, we:

(a) Reduce your cash benefits by twenty-five percent; and

(b) Stop your medical benefits unless you are pregnant. The children in your AU will continue to get medical.

(6) If you get family medical and do not have a good reason for not cooperating with DCS, your medical will stop unless you are pregnant. The children in your AU will continue to get medical.

(7) If you are afraid that cooperating with DCS may be dangerous for you or a child in your care, see WAC 388-14A-2045 for a definition of what a good reason to not cooperate with DCS is. We also call this "good cause."

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-19-041, § 388-422-0010, filed 9/11/02, effective 10/12/02; 98-16-044, § 388-422-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0560.]

**WAC 388-422-0020 What if you are afraid that cooperating with the division of child support (DCS) may be dangerous for you or the child in your care?** (1) You can be excused from cooperating with DCS when you have a good reason. A good reason not to cooperate is also called good cause. You have a good reason when you can prove that:

(a) Cooperating with DCS would result in serious physical or emotional harm to you or the child in your care.

(b) Establishing paternity or getting support would be harmful to the child who:

(i) Was conceived as a result of incest or rape; or  
(ii) Is the subject of legal adoption proceedings pending before a superior court; or

(iii) Is the subject of ongoing discussions between you and a public or licensed child placement agency to decide whether you will keep the child or put the child up for adoption. The discussions cannot have gone on for more than three months.

(2) Once you claim good cause, you have twenty days to give us the information that proves you have good cause not to cooperate with DCS. This information can include official records, sworn statements, or other information that supports your good cause claim. If you need to, you may ask for:

(a) More time to give proof; or  
(b) Help in getting proof.

(3) While we review your good cause claim, DCS does not take any action to establish or enforce support on your case.

(4) You have the right to:

(a) Be told of your right to claim good cause for not cooperating with DCS;

(b) Get benefits while we are deciding your good cause claim, as long as you have given the proof needed to make a decision;

(c) Get a decision within thirty days from the date you made your good cause claim, as long as you have given the proof needed to make a decision within twenty days; and

(d) Get information about how to request a fair hearing if we deny your good cause claim.

(5) If we approve your good cause claim, we periodically review the claim depending on your circumstances.

(6) To see what DCS does when good cause is approved see WAC 388-14A-2060.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-19-041, § 388-422-0020, filed 9/11/02, effective 10/12/02; 98-16-044, § 388-422-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0570 and 388-505-0560.]

**WAC 388-422-0030 What happens if my support is more than my TANF or SFA cash benefit?** (1) If DCS collects current support that is more than your TANF or SFA cash benefit for two months in a row, your cash benefit stops at the end of the third month.

(2) You can read WAC 388-418-0025 for information on continued medical benefits.

(3) You may be able to get continued food assistance benefits.

(4) You can read WAC 388-310-0800 to see what kinds of support services you may be able to get.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-19-041, § 388-422-0030, filed 9/11/02, effective 10/12/02; 98-16-044, § 388-422-0030, filed 7/31/98, effective 9/1/98.]

## Chapter 388-424 WAC CITIZENSHIP/ALIEN STATUS

### WAC

388-424-0005	The effect of citizenship and alien status on eligibility for benefits.
388-424-0010	Alien status—Eligibility requirements for the temporary assistance for needy families program and medical benefits.
388-424-0015	Citizenship and alien status—Eligibility requirements for the state family assistance program (SFA).
388-424-0020	How does my alien status impact my eligibility for the federal food stamp program?
388-424-0025	Citizenship and alien status—Eligibility requirements for the food assistance program for legal immigrants.

**WAC 388-424-0005 The effect of citizenship and alien status on eligibility for benefits.** (1) To receive benefits under the temporary assistance for needy families (TANF), Medicaid, children's health insurance program (CHIP) or federal food stamp program, a person must be a:

(a) U.S. citizen;  
(b) U.S. national; or  
(c) Qualified alien who meets the eligibility requirements described in:

(i) WAC 388-424-0010 for TANF, Medicaid, and CHIP;  
or  
(ii) WAC 388-424-0020 for federal food stamps.

(2) To receive benefits under the general assistance and ADATSA programs, a person must be a:

- (a) U.S. citizen;
- (b) U.S. national;
- (c) Qualified alien; or
- (d) A PRUCOL alien as defined in subsection (4) of this section.

(3) Qualified aliens are any of the following:

(a) Lawful permanent residents under the Immigration and Nationality Act (INA);

(b) Those granted asylum under section 208 of the INA;

(c) Those paroled under section 212 (d)(5) of the INA for at least one year;

(d) Those admitted as refugees under section 207 of the INA;

(e) Aliens whose deportation (removal) is being withheld under section 241 (b)(3) or 243(h) of the INA;

(f) Those granted conditional entry under section 203 (a)(7) of the INA as in effect prior to April 1, 1980;

(g) Cuban and Haitian entrants as defined in section (501)(e) of the Refugee Education Assistance Act of 1980; or

(h) Amerasians admitted under section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as amended); or

(i) Aliens who are victims of domestic violence, or whose children are victims of domestic violence, when:

(i) The domestic violence was committed in the U.S. by the alien's spouse, parent, or a member of the spouse or parent's family residing in the same household as the alien;

(ii) The alien did not actively participate in the violence against his or her own children when the children are the victims of domestic violence;

(iii) The alien no longer resides with the person who committed the domestic violence;

(iv) There is a substantial connection between the domestic violence and the need for public assistance benefits; and

(v) The alien has an application with the Immigration and Naturalization Service (INS) either approved or pending for:

(A) Legal immigration status under section 204 (a)(1)(A) or section 204 (a)(1)(B) of the INA; or

(B) Cancellation of removal under section 244 (a)(3) of the INA as in effect prior to April 1, 1997 or section 240A (b)(2) of the INA.

(4) A PRUCOL alien must meet all of the following conditions:

(a) They are permanently residing in the U.S.;

(b) They do not meet a definition of a qualified alien as defined in subsection (3) of this section;

(c) The INS knows they are residing in the U.S.; and

(d) The INS is not likely to enforce their departure.

(5) During the application process, one of the following persons must indicate on the application for benefits whether each household member is a U.S. citizen or qualified alien:

(a) An adult applicant in the household; or

(b) The person applying for benefits when there are no adults in the household.

[Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-424-0005, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW

(2003 Ed.)

74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520, 388-518-1805 and 388-510-1020.]

**WAC 388-424-0010 Alien status—Eligibility requirements for the temporary assistance for needy families program and medical benefits.** (1) Qualified aliens as described in WAC 388-424-0005(3) who were residing in the United States (U.S.) before August 22, 1996 may receive temporary assistance for needy families (TANF), Medicaid, and CHIP benefits.

(2) Qualified aliens who first physically entered the U.S. after August 21, 1996 cannot receive TANF, Medicaid, or SCHIP for five years after obtaining status as a qualified alien, unless they are any of the following:

(a) An alien as described under WAC 388-424-0005 (3)(b), (d), (e), (g), or (h); or

(b) A lawful permanent resident who is:

(i) On active duty in the U.S. military, other than active duty for training;

(ii) An honorably discharged U.S. veteran;

(iii) A veteran of the military forces of the Philippines who served prior to July 1, 1946, as described in Title 38, section 107 of the U.S. code;

(iv) A Hmong or Highland Lao veteran who served in the military on behalf of the U.S. Government during the Vietnam conflict; or

(v) The spouse or unmarried dependent child(ren) of a person described in subsection (2)(b)(i) through (iv) of this section.

(3) A child born outside of the U.S. automatically becomes a U.S. citizen when:

(a) At least one of the parents is a U.S. citizen by birth or naturalization;

(b) The child is under eighteen years of age;

(c) The child is residing in the U.S. in legal and physical custody of the citizen parent; and

(d) The child is a lawful permanent resident.

(4) An Indian as described in WAC 388-424-0020 (2)(b) and (c) may receive Medicaid or CHIP benefits.

(5) Aliens, including PRUCOL aliens as defined in WAC 388-424-0005(4), who would qualify for Medicaid benefits, but are determined ineligible because of alien status or requirements for a Social Security Number, may receive medical coverage as follows:

(a) State-funded categorically needy (CN) scope of care for pregnant women, as described in WAC 388-462-0015; and

(b) Alien emergency medical services as described in WAC 388-438-0110.

(6) Alien status does not affect eligibility for the medical indigent program described in WAC 388-438-0100.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-424-0010, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and Public Law 106-395. 02-03-008, § 388-424-0010, filed 1/4/02, effective 2/4/02. Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-424-0010, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520 and 388-518-1805.]



**WAC 388-424-0015 Citizenship and alien status—Eligibility requirements for the state family assistance program (SFA).** To receive SFA benefits, you must be:

(1) A qualified alien who is not eligible for TANF benefits because of the five-year period of ineligibility described in WAC 388-424-0010(2); or

(2) An alien who is permanently residing in the U.S. under color of law (PRUCOL) as defined in WAC 388-424-0005(4).

#### Column 1

Refugee

Asylee

Deportation withheld

Cuban or Haitian entrant

Aliens lawfully admitted for permanent residence (immigrants)

Parolee for at least one year

Conditional Entrant

Battered spouse, battered child, or parent or child of a battered person as defined in WAC 388-424-0005

(2) In addition to the above noncitizens, you may be eligible for federal food stamp benefits if you legally live in the U.S. and are a member of one of the following groups:

(a) Hmong or Highland Laotian tribe members (including the tribal member's spouse and dependent children) when tribe assisted the U.S. during the Vietnam era beginning August 5, 1964 and ending May 7, 1975;

(b) Canadian born American Indians who are fifty percent American Indian blood; and

(c) American Indians who are noncitizens and members of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act.

(3) If you are a lawful permanent resident, you can receive credit for SSA work quarters by:

(a) Earning enough money to qualify for work quarters;

(b) Getting credit for quarters earned by a parent or step-parent while you are under eighteen; or

(c) Getting credit for quarters earned by a spouse while you are married if you are still married to them or they are deceased.

(4) You cannot receive credit for a SSA work quarter after January 1, 1997 if you received TANF, nonemergency Medicaid, or food stamp benefits during the quarter.

[Statutory Authority: RCW 74.04.050, 74.08.090, 00-08-060, § 388-424-0015, filed 3/31/00, effective 4/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-424-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

**WAC 388-424-0020 How does my alien status impact my eligibility for the federal food stamp program?** (1) If you are not a U.S. citizen, you must meet the following conditions and be otherwise eligible in order to receive federal food stamp benefits:

#### Column 2

**You are eligible for seven years from the date you entered the U.S. or from the date you were granted INS status:**

Refugee/Amerasian/Asylee

Deportation withheld/Cuban or Haitian entrant

If you entered the U.S. under an INS status listed above, you are still eligible for federal food stamps even if you change your INS status to immigrant during the seven-year period.

**You may be eligible for federal benefits without a time limit if you meet any of the following conditions:**

1. You are a permanent resident alien and you have worked or can get credit for forty Social Security Administration (SSA) work quarters.

2. You are a honorably discharged veteran, you are in active duty military (other than training), or you are the spouse, or unmarried dependent child of someone who meets this requirement.

3. You are blind or disabled and receive cash or medical benefits based on supplemental Security Income (SSI) disability or blindness criteria.

4. You were legally living in U.S. on August 22, 1996 and:

- You are currently under age eighteen, or
- You were born on or before August 22, 1931.

(5) If you apply for TANF, nonemergency Medicaid, or food stamp benefits during your fortieth quarter and you earned enough money to qualify for the quarter before you applied for benefits, you get credit for that quarter.

(6) You can get federal food stamp benefits for up to six months while we wait for verification of your eligibility if you or the department:

(a) Asked SSA for proof of your work quarters, SSA responded that you have less than forty quarters, and you provide proof that SSA is making an investigation to decide if they can credit you with more quarters; or

(b) Turned in a request to a federal agency for proof that you meet immigrant eligibility requirements for federal food stamp benefits. If you requested this proof, you must provide proof that the agency has accepted this request.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and H.R. 2646 Farm Security and Rural Investment Act of 2002, 02-22-046, § 388-424-0020, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.510, S. 1150, the Agricultural Research, Extension, and Education Reform Act of 1998, 99-01-058, § 388-424-0020, filed 12/11/98, effective 1/11/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-424-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

**WAC 388-424-0025 Citizenship and alien status—Eligibility requirements for the food assistance program for legal immigrants.** To receive benefits under the food assistance program (FAP) for legal immigrants, you must be one of the following:

(1) A qualified alien, as defined in WAC 388-424-0005, who cannot receive federal food stamps because of the eligibility restrictions described in WAC 388-424-0020; or

(2) An alien who does not meet the definition of a qualified alien as defined in WAC 388-424-0005 but who is:

(a) Allowed to enter the U.S. for permanent residence by permission of the U.S. Attorney General under section 249 of the Immigration and Nationality Act (INA);

(b) Admitted for temporary residence under section 245A of the INA and is aged, blind, or disabled as described in Title XVI of the Social Security Act;

(c) Granted temporary resident status by the Immigration and Naturalization Service (INS) as a special agricultural worker under section 210 of the INA;

(d) Granted family unity status by the INS and the alien's spouse or parent is eligible to participate in FAP or the federal food stamp program; or

(e) Permanently residing under color of law (PRUCOL) in the United States as defined in WAC 388-424-0005(4).

[Statutory Authority: RCW 74.08A.120. 00-13-036, § 388-424-0025, filed 6/13/00, effective 7/14/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

### Chapter 388-426 WAC CLIENT COMPLAINTS

WAC  
388-426-0005 Client complaints.

**WAC 388-426-0005 Client complaints.** (1) Clients who believe they have been discriminated against by the department for reason of race, color, creed, political affiliation, national origin, religion, age, gender, disability, or birthplace have the right to file a complaint. Clients can file discrimination complaints with the:

(a) DSHS, Division of Access and Equal Opportunity, PO Box 45012, Olympia, WA, 98504;

(b) Administrator, Food and Nutrition Services, 3101 Park Center Drive, Alexandria, VA, 22302; or

(c) Secretary of Agriculture, U.S. Department of Agriculture, Washington D.C., 20250.

(2) Clients with a complaint about a department decision or action have the right to present their complaint, in writing, to a supervisor.

(a) Within ten days of the receipt of the complaint:

(i) A decision will be made on the client's complaint; and

(ii) The client will be sent written notice of the decision, including information about the right to further review by the local office administrator.

(b) Clients not satisfied with the decision of a supervisor have the right to present a written complaint to the local office administrator. Within ten days of the receipt of the complaint:

(i) A decision will be made on the complaint, and

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(ii) The client will be sent written notice of the decision.

(c) Written notice of the administrator's decision concludes the complaint procedure.

(d) The filing of a written complaint does not prevent a client from requesting a fair hearing under WAC 388-08-413.

(e) Clients have the right to speak to a worker's supervisor or have a decision or action reviewed by the supervisor, whether or not a formal complaint has been filed.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-426-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-426-0005, filed 7/31/98, effective 9/1/98.]

### Chapter 388-428 WAC CONFIDENTIALITY

WAC  
388-428-0010 Request for address disclosure by a parent when a child is living with a nonparental caretaker.

**WAC 388-428-0010 Request for address disclosure by a parent when a child is living with a nonparental caretaker.** (1) When TANF or SFA has been approved for a child who is living with a nonparental caretaker, the address and location of the child may be released to the child's parent when:

(a) The parent has legal custody of the child or is allowed visitation rights or residential time with the child under a court order; and

(b) No court order restricts or limits the parent's right to contact or visit the child or the child's caretaker by imposing conditions to protect the child or the caretaker from harm;

(c) The department has not found that the caretaker has good cause for refusing to cooperate in child support enforcement activities related to the parent's support obligation; and

(d) There is no substantiated claim or pending investigation involving abuse or neglect of any child by the parent;

(e) There are no pending proceedings as listed in subsections (1)(b) through (d).

(2) A parent may request the child's address and location:

(a) In person, with satisfactory evidence of identity, at the community services office where the child's record is being maintained;

(b) Through an attorney; or

(c) If residing outside the state of Washington, by submitting a notarized request.

(3) If the request for the child's address and location is based on a court order granting the parent legal custody, visitation rights or residential time, the parent must also submit:

(a) A copy of the court order; and

(b) A sworn statement that the order has not been modified.

(4) Prior to release of the child's address and location, the child's caretaker will be notified that:

(a) The child's parent has requested the information; and

(b) The information will be released within thirty days from the date of the notice unless the caretaker:

(i) Provides proof of a current investigation or pending court case involving the abuse or neglect of any child by the parent;

[Title 388 WAC—p. 695]

(ii) Provides a copy of a court order which prevents disclosure of the address or restricts the parent's right to contact or visit the caretaker or the child by imposing conditions to protect the caretaker or child from harm;

(iii) Requests a fair hearing which results in a decision that disclosure must be denied because of the existence of one or more of the conditions in subsection (1) of this section.

(5) A parent's request for disclosure of a child's address and location will be responded to within thirty-five days. The response will notify the parent:

(a) Of the child's address and location if the information may be disclosed;

(b) The reasons for denying the request if the information may not be disclosed; or

(c) That a decision has not been made because the child's caretaker:

(i) Has requested a hearing and a final hearing decision has not been entered; or

(ii) Is claiming good cause for refusing to cooperate in child support enforcement activities related to the parent's support obligation and a final decision has not been made on the caretaker's claim.

(d) When the decision has not been made because of a pending fair hearing decision or good cause claim determination, the parent will be notified of the decision within ten days of the hearing decision or good cause determination.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-428-0010, filed 7/31/98, effective 9/1/98.]

### Chapter 388-432 WAC

#### DIVERSION ASSISTANCE

##### WAC

388-432-0005 Can I get help from DSHS for a family emergency without receiving monthly cash assistance?

**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

388-434-0005 The department reviews each client's eligibility for benefits on a regular basis.

388-434-0010 How do I get food assistance benefits after my certification period has ended?

**WAC 388-434-0005 The department reviews each client's eligibility for benefits on a regular basis.** (1) If you receive cash assistance, the department reviews your eligibility for assistance at least once every six months.

(2) When it is time for your eligibility review, the department requires you to complete a review form. We use the information you provide to determine your eligibility for all assistance programs.

(3) If you complete an interview for assistance with a department representative and sign the printed application for benefits (AFB) form, you do not have to complete a separate review form.

(4) For cash assistance, the eligibility review form or the AFB must be dated and signed by both husband and wife, or both parents of a child in common when the parents live together.

(5) If you receive medical assistance only, the eligibility review form or the AFB must be signed by at least one parent when the parents live together.

(6) We may move the date of your eligibility review if we decide your circumstances need to be reviewed sooner.

(7) At your review, we look at:

(a) All eligibility requirements under WAC 388-400-0005 through 388-400-0035, 388-503-0505 through 388-503-0515, and 388-505-0210 through 388-505-0220;

(b) Changes that happened since we last determined your eligibility; and

(c) Changes that are anticipated to happen during the next review period.

(8) If you receive medical assistance only, we set your eligibility review date in advance under WAC 388-416-0005 through 388-416-0035. We will start the review process before your benefits end.

(9) Clients are responsible for attending an interview if one is required under WAC 388-452-0005.

(10) If you do not complete the eligibility review for cash assistance, you are considered to be withdrawing your request for continuing assistance.

(a) Your cash assistance benefits will end.

(b) Your medical assistance will continue for twelve consecutive months from the last:

(i) Application;

(ii) Eligibility review; or

(iii) Food assistance application or recertification.

(11) We must send you written notice under WAC 388-458-0005, 388-458-0010, and 388-450-0015 before assistance can be suspended, terminated, or a benefit error is established as a result of your eligibility review.

(12) If you are currently receiving cash or medical assistance, and you are found to no longer be eligible for benefits, we will determine if you are eligible for other medical programs. Until we decide if you are eligible for other programs, your medical assistance will continue under WAC 388-418-0025 even if you request that your benefits end.

(13) When a client is determined to need necessary supplemental accommodation (NSA) under WAC 388-200-1300, we will help the client meet the requirements of this section.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-434-0005, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW

(2003 Ed.)

74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-434-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2230.]

**WAC 388-434-0010 How do I get food assistance benefits after my certification period has ended?** To keep getting food assistance benefits after your certification period in WAC 388-416-0005 has ended, we must determine if you are still eligible for benefits. This is called recertification.

(1) To be recertified for food assistance, you must:

(a) Turn in and sign an application for benefits as required under WAC 388-406-0010. If you complete an electronic application, your signature is the password you use to complete the electronic application;

(b) Complete an interview if you are required to have an interview under WAC 388-452-0005; and

(c) Submit needed proof of your circumstances if we ask for it.

(2) If you reapply timely and get recertified before your certification period ends, we will keep depositing your benefits into your EBT (electronic benefit transfer) account on the same day of the month. To reapply timely, we must get your application by:

(a) The fifteenth day of the last month of your certification period; or

(b) The fifteenth day after you get your approval letter for food assistance when your certification period is two months or less.

(3) When we decide if you are eligible for benefits, we will send you a letter to tell you that your benefits have been approved or denied as required under chapter 388-458 WAC. If you reapply timely and complete the steps required in subsection (1), you get the approval or denial letter:

(a) By the end of your current certification period if you completed the steps required in subsection (1) by the fifteenth day of the last month of your certification period; or

(b) By the thirtieth day after you got your last benefit amount if you were certified for one month.

(4) If you do not turn in an application form by the end of your current certification period, you have not taken the action we require for you to get ongoing food assistance benefits. Your food assistance benefits stop at the end of your certification period.

(5) If you turn in your application before your certification period ends, we start your food assistance from the first of the month of your new certification period after we determine if you are eligible for food assistance. If you do not reapply timely, your benefits for the first month of your new certification period may be delayed.

(6) If you turn in your application after your certification period ends, we treat the application as a new application for benefits. We start your food assistance from the date you turned in the application after we determine if you are eligible for food assistance.

[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. 02-18-083, § 388-434-0010, filed 8/30/02, effective 10/1/02. 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 388-436 WAC

## EMERGENCY CASH ASSISTANCE

## WAC

388-436-0002	If my family has an emergency, can I get help from DSHS to get or keep our housing or utilities?
388-436-0015	Consolidated emergency assistance program (CEAP).
388-436-0020	CEAP assistance unit composition.
388-436-0025	Eligibility conditions for CEAP—Job refusal.
388-436-0030	Eligibility for CEAP depends on other possible cash benefits.
388-436-0035	Income and resources for CEAP.
388-436-0040	Excluded income and resources for CEAP.
388-436-0045	Income deductions for CEAP.
388-436-0050	Determining financial need and benefit amount for CEAP.

DISPOSITION OF SECTIONS FORMERLY  
CODIFIED IN THIS CHAPTER

388-436-0001	Additional requirement for emergent needs (AREN). [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0001, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-046, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055 and 74.08.090.
388-436-0005	AREN good cause. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-046, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055 and 74.08.090.
388-436-0010	Winterization. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0010, filed 7/31/98, effective 9/1/98.] Repealed by 00-10-036, filed 4/24/00, effective 6/1/00. Statutory Authority: RCW 74.08.090.

**WAC 388-436-0002** If my family has an emergency, can I get help from DSHS to get or keep our housing or utilities? DSHS has a program called additional requirements for emergent needs (AREN). If your family has an emergency and you need a one-time cash payment to get or keep safe housing or utilities, you may be eligible. The special AREN payment is in addition to the regular monthly cash grant your family may already get.

(1) To get AREN, you must:

(a) Be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or refugee cash assistance (RCA);

(b) Have an emergency housing or utility need; and

(c) Have a good reason that you do not have enough money to pay your housing or utility costs.

(2) To get AREN, you must be eligible for TANF, SFA, or RCA. This means you must:

(a) Get benefits through TANF, SFA, or RCA. For RCA you must also be pregnant or have an eligible child; or

(b) Apply for TANF, SFA, and RCA, and meet all eligibility criteria including:

(i) The maximum earned income limit under WAC 388-478-0035;

(ii) The requirement that your unearned income not exceed the grant payment standard;

(iii) The requirement that your countable income as defined under WAC 388-450-0162 must be below the payment standard in WAC 388-478-0020 when you have both earned income and unearned income;

(iv) The resource limits under chapter 388-470 WAC;

(v) The program summary rules for either TANF (WAC 388-400-0005); SFA (WAC 388-400-0010); or RCA (WAC 388-400-0030); and

(vi) The requirement that you must be pregnant or have an eligible child.

(3) If you do not get or do not want to get TANF, SFA or RCA, you cannot get AREN to help with one-time housing or utility costs. We will look to see if you are eligible for diversion cash assistance (DCA) under WAC 388-432-0005.

(4) To get AREN, you must have an emergency housing or utility need. You may get AREN to help pay to:

(a) Prevent eviction or foreclosure;

(b) Get housing if you are homeless or need to leave your home because of domestic violence;

(c) Hook up or prevent a shut off of utilities related to your health and safety. We consider the following utilities to be needed for health and safety:

(i) Electricity or fuel for heating, lighting, or cooking;

(ii) Water;

(iii) Sewer; and

(iv) Basic local telephone service if it is necessary for your basic health and safety.

(d) Repair damage or defect to your home when it causes a risk to your health or safety:

(i) If you own the home, we may approve AREN for the least expensive method of ending the risk to your health or safety;

(ii) If you do not own the home, you must ask the landlord in writing to fix the damage according to the Residential Landlord-Tenant Act at chapter 59.18 RCW. If the landlord refuses to fix the damage or defect, we may pay for the repair or pay to move you to a different place whichever cost is lower.

(e) If you receive TANF or SFA, WorkFirst support services under WAC 388-310-0800 may be used to help you relocate to new housing to get a job, keep a job, or participate in WorkFirst activities. Nonhousing expenses, that are not covered under AREN, may be paid under WorkFirst support services. This includes expenses such as car repair, diapers, or clothing.

(5) To get AREN, you must have a good reason for not having enough money to pay for your housing or utility costs. You must prove that you:

(a) Did not have money available that you normally use to pay your rent and utilities due to an emergency situation that reduced your income (such as a long-term illness or injury);

(b) Had to use your money to pay for necessary or emergency expenses. Examples of necessary or emergency expenses include:

(i) Basic health and safety needs for shelter, food and clothing;

(ii) Medical care;

(iii) Dental care needed to get a job or because of pain;

(iv) Emergency child care;

(v) Emergency expenses due to a natural disaster, accident, or injury; and

(vi) Other reasonable and necessary expenses.

(c) Are currently homeless; or

(d) Had your family's cash grant reduced or suspended when we budgeted your expected income for the month, but the income will not be available to pay for the need when the payment is due. You must make attempts to negotiate later payments with your landlord or utility company before you can get AREN.

(6) In addition to having a good reason for not having enough money to pay for your costs, you must also explain how you will afford to pay for the on-going need in the future. We may deny AREN if your expenses exceed your income (if you are living beyond your means). We may approve AREN to help you get into housing you can afford.

(7) If you meet the above requirements, we decide the amount we will pay based on the following criteria.

(a) AREN payments may be made up to a maximum of fifteen hundred dollars.

(b) We can make the payment all at once or as separate payments over a thirty-day period. The thirty-day period starts with the date of the first payment.

(c) The amount of AREN is in addition to the amount of your monthly TANF, SFA, or RCA cash grant.

(d) We will decide the lowest amount we must pay to end your housing or utility emergency. We will contact your landlord, utility company, or other vendor for information to make this decision. We may take any of the following steps when deciding the lowest amount to pay:

(i) We may ask you to arrange a payment plan with your landlord or utility company. This could include us making a partial payment, and you setting up a plan for you to repay the remaining amount you owe over a period of time.

(ii) We may have you use some of the money you have available in cash, checking, or savings to help pay for the expense. We will look at the money you have available as well as your bills when we decide how much we will pay.

(iii) We may consider income that is excluded or disregarded for cash assistance benefit calculations, such as SSI, as available to meet your emergency housing need.

(iv) We may consider money other individuals such as family or friends voluntarily give you. We will not count loans of money that you must repay to friends or family members.

(v) We may consider money from a nonneedy caretaker relative that lives in the home.

(vi) We may look at what other community resources you currently have to help you with your need.

(8) Starting August 1, 2000, your family can get AREN for your emergency housing or utility needs for one thirty-day period every twelve months:

(a) The thirty-day period starts on the date we issue your first AREN payment and lasts thirty consecutive days.

(b) The twelve-month period starts the month we issued your first AREN payment. The next time you could be eligible for AREN is the first day of the twelfth month after we issued the first AREN payment. For example, if we issued you AREN on January 15th, you could be eligible again on the first of January the next year.

(c) The limit of one thirty-day period every twelve months applies to the following people even if they leave the assistance unit:

(i) Adults; and

(ii) Minor parents that get AREN when no adults are in the assistance unit.

(d) We do not look at AREN benefits you received before August 1, 2000 when we look to see if you received AREN in the last twelve months.

(9) We pay AREN:

(a) Directly to the landlord, mortgage company, utility, or other vendor whenever we can.

(b) If we cannot pay AREN directly to the landlord or other vendor, we will issue the AREN as a part of your TANF, SFA, or RCA cash grant. If we issue the AREN as a part of your grant, you must use it for your emergency need.

(10) We may assign you a protective payee for your monthly grant under WAC 388-265-1250.

[Statutory Authority: RCW 74.08.090, 74.04.050, 00-22-064, § 388-436-0002, filed 10/27/00, effective 12/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, and 74.08.090, 99-14-046, § 388-436-0002, filed 6/30/99, effective 8/1/99.]

**WAC 388-436-0015 Consolidated emergency assistance program (CEAP).** (1) CEAP is available to the following persons:

(a) A pregnant woman in any stage of pregnancy; or

(b) Families with dependent children.

(2) Applicants must be residents of Washington state as defined in WAC 388-468-0010.

(3) Applicants must demonstrate a financial need for emergency funds for one or more of the following basic requirements:

(a) Food;

(b) Shelter;

(c) Clothing;

(d) Minor medical care;

(e) Utilities;

(f) Household maintenance supplies;

(g) Necessary clothing or transportation costs to accept or retain a job; or

(h) Transportation for a minor, not in foster care, to a home where care will be provided by family members or approved caretakers.

(4) Payment under this program is limited to not more than thirty consecutive days within a period of twelve consecutive months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-436-0015, filed 7/31/98, effective 9/1/98.]

**WAC 388-436-0020 CEAP assistance unit composition.** (1) To be eligible for CEAP, a child must be living with:

(a) A parent or a relative of specified degree as defined under WAC 388-454-0010; or

(b) Has lived with such a relative within six months of the request for assistance.

(2) The following persons living in the household must be included as members of the CEAP assistance unit:

(a) All full, half, or adopted siblings under eighteen years of age, including a minor parent; and

(b) The parent, adoptive parent, or stepparent living with the child or children.



(3) The following persons living in the household do not have to be included but may be included as members at the option of the applicant:

- (a) One caretaker relative of specified degree when the child's parent does not live in the home;
- (b) Stepbrothers or stepsisters to all children in the assistance unit.

(4) The following persons may make up a CEAP assistance unit without including others living in the home:

- (a) The child of a parent who is a minor when the minor parent is not eligible due to the income and resources of his/her parents; or
- (b) A pregnant woman when no other child is in the home.

(5) The following persons living in the household are not included as members of the CEAP assistance unit:

- (a) A household member receiving Supplemental Security Income (SSI);
- (b) A household member ineligible due to reasons stated in WAC 388-436-0025 and 388-436-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0020, filed 7/31/98, effective 9/1/98.]

**WAC 388-436-0025 Eligibility conditions for CEAP—Job refusal.** (1) Within thirty days of the date of application, applicants for CEAP cannot have refused without good cause:

- (a) A bona fide job offer; or
- (b) Training for employment.

(2) Applicants have good cause for refusal when the applicant:

- (a) Can not perform the work satisfactorily because of a physical, mental, or emotional inability;
- (b) Is not able to get to and from the job without undue cost or hardship;
- (c) Would be forced to perform hazardous work;
- (d) Would be working for less than minimum wage or the wages are not customary for that type of work;
- (e) Is offered the job only because of a labor dispute; or
- (f) Is not able to obtain necessary child care.

(3) An applicant who cannot demonstrate good cause for refusing a job offer makes the entire assistance unit ineligible for CEAP:

- (a) For thirty days from the date of refusal; or
- (b) Until the applicant accepts employment, whichever comes first.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0025, filed 7/31/98, effective 9/1/98.]

**WAC 388-436-0030 Eligibility for CEAP depends on other possible cash benefits.** (1) Before the department approves CEAP benefits, we must determine that all household members are ineligible for benefits from any of the following programs:

- (a) Temporary assistance for needy families (TANF);
- (b) State family assistance (SFA);
- (c) Refugee cash assistance (RCA);
- (d) Diversion cash assistance (DCA).

[Title 388 WAC—p. 700]

(2) To receive CEAP, the applicant must take any required action to receive benefits from the following programs:

- (a) TANF, SFA, and RCA;
- (b) Supplemental security income (SSI);
- (c) Medical assistance for those applicants requesting help for a medical need;
- (d) Food assistance for those applicants requesting help for a food need;
- (e) Housing assistance from any available source for those applicants requesting help for a housing need;
- (f) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(3) The department may not authorize CEAP benefits to any household containing a member who is under a grant penalty for failure to comply with program requirements of TANF/SFA, RCA, or WorkFirst under chapter 388-310 WAC.

[Statutory Authority: RCW 74.04.660, 99-24-130, § 388-436-0030, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0030, filed 7/31/98, effective 9/1/98.]

**WAC 388-436-0035 Income and resources for CEAP.** (1) Estimated income, resources and circumstances of the following persons are used in determining need and payment for CEAP:

- (a) All persons included as members of the CEAP assistance unit;
- (b) If living in the home, the spouses and minor brothers and sisters of persons included as members of the CEAP assistance unit.

(2) Public assistance payments plus authorized additional requirements received in the calendar month of CEAP application are considered as income.

(3) The value of resources not listed as excluded in WAC 388-436-0040 is considered available to meet the emergent needs of the CEAP assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0035, filed 7/31/98, effective 9/1/98.]

**WAC 388-436-0040 Excluded income and resources for CEAP.** Resources and income listed below will not be considered in determining need or payment for CEAP:

- (1) A home as defined under WAC 388-470-0030;
- (2) One vehicle, running and used regularly by the assistance unit, with an equity value not to exceed one thousand five hundred dollars);
- (3) Household furnishings being used by the assistance unit;
- (4) Personal items being used by members of the assistance unit;
- (5) Tools and equipment being used in the applicant's occupation;
- (6) The value of the coupon allotment under the Food Stamp Act of 1977, as amended;
- (7) Benefits received under the women, infants and children program (WIC) of the child nutrition Act of 1966, as

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amended, and the special food service program for children under the National School Lunch Act, as amended;

- (8) Energy assistance payments;
- (9) Grants, loans, or work study to a student under Title IV of the Higher Education Amendments or Bureau of Indian Affairs for attendance costs as identified by the institution;
- (10) Income and resources of an SSI recipient;
- (11) Livestock when the products are consumed by members of the assistance unit;
- (12) All resources and income excluded for the TANF program under WAC 388-450-0015, 388-470-0020, and 388-470-0025 and by federal law.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0040, filed 7/31/98, effective 9/1/98.]

**WAC 388-436-0045 Income deductions for CEAP.**

The following deductions are allowed when determining the CEAP assistance unit's net income:

- (1) A ninety dollar work expense from each member's earned income;
- (2) Actual payments made by a member with earned income for care of a member child up to the following maximums:

Hours Worked Per Month	Each Child Under Two Years	Each Child Two Years Or Older
0 - 40	\$ 50.00	\$ 43.75
41 - 80	100.00	87.50
81 - 120	150.00	131.25
121 or More	200.00	175.00

(3) Verified expenses for members of the assistance unit during the current month as follows:

- (a) Medical bills;

	1	2	3	4	5	6	7	8 or more
Food	\$211	\$268	\$332	\$391	\$450	\$511	\$583	\$645
Shelter	258	325	404	476	548	621	719	795
Clothing	30	38	47	56	64	73	83	94
Minor Medical Care	179	228	282	332	382	432	501	554
Utilities	87	110	136	160	184	210	243	268
Household maintenance	64	81	100	118	136	155	178	197
Job related transportation	349	440	546	642	740	841	971	1075

(3) The assistance unit's CEAP payment is determined by computing the difference between the allowable amount of need, as determined under subsection (2) of this section, and the total of:

- (a) The assistance unit's net income, as determined under subsection (1) of this section;
  - (b) Cash on hand, if not already counted as income; and
  - (c) The value of other nonexcluded resources available to the assistance unit.
- (4) The assistance unit is not eligible for CEAP if the amount of income and resources, as determined in subsection (3) of this section, is equal to or exceeds its allowable amount of need.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0050, filed 7/31/98, effective 9/1/98.]

- (b) Child care paid in an emergency in order to avoid abuse;
- (c) Dental care to relieve pain; or
- (d) Costs incurred in obtaining employment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0045, filed 7/31/98, effective 9/1/98.]

**WAC 388-436-0050 Determining financial need and benefit amount for CEAP.** (1) To be eligible for CEAP assistance, the assistance unit's nonexcluded income, minus allowable deductions, must be less than ninety percent of the TANF payment standard for households with shelter costs. The net income limit for CEAP assistance units is:

Assistance Unit Members	Net Income Limit
1	\$ 314
2	396
3	491
4	577
5	666
6	756
7	873
8 or more	967

(2) The assistance unit's allowable amount of need is the lesser of:

- (a) The TANF payment standard, based on assistance unit size, for households with shelter costs as specified under WAC 388-478-0020; or
- (b) The assistance unit's actual emergent need, not to exceed maximum allowable amounts, for the following items:

Need Item: Maximum allowable amount by assistance unit size:

**Chapter 388-437 WAC**

**EMERGENCY ASSISTANCE FOR FOOD STAMPS**

**WAC**

388-437-0001 Disaster food stamp program.

**WAC 388-437-0001 Disaster food stamp program.**

- (1) Assistance units that suffer a loss as a result of a federally declared disaster may receive disaster food stamp benefits.
- (2) Food and nutrition services (FNS) must approve use of this program when a disaster is declared.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-437-0001, filed 7/31/98, effective 9/1/98.]

## Chapter 388-438 WAC

## EMERGENCY ASSISTANCE FOR MEDICAL NEEDS

## WAC

388-438-0100 Medically indigent (MI) program.  
388-438-0110 The alien emergency medical (AEM) program.

**WAC 388-438-0100 Medically indigent (MI) program.** (1) The medically indigent (MI) program is a state funded medical program limited to coverage for emergency medical services.

(a) An emergency medical condition is described in WAC 388-500-0005;

(b) The client must have had a qualifying emergency medical condition in the month of application or within the three months immediately preceding the month of application;

(c) A client must have incurred an emergency medical expense requirement (EMER) of two thousand dollars per family over a twelve-month period. Qualifying EMER expenses are:

(i) Emergency hospital services and related physician services in a hospital; and

(ii) Emergency ground or air ambulance transportation to a hospital.

(2) The EMER period:

(a) Begins on the first day of the month of certification for MI; and

(b) Continues through the last day of the following twelve-calendar months.

(3) If a client does not meet the EMER amount within the three month base period, as described in WAC 388-519-0100, the amount incurred can be applied to any other application for MI within twelve-month period described in subsection (2).

(4) A client is limited a singly three-month period of MI eligibility per twelve-month EMER period.

(5) A client in a nursing facility can exceed the three-month MI eligibility limit.

(6) Conditions which require the following services meet the definition of emergency for MI, but the client is exempt from the EMER requirement:

(a) Treatment under the involuntary treatment act (ITA); and

(b) DETOX services; and

(c) Institutional and/or waived services.

(7) Pregnancy meets the definition of emergency for MI. A pregnant client must meet the EMER requirements.

(8) Resource rules for the MI program follow the TANF and TANF-related resource rules in chapter 388-470 WAC.

(9) If a client's income and/or resources exceed the standards for this program, as described in WAC 388-478-0070, the excess must be spent down as described in WAC 388-519-0100, for the client to be eligible for MI.

(10) A client is not eligible for MI if they:

(a) Are eligible for, or receiving, any other cash or medical program; or

(b) Entered the state specifically to obtain medical care; or

(c) Are an inmate of a federal or state prison.

[Title 388 WAC—p. 702]

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0100, filed 7/31/98, effective 9/1/98. Formerly 388-503-0370, 388-518-1805, 388-518-1810 and 388-518-1850.]

**Notice of Objection (1):** It is the opinion of the Joint Administrative Rules Review Committee that the Department of Social and Health Services has not modified, amended, withdrawn or repealed WAC 388-100-005 to conform with the intent of the legislature, as expressed in both chapters 70.48 and 74.09 RCW.

Although the department has statutory authority in chapter 74.09 RCW, to determine who is eligible to receive assistance under the limited casualty medical program, that authority is not without limitation. The City and County Jail Act of 1977 requires the Department of Social and Health Services to reimburse the local government for inmate medical costs, provided that inmate is otherwise eligible for such care. Inmates have not been denied coverage based on their status as inmates since the enactment of the City and County Jail Act.

In determining legislative intent, a portion of a statute cannot be examined in a vacuum. Rather, all statutes relating to the same subject should be read together and given a harmonious interpretation. The legislature is presumed to enact law with knowledge of existing law. RCW 70.48.130 is made moot by the department's administrative denial of inmate medical coverage, and the legislature does not intend to enact "moot" legislation.

The Joint Administrative Rules Review Committee objects to WAC 388-100-005 and herewith directs the code reviser to publish this Notice of Objection...pursuant to RCW 34.04.240.

[Joint Administrative Rules Review Committee, Memorandum, July 10, 1987—Filed July 27, 1987, WSR 87-16-031]

**Notice of Objection (2):** The Joint Administrative Rules Review Committee (JARRC) held on July 27, 1987, that WAC 388-100-005 did not conform with the intent of the Legislature. This rule, adopted by the Department of Social and Health Services (DSHS), excluded inmates of federal or state prisons from eligibility for the limited casualty-medically indigent program of medical assistance.

As authority for its opinion, the committee cited RCW 70.48.130 of the City and County Jail Act of 1977 which requires DSHS to reimburse local governments for inmate medical costs provided to otherwise eligible inmates.

There has been no amendment to RCW 70.48.130 changing its meaning since 1986. Effective May 15, 1993, an amendment resulted in even further emphasis of the intent of the Legislature that all jail inmates receive cost-effective medical care. (1993 C 409 § 2)

On May 31, 1994, DSHS refiled a permanent rule, WSR 94-10-065, WAC 388-503-0370 which recodified WAC 388-100-005. The eligibility requirement that an applicant for the medically indigent program not be an inmate of a federal or state prison is retained in the new rule.

Since neither the statutory authority nor the substance of the rule has changed since the JARRC decision of July 27, 1987, the committee is of the opinion that DSHS has not modified, amended, withdrawn or repealed WAC 388-100-005 to conform with the intent of the Legislature. This being the case, pursuant to RCW 34.05.640 (5) and (6), the committee respectfully requests that the notice of objection published along with WAC 388-100-005 continue to be published along with WAC 388-503-0370.

[Joint Administrative Rules Review Committee, Memorandum February 21, 1995—Filed February 27, 1995, WSR 95-06-053.]

**Reviser's note:** The substance of WAC 388-503-0370 was moved into WAC 388-438-0100 filed as WSR 98-16-044 on July 31, 1998.

**WAC 388-438-0110 The alien emergency medical (AEM) program.** (1) The alien emergency medical (AEM) program is a federally-funded program. It is for aliens who are ineligible for other Medicaid programs, due to citizenship or alien status requirements described in WAC 388-424-0005 and 388-424-0010.

(2) Except for the social security number, citizenship, or alien status requirements, 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

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(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.

(6) The department does not deem a sponsor's income and resources as available to the client when determining eligibility for the AEM program. The department counts only the income and resources a sponsor makes available to the client.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-438-0110, filed 8/12/02, effective 9/12/02. 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 388-440 WAC EXCEPTION TO RULE

#### WAC

388-440-0001  
388-440-0005

Exceptions to rule.  
Exception to rule—Notification requirement.

**WAC 388-440-0001 Exceptions to rule.** (1) The secretary of the department, or designee, authorizes department staff to request an exception to a rule in the Washington Administrative Code (WAC) for individual cases, except as noted in subsection (5) of this section, when:

(a) The exception would not contradict a specific provision of federal law or state statute; and

(b) The client's situation differs from the majority; and

(c) It is in the interest of overall economy and the client's welfare; and

(d) It increases opportunities for the client to function effectively; or

(e) A client has an impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment.

(2) The secretary or the secretary's designee makes the final decision on all requests for exceptions to a rule.

(3) Clients have no fair hearing rights as defined under chapter 388-08 WAC regarding exception to rule decisions by department staff.

(4) Clients who do not agree with a decision on an exception to rule may file a complaint according to chapter 388-426 WAC.

(5) This section does not apply to requests for noncovered medical or dental services or related equipment. See WAC 388-501-0160.

(2003 Ed.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 00-03-034, § 388-440-0001, filed 1/12/00, effective 2/12/00; 98-16-044, § 388-440-0001, filed 7/31/98, effective 9/1/98.]

**WAC 388-440-0005 Exception to rule—Notification requirement.** (1) Clients are notified in writing within ten days of:

(a) The department staff's decision to file an exception to rule request; and

(b) The department's decision to approve or deny an exception to rule request.

(2) The notice will include the complaint procedures as specified in chapter 388-426 WAC.

(3) This section does not apply to notification requirements for exceptions to rules concerning noncovered medical or dental services or related equipment. See WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 00-03-034, § 388-440-0005, filed 1/12/00, effective 2/12/00; 98-16-044, § 388-440-0005, filed 7/31/98, effective 9/1/98.]

### Chapter 388-442 WAC FELONS

#### WAC

388-442-0010

How being a felon impacts your eligibility for benefits.

**WAC 388-442-0010 How being a felon impacts your eligibility for benefits.** (1) You are not eligible for TANF/SFA, GA and/or food assistance if you are:

(a) Fleeing to avoid prosecution, custody, or confinement after conviction of a crime, or an attempt to commit a crime which is considered a felony in the place from which you are fleeing; or

(b) Violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision.

(2) You are not eligible for TANF/SFA and/or food assistance if you were convicted of a felony committed after August 21, 1996 involving an element of possession, use, or distribution of an illegal drug, unless you:

(a) Were convicted only of possession or use of an illegal drug; and

(b) Were not convicted of a felony for illegal drugs within three years of the latest conviction; and

(c) Were assessed as chemically dependent by a program certified by the division of alcohol and substance abuse (DASA); and

(d) Are taking part in or have completed a rehabilitation plan consisting of chemical dependency treatment and job services.

(3) If you are pregnant, but cannot get TANF/SFA because you were convicted of a drug-related felony, you can get SFA while you are pregnant if you meet all other TANF/SFA eligibility criteria under WAC 388-400-0005 or 388-400-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-442-0010, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-442-0010, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050,

74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-442-0010, filed 7/31/98, effective 9/1/98.]

### Chapter 388-444 WAC

#### FOOD STAMP EMPLOYMENT AND TRAINING

##### WAC

388-444-0005	The food stamp employment and training (FS E&T) program—General requirements.
388-444-0010	Clients who are required to register for work and must participate in FS E&T.
388-444-0015	When are clients not required to register for work or participate in FS E&T (exempt clients)?
388-444-0020	When must clients register for work but are not required to participate in the food stamp employment and training program (FS E&T)?
388-444-0025	Payments for FS E&T related expenses.
388-444-0030	Work requirements for persons who are able-bodied adults without dependents (ABAWDS).
388-444-0035	When am I (able-bodied adult with no dependents) exempt from ABAWD provisions?
388-444-0040	Work programs for ABAWDs in the food stamp employment and training program.
388-444-0045	Regaining eligibility for food assistance.
388-444-0050	Good cause for failure to register for work or for not participating in the FS E&T program.
388-444-0055	What are the penalties for refusing or failing to comply?
388-444-0060	FS E&T—Unsuitable employment.
388-444-0065	What happens if I quit my job?
388-444-0070	Good cause for quitting a job.
388-444-0075	What are the disqualification periods for quitting a job without good cause?

#### WAC 388-444-0005 The food stamp employment and training (FS E&T) program—General requirements.

(1) To receive food assistance some clients must register for work and if required by the department, must participate in the food stamp employment and training (FS E&T) program.

(2) Clients who must register for work and may be required to participate in FS E&T are called nonexempt clients. All other members of the food assistance unit are called exempt clients.

(3) All nonexempt members of the food assistance unit are registered for work by the department, at the first food assistance application and once every twelve months thereafter. A person who enters an existing assistance unit will be registered for work and FS E&T, if not exempt.

(4) Clients must comply with all FS E&T program requirements as provided in subsection (5) of this section. Failure to comply without good cause will disqualify the client from receiving food assistance:

(a) Good cause rules are provided in WAC 388-444-0050; and

(b) Disqualification rules are provided in WAC 388-444-0055.

(5) Nonexempt clients are required to:

(a) Report to DSHS or the service provider and participate as required;

(b) Provide information regarding employment status and availability for work as requested;

(c) Report to an employer when referred by DSHS; and

(d) Accept a bona fide offer of suitable employment.

Unsuitable employment is defined in WAC 388-444-0060.

(6) A nonexempt client will participate in one or more of the following activities:

(a) Job search;

(b) General education development (GED) classes; or

(c) English as a second language (ESL) classes.

(7) A client is not required to participate in FS E&T activities more than one hundred twenty hours in a month. Hours of participation may include a combination of FS E&T activities as described in subsection (6) of this section and hours worked for pay, either cash or in-kind.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0005, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0010 Clients who are required to register for work and must participate in FS E&T.** The following clients are nonexempt, must register for work and are required to participate in FS E&T:

(1) Age sixteen through fifty-nine with dependents;

(2) Age sixteen or seventeen, not attending secondary school and not the head-of-household;

(3) Age fifty through fifty-nine with no dependents.

(4) Age eighteen to fifty, able-bodied and with no dependents as provided in WAC 388-444-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0015 When are clients not required to register for work or participate in FS E&T (exempt clients)?** You (as a client) are not required to register for work or to participate in FS E&T if you meet any of the following conditions:

(1) Age sixteen or seventeen and not the head-of-household and:

(a) Attending school (such as high school or GED programs); or

(b) Enrolled at least half time (as defined by the institution) in a program under temporary assistance for needy families (TANF), a program under The Workforce Investment Act, (formerly the Job Training Partnership Act (JTPA)), a program under section 236 of the Trade Act of 1974, or other state or local employment and training programs.

(2) Determined to be physically or mentally unable to work;

(3) Responsible for the care of a dependent child under six years of age or of a person determined to be incapacitated;

(4) Applying for or receiving unemployment compensation (UC);

(5) Participating in an employment and training program under TANF;

(6) Employed or self-employed person working thirty hours or more per week, or receiving weekly earnings equal to the federal minimum wage multiplied by thirty;

(7) Students eighteen or older enrolled at least half time as defined by the institution in:

(a) Any accredited school;

(b) Training program; or

(c) An institution of higher education. Students enrolled in higher education must follow the student criteria as defined in chapter 388-482 WAC, Student status.

(8) Regularly participating in a drug addiction or alcoholic treatment and rehabilitation program.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0015, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW

74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0015, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0020 When must clients register for work but are not required to participate in the food stamp employment and training program (FS E&T)?** You, as a client must register for work, as provided in WAC 388-444-0005, even though you are exempt from participation in the FS E&T program if you are:

- (1) Participating in a refugee assistance program;
- (2) Living in an area where the FS E&T program is not provided (exempt area), see Food Stamp E&T Appendix 1 for exempt areas;
- (3) Living one hour or more travel distance from available FS E&T services;
- (4) Without a mailing address or message telephone;
- (5) Temporarily unable to work and it is expected to last longer than sixty days; or
- (6) A client who has dependent care needs that exceed the maximum amount payable by the department. The exemption continues until:

- (a) A different work activity is available; or
- (b) Circumstances change and monthly dependent care costs no longer exceed the reimbursement limit set by the department.

[Statutory Authority: RCW 74.04.510 and 74.04.050. 00-21-111, § 388-444-0020, filed 10/18/00, effective 11/18/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0020, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0025 Payments for FS E&T related expenses.** (1) Some of a client's actual expenses needed to participate in the FS E&T program may be paid by the department. Allowable expenses are:

- (a) Transportation related costs; and
  - (b) Dependent care costs for each dependent six through twelve years of age.
- (2) Dependent care payments are not paid if:
- (a) The child is thirteen years of age or older unless the child is:
    - (i) Physically and/or mentally incapable of self-care; or
    - (ii) Under court order requiring adult supervision; or
  - (b) Any member in the food assistance unit provides the dependent care.

(3) Dependent care payments paid by the department cannot be claimed as an expense and used in calculating the dependent care deduction as provided in WAC 388-450-0185.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0025, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0030 Work requirements for persons who are able-bodied adults without dependents (ABAWDS).** (1) Clients who are age eighteen to fifty and have no dependents must, unless exempt, participate in specific employment and training activities to receive food assistance.

(2) Nonexempt clients who fail to participate are eligible for no more than three months of food assistance in a thirty-six month period.

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(3) Except as provided in WAC 388-444-0035, a person is not eligible to receive food assistance for more than three full months in the thirty-six month period beginning January 1, 1997 unless that person:

- (a) Works at least twenty hours a week averaged monthly; or
- (b) Participates in and complies with the requirements of a work program for twenty hours or more per week; or
- (c) Participates in a workfare program as provided in WAC 388-444-0040.
- (4) A work program is defined as a program under:
  - (a) The Job Training Partnership Act (JTPA);
  - (b) Section 236 of the Trade Act of 1974; or
  - (c) A state-approved employment and training program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0030, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0035 When am I (able-bodied adult with no dependents) exempt from ABAWD provisions?** You are exempt from the ABAWD rules provided in WAC 388-444-0030 if you are:

- (1) Under eighteen or fifty years of age or older;
- (2) Determined to be physically or mentally unable to work;
- (3) A parent or other member of a household with responsibility for a dependent child under eighteen years of age or a person determined to be incapacitated;
- (4) Pregnant;
- (5) Living in an area approved as exempt by U.S. Department of Agriculture;
- (6) Complying with the work requirements of an employment and training program under temporary assistance for needy families (TANF);
- (7) Applying for or receiving unemployment compensation;
- (8) Students enrolled at least half time as defined by the institution in:
  - (a) Any accredited school;
  - (b) Training program; or
  - (c) Institution of higher education. A student enrolled in higher education must follow the student criteria defined in chapter 388-482 WAC.
- (9) Participating in a chemical dependency treatment program;
- (10) Employed a minimum of thirty hours per week or receiving weekly earnings which equal the minimum hourly rate multiplied by thirty hours;
- (11) Eligible for one of the annual federal-approved exemption slots under what is called the fifteen percent exemption rule.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0035, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0035, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0035, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0040 Work programs for ABAWDs in the food stamp employment and training program.** Work programs are available to clients eighteen to fifty years of age who are able to work and have no dependents.

[Title 388 WAC—p. 705]



(1) The following are considered work programs:

(a) Workfare consists of:

(i) Thirty days of job search activities in the first month beginning with the first day of application, or sixteen hours of volunteer work with a public or private nonprofit agency; and

(ii) In subsequent months, sixteen hours per month of volunteer work with a public or private nonprofit agency allows the client to remain eligible for food stamps. Workfare is not enforced community service or for paying fines or debts due to legal problems.

(b) Work experience (WEX) is supervised, unpaid work for at least twenty hours a week. The work must be for a nonprofit agency or governmental or tribal entity. This work is to improve the work skills of the client.

(c) On-the-job training (OJT) is paid employment for at least twenty hours a week. It is job training provided by an employer at the employer's place of business and may include some classroom training time.

(2) The department may not require more than thirty hours a week of Workfare and paid work combined.

(3) The department may pay for some of a client's actual expenses needed for the client to participate in work programs. Standards for paying expenses are set by the department.

[Statutory Authority: RCW 74.04.510, 99-07-024, § 388-444-0040, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-444-0040, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0045 Regaining eligibility for food assistance.** (1) A client who is ineligible for food assistance because that client has exhausted the three-month limit in WAC 388-444-0030, can regain eligibility by:

(a) Working eighty hours or more during a thirty-day period;

(b) Participating in and complying with a work program for eighty hours or more during a thirty-day period;

(c) Participating in and complying with the community service part of a Workfare program; or

(d) Meeting any of the work requirements in (a) through (c) of this subsection in the thirty days after an application for benefits has been filed.

(2) A client who regains eligibility for food assistance under subsection (1) of this section is eligible from the date of application and as long as the requirements of WAC 388-444-0030 are met.

(3) If otherwise eligible, a client who regains eligibility under the provision of subsection (1) of this section, may receive an additional three consecutive months of food assistance when the client:

(a) Loses employment; or

(b) Loses the opportunity to participate in a work program.

(4) The provisions in subsection (3) of this section are allowed only once in the thirty-six month period.

[Statutory Authority: RCW 74.04.510, 99-07-024, § 388-444-0045, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-444-0045, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0050 Good cause for failure to register for work or for not participating in the FS E&T program.** (1) A nonexempt client may have good cause for refusing or failing to register for work or to participate in the FS E&T program.

(2) Good cause reasons include, but are not limited to:

(a) Illness of the client;

(b) Illness of another household member requiring the help of the client;

(c) A household emergency;

(d) The unavailability of transportation; or

(e) Lack of adequate dependent care for children six through twelve years of age.

(3) A client who is determined by the department to lack good cause for failing or refusing to participate in FS E&T is disqualified and is not eligible to receive food assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-444-0050, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0055 What are the penalties for refusing or failing to comply?** (1) If you are nonexempt you must follow the food assistance work requirements as defined in WAC 388-444-0005 or 388-444-0030 unless you have good cause as defined in WAC 388-444-0050. If you do not follow these rules, you will become an ineligible assistance unit member as provided in WAC 388-450-0140. The remaining members of the assistance unit continue to be eligible for food assistance.

(2) If you do not follow these rules unless you have good cause, you cannot receive food assistance for the following periods of time and until you comply with program requirements:

(a) For the first failure to comply, one month;

(b) For the second failure to comply, three months; and

(c) For the third or subsequent failure to comply, six months.

(3) If you become exempt under WAC 388-444-0015 and are otherwise eligible, you may begin to receive food assistance.

(4) If you are nonexempt and you do not comply with the work requirements of the following programs, you cannot receive food assistance:

(a) WorkFirst;

(b) Unemployment compensation;

(c) The refugee cash assistance program.

(5) Within ten days after learning of your refusal to participate in your program, the financial worker will send you a notice that your food assistance will end unless you comply with your program requirements.

(6) If you do not comply within ten days, you will be issued a notice disqualifying you from receiving food assistance until you comply with your program, or until you meet the FS E&T disqualification requirements in subsection (2) of this section.

(7) After the penalty period in subsection (2) of this section is over, and you have complied with your program requirements, and you are otherwise eligible, you may receive food assistance:

(a) If you are alone in the assistance unit and apply to reestablish eligibility; or

(b) If you are a member of an assistance unit, you may resume receiving food assistance.

(8) During the penalty period, if you begin to participate in one of the programs listed in subsection (4)(a) through (c) and that penalty is removed, the FS E&T disqualification also ends. If you are otherwise eligible, you may begin to receive food assistance.

(9) You have a right to a fair hearing as provided in WAC 388-08-413.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0055, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0055, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0060 FS E&T—Unsuitable employment.** Nonexempt clients participating in FS E&T must accept a bona fide offer of suitable employment. Employment is considered unsuitable when:

(1) The wage offered is less than the federal or state minimum wage, whichever is highest;

(2) The job offered is on a piece-rate basis and the average hourly yield expected is less than the federal or state minimum wage, whichever is highest;

(3) The employee, as a condition of employment, is required to join, resign from or is barred from joining any legitimate labor union;

(4) The work offered is at a site subject to strike or lock-out at the time of offer unless:

(a) The strike is enjoined under the Taft-Hartley Act; or

(b) An injunction is issued under section 10 of the Railway Labor Act.

(5) The degree of risk to health and safety is unreasonable;

(6) The client is physically or mentally unable to perform the job as documented by medical evidence or reliable information from other sources;

(7) The employment offered within the first thirty days of registration for FS E&T is not in the client's major field of experience;

(8) The distance from the client's home to the job is unreasonable considering the wage, time and cost of commute:

(a) The job is not suitable when daily commuting time exceeds two hours per day, not including transporting a child to and from child care; and

(b) The job is not suitable when the distance to the job prohibits walking and public or private transportation is not available.

(9) The working hours or nature of the job interferes with the client's religious observances, convictions, or beliefs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0060, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0065 What happens if I quit my job?**

(1) You are not eligible for food assistance if you quit your current job without good cause as defined in WAC 388-444-0070, and you are in one of the following categories:

(a) You were working twenty hours or more per week or the job provided weekly earnings equal to the federal minimum wage multiplied by twenty hours;

(b) The quit was within sixty days before you applied for food assistance or any time after;

(c) At the time of quit you were an applicant and would have been required to register for work as defined in WAC 388-444-0010;

(d) If you worked or you were self-employed and working thirty hours a week or you had weekly earnings at least equal to the federal minimum wage multiplied by thirty hours.

(2) You are not eligible to receive food assistance if you have participated in a strike against a federal, state or local government and have lost your employment because of such participation.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0065, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0065, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0070 Good cause for quitting a job.** Unless otherwise specified the following rules apply to all food assistance clients.

(1) Good cause for quitting a job includes the following:

(a) For all food assistance clients, the employment is unsuitable as defined under WAC 388-444-0060;

(b) The client is discriminated against by an employer based on age, race, sex, color, religious belief, national origin, political belief, marital status, or the presence of any sensory, mental, or physical disability or other reasons in RCW 49.60.180;

(c) Work demands or conditions make continued employment unreasonable, such as working without being paid on schedule;

(d) The client accepts other employment or is enrolled at least half time in any recognized school, training program, or institution of higher education;

(e) The client must leave a job because another assistance unit member accepts a job or is enrolled at least half time in any recognized school, training program, or institution of higher education in another county or similar political subdivision and the assistance unit must move;

(f) The client who is under age sixty and retires as recognized by the employer;

(g) The client accepts a bona fide offer of employment of twenty or more a week or where the weekly earnings are equivalent to the federal minimum wage multiplied by twenty hours. However, because of circumstances beyond the control of the client, the job either does not materialize or results in employment of twenty hours or less a week or weekly earnings of less than the federal minimum wage multiplied by twenty hours;

(h) The client leaves a job in connection with patterns of employment where workers frequently move from one employer to another, such as migrant farm labor or construction work; and.

(i) For FS E&T participants, circumstances included under WAC 388-444-0050;

(2) A client who quits the most recent job is eligible for food assistance if the circumstances of the job involve:

(a) Changes in job status resulting from reduced hours of employment while working for the same employer;

- (b) Termination of a self-employment enterprise; or
- (c) Resignation from a job at the demand of an employer.

(3) The client must verify good cause for quitting. Food assistance is not denied if the client and the department are unable to obtain verification.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0070, filed 7/31/98, effective 9/1/98.]

**WAC 388-444-0075 What are the disqualification periods for quitting a job without good cause?** (1) If you are an applicant who quits a job without good cause sixty days before applying for food assistance, the department will deny your application. The penalty period in subsection (3) of this section begins from the date of application.

(2) If you are already receiving food assistance and you quit your job without good cause, the department must send you a letter notifying you that you are going to be disqualified from food assistance. The disqualification in subsection (3) of this section begins the first of the month following the notice of adverse action.

(3) You are disqualified for the following minimum periods of time and until the conditions in subsection (4) of this section are met:

- (a) For the first quit, one month;
- (b) For the second quit, three months; and
- (c) For the third or subsequent quit, six months.

(4) You may 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 388-446 WAC

### FRAUD

#### WAC

388-446-0001	Cash and medical assistance fraud.
388-446-0005	Disqualification period for cash assistance.
388-446-0010	TANF disqualification period for fraud convictions of misrepresenting interstate residence.

388-446-0015	Intentional program violation (IPV) and disqualification hearings for food assistance.
388-446-0020	Food assistance disqualification penalties.

**WAC 388-446-0001 Cash and medical assistance fraud.** (1) All cash or medical assistance cases in which substantial evidence is found supporting a finding of fraud are referred to the county prosecuting attorney. The prosecuting attorney's office determines which cases are subject to criminal prosecution.

(2) An applicant or recipient is suspected of committing fraud if intentional misstatement or failure to reveal information affecting eligibility results in an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0001, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0140.]

**WAC 388-446-0005 Disqualification period for cash assistance.** (1) An applicant or recipient who has been convicted of unlawful practices in obtaining cash assistance is disqualified from receiving further cash benefits if:

(a) For TANF/SFA, the conviction was based on actions which occurred on or after May 1, 1997; or

(b) For general assistance, the conviction was based on actions which occurred on or after July 23, 1995.

(2) The disqualification period must be determined by the court and will be:

(a) For a first conviction, no less than six months; and

(b) For a second or subsequent conviction, no less than twelve months.

(3) The disqualification applies only to the person convicted and begins on the date of conviction.

(4) A recipient's cash benefits are terminated following advance or adequate notice requirements as specified in WAC 388-418-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0005, filed 7/31/98, effective 9/1/98.]

**WAC 388-446-0010 TANF disqualification period for fraud convictions of misrepresenting interstate residence.** (1) An applicant or recipient is disqualified from receiving cash benefits under TANF if convicted of fraud by misrepresentation of residence in order to receive assistance from two or more states at the same time from any assistance program funded by the following:

(a) TANF and any other benefit authorized by Title IV-A of the Social Security Act; or

(b) Any benefit authorized by The Food Stamp Act of 1997; or

(c) Any benefit authorized by Title XIX, Medicaid; or

(d) SSI benefits authorized by Title XVI.

(2) The disqualification penalty is applied as follows:

(a) Only to convictions based on actions which occurred on or after May 1, 1997; and

(b) Only to the person convicted of fraud in federal or state court; and

(c) For a disqualification period of ten years or a period determined by the court, whichever is longer.

(3) The disqualification period begins the date the person is convicted of fraud by misrepresentation of residence in

order to receive assistance from two or more states at the same time.

(4) The provisions of subsections (1) through (3) of this section do not apply when the President of the United States has granted a pardon for the conduct resulting in the conviction of fraud by misrepresentation of residence. The disregard of the provisions because of a pardon is effective the date the pardon is granted and continues for each month thereafter.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-446-0015 Intentional program violation (IPV) and disqualification hearings for food assistance.**

(1) An intentional program violation (IPV) is defined as an act in which a person intentionally:

- (a) Makes a false or misleading statement;
- (b) Misrepresents, conceals or withholds facts; or
- (c) Acts in violation of the Food Stamp Act, the food stamp program regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt, or possession of food stamp coupons or FCAs.

(2) Food assistance clients suspected of committing an (IPV) are subject to referral for an administrative disqualification hearing, if:

- (a) The suspected IPV causes an overissuance of four hundred fifty dollars or more; and
- (b) The administrative proceedings will not jeopardize criminal proceedings; and
- (c) The person resides in Washington state, at the time of the referral; or
- (d) The person resides outside Washington state, but is within one hour's reasonable drive to a CSO.

(3) An administrative disqualification hearing (ADH) is a formal hearing to determine if a person committed an IPV. ADHs are governed by the rules found in chapter 388-08 WAC. However, rules in this section are the overriding authority if there is a conflict.

(4) A client who commits one or more IPVs and is suspected of committing another, is referred for an ADH when the act of suspected violation occurred:

- (a) After the department mailed the disqualification notice to the client for the most recent IPV; or
- (b) After an order was entered in criminal proceedings for the most recent IPV.

(5) A person suspected of IPV is entitled to receive notice of an ADH at least thirty days in advance of the hearing date. The notice is sent by certified mail, or provided to the client by personal service and will contain the following:

- (a) The date, time, and place of the hearing;
- (b) The charges against the individual;
- (c) A summary of the evidence, and how and where the evidence can be examined;
- (d) A warning that a decision will be based solely on evidence provided by the department, if the individual fails to appear at the hearing;
- (e) A statement that the individual has ten days from the date of the scheduled hearing to show good cause for failure to appear at the hearing and to request rescheduling;

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(f) A warning that a determination of IPV will result in a disqualification period; and

(g) A statement that if a telephone hearing is scheduled, the individual can request an in-person hearing by filing a request with the administrative law judge one week or more prior to the date of the hearing.

(6) The person or a representative shall have the right to one continuance of up to thirty days if a request is filed ten days or more prior to the hearing date.

(7) The hearing will be conducted and a decision rendered even if the person or representative fail to appear, unless within ten days from the date of the scheduled hearing:

(a) The person can show good cause for failing to appear; and

(b) The person or representative requests the hearing be re-instated.

(8) A scheduled telephone hearing may be changed to an in-person hearing if requested one week or more in advance. If requested less than one week in advance the person must show good cause for the requested change.

(9) The ALJ issues a preliminary decision based on evidence presented by the department establishing the person committed and intended to commit an IPV. The department and the client each have the right to request a review of the ALJ's decision by writing to the department's board of appeals as specified in WAC 388-08-464.

(10) A final decision of the disqualification hearing is mailed by the department's board of appeals.

(11) A client's disqualification is not implemented and benefits continue at the current amount when:

(a) The client can show good cause for not attending the hearing within thirty days from the date the disqualification notice was mailed; and

(b) An administrative law judge determines the client had good cause; or

(c) The client files a petition for review to appeal the disqualification

(12) An administrative disqualification hearing and an overissuance hearing can be combined when the cause for both hearings is related. The hearing procedures and notice requirements are the same as for administrative disqualification hearings.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0015, filed 7/31/98, effective 9/1/98.]

**WAC 388-446-0020 Food assistance disqualification penalties.** (1) Disqualification penalties apply only to the person or persons found to have committed an intentional program violation (IPV) as follows:

(a) If the intentional program violation occurred in whole or in part after the household was notified of the following penalties:

- (i) Twelve months for the first violation;
- (ii) Twenty-four months for the second violation;
- (iii) Permanently for the third violation.

(b) If the violation ended before the household was notified of the penalties in subsection (1)(a) of this section:

- (i) Six months for the first violation;
- (ii) Twelve months for the second violation;
- (iii) Permanently for the third violation.

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(2) The disqualification and penalty period for a person convicted in another state stays in effect until satisfied regardless of where a person moves.

(3) Multiple program violations are considered as one violation when determining the penalty for disqualification when the violations occurred before the department notified the household of the penalties, as described in subsection (1), (4) and (5) of this section.

(4) Disqualification penalties for persons convicted by a federal, state, or local court of trading or receiving food coupons for a controlled substance are:

- (a) Two years for a first conviction; and
- (b) Permanently for a second conviction.

(5) A first conviction by federal, state, or local court permanently disqualifies persons who:

(a) Trade or receive food coupons for firearms, ammunition, or explosives; or

(b) Knowingly buy, sell, trade, or present for redemption food coupons totalling five hundred dollars or more in violation of section 15 (b) and (c) of the Food Stamp Act of 1977, as amended.

(6) Persons convicted of providing false identification or residency information to receive multiple coupon benefits are disqualified for ten years.

(7) When a court convicts a person of an IPV, the disqualification penalties specified in subsection (1) through (5) apply as follows;

(a) In addition to any civil or criminal penalties; and

(b) Within forty-five days of the date of conviction; unless

(c) Contrary to the court order.

(8) Disqualification penalties are applied after notifying the household of the disqualification, the effective date, the amount of benefits the household will receive during the disqualification period and the need to reapply when the certification period expires.

(9) Even though only the individual is disqualified, the food assistance household is responsible for making restitution for the amount of any overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0020, filed 7/31/98, effective 9/1/98.]

### Chapter 388-448 WAC INCAPACITY

#### WAC

388-448-0001	Establishing incapacity for general assistance unemployable.
388-448-0010	How we decide if you are incapacitated.
388-448-0020	How and from whom you can get medical evidence for incapacity determination.
388-448-0030	The kind of medical evidence you need to provide for determination of incapacity.
388-448-0035	How we assign severity ratings to your impairment.
388-448-0040	PEP step I—Review of medical evidence required for eligibility determination.
388-448-0050	PEP step II—How we determine the severity of mental impairments.
388-448-0060	PEP step III—How we determine the severity of physical impairments.
388-448-0070	PEP step IV—How we determine the severity of multiple impairments.
388-448-0080	PEP step V—How we determine your ability to function in a work environment if you have a mental impairment.

388-448-0090	PEP step V—How we determine your ability to function in a work environment if you have a physical impairment.
388-448-0100	PEP step VI—How we evaluate capacity to perform relevant past work.
388-448-0110	PEP step VII—How we evaluate your capacity to perform other work.
388-448-0120	How we decide how long you are incapacitated.
388-448-0130	Treatment and referral requirements.
388-448-0140	Good cause for refusing medical treatment or other agency referrals.
388-448-0150	Penalty for refusing medical treatment or other agency referrals.
388-448-0160	Review of your incapacity.
388-448-0170	Termination requirement—How we determine you are no longer incapacitated.
388-448-0180	How and when we redetermine your eligibility if we decide you are eligible for GAX.
388-448-0190	Reinstating your eligibility after termination due to lack of medical evidence.
388-448-0200	Eligibility for general assistance unemployable pending SSI eligibility.
388-448-0210	Assignment and recovery of interim assistance.

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

388-448-0005	The following criteria is used to determine if a child is deprived of parental support due to incapacity. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0005, filed 7/31/98, effective 9/1/98.] Repealed by 00-15-051, filed 7/17/00, effective 9/1/00. Statutory Authority: RCW 74.04.057, 74.08.090.
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**WAC 388-448-0001 Establishing incapacity for general assistance unemployable.** For the purposes of this chapter, "we" and "us" refer to the department of social and health services. "You" means the applicant or recipient. In order for you to receive general assistance unemployable (GAU) benefits, we must first determine if you are incapacitated.

(1) We determine you are incapacitated if you are:

- (a) Eligible for payments based on Social Security Administration (SSA) disability criteria;
- (b) Eligible for services from the division of developmental disabilities (DDD);
- (c) Diagnosed as mentally retarded based on a full scale score of seventy or lower on the Wechsler adult intelligence scale (WAIS);
- (d) At least sixty-five years old;
- (e) Eligible for services from aging and adult services administration; or
- (f) Approved by the progressive evaluation process (PEP).

(2) We consider you to be incapacitated for ninety days following your release from:

- (a) An inpatient psychiatric treatment facility if:
  - (i) You directly participate in outpatient mental health treatment; and
  - (ii) The release from in-patient treatment was not against medical advice.
- (b) A medical institution where you received long-term care services from the aging and adult services administration.

[Statutory Authority: RCW 74.04.057, 74.08.090. 00-15-018, § 388-448-0001, filed 7/10/00, effective 9/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0001, filed 7/31/98, effective 9/1/98.]

**WAC 388-448-0010 How we decide if you are incapacitated.** When you apply for general assistance unemployable (GAU) program benefits, you must provide medical evidence to us to show that you are unable to work. If we say that you are "**incapacitated**," it means that you are incapable of gainful employment as a result of a physical or mental impairment that is expected to continue for ninety days or more from the date of application.

(1) If you are gainfully employed at the time of your application for GAU, we deny incapacity. "**Perform gainful employment**" means you can perform, in a regular and predictable manner, an activity usually done for pay or profit. We do not consider work to be gainful employment when you are:

(a) Working under special conditions, like a sheltered workshop we have approved; or

(b) Working occasionally or part-time if your medical condition limits the hours you can work compared to unimpaired workers in the same job.

(2) We decide if you are able to perform gainful employment when:

(a) We receive an application for benefits. We may waive this decision if medical documentation requirements are waived under WAC 388-448-0001;

(b) You become employed; or

(c) We get new information that indicates you may be employable.

(3) Unless medical documentation requirements are waived under WAC 388-448-0001, we determine if incapacity exists using the progressive evaluation process (PEP). When we receive your medical evidence, we use the PEP to decide if there is a medical impairment that prevents you from being gainfully employed. The PEP is a sequence of seven-steps.

(4) You are not eligible for GAU benefits if you are incapacitated only because of alcoholism or drug addiction. If you have a physical or mental impairment and you are impaired by alcohol or drug addiction, we decide if you are eligible for general assistance. If you qualify for both GAU and ADATSA shelter, you may choose either program.

(5) In determining incapacity, we consider only your ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: Sitting, standing, walking, lifting, carrying, handling, seeing, hearing, communicating, and understanding and following instructions.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0010, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0020 How and from whom you can get medical evidence for incapacity determination.** Before we can 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

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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 388-448-0030 The kind of medical evidence you need to provide for determination of incapacity.** You must provide medical evidence that clearly explains what physical or mental health problem you have that incapacitates you. "**Impairment**" means any diagnosable physical or mental condition except alcoholism or drug addiction. The following describes how we decide if the medical evidence that you provide regarding your impairment meets the requirements:

(1) We only accept written medical evidence. It must contain clear, objective medical documentation that includes:

(a) A diagnosis for the incapacitating condition;

(b) The effect of the condition on your ability to perform work-related activities; and

(c) Relevant medical history and sufficient medical documentation to support conclusions of incapacity.

[Title 388 WAC—p. 711]



(2) The medical evidence must be based on an exam within the last ninety days.

(3) When making an incapacity decision, we do not use your report of symptoms as evidence unless medical findings show there is a medical condition that could reasonably be expected to produce the symptoms reported. In those cases, you must provide us with clear and objective medical information, including observation by the medical practitioner and relevant medical history that supports conclusions about:

- (a) The existence and persistence of the symptom(s); and
- (b) Its effect on your ability to perform basic work activities.

(4) We decide incapacity based solely on the objective information we receive. We are not obligated to accept a decision that you are incapacitated or unemployable made by another agency or person.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090.00-16-113, § 388-448-0030, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0035 How we assign severity ratings to your impairment.** (1) "Severity rating" means a rating of the extent of your incapacity, and how severely it impacts your ability to perform the basic work activities. Severity ratings are assigned in Steps II through IV of the PEP. The following chart provides a description of levels of limitations on work activities and the severity ratings that would be assigned to each.

Effect on work activities	Severity rating
(a) There is no effect on your performance of basic work-related activities.	1
(b) There is no significant effect on your performance of basic work-related activities.	2
(c) There are significant limits on your performance of at least one basic work-related activity.	3
(d) There are very significant limits on your performance of at least one basic work-related activity.	4
(e) You are unable to perform at least one basic work-related activity.	5

(2) We use the severity rating given by the medical evidence provider:

- (a) If the rating is supported by and consistent with the medical evidence;
- (b) If the provider's assessment of your limitations is consistent with our definition of the rating; and
- (c) If the rating is consistent with other medical evidence provided to us.

(3) If the medical evidence provider assigns a severity rating that is not consistent with the objective evidence and your symptoms from your impairment as described in the medical evidence, we take the following action:

- (a) If your limitations are more severe than the rating given, we raise your severity rating; or
- (b) If your limitations are less severe than the rating given, we lower your severity rating; and
- (c) We give clear and convincing reasons for adjusting the rating.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090.00-16-113, § 388-448-0035, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0040 PEP step I—Review of medical evidence required for eligibility determination.** When we receive your medical evidence, we review it to see if it is complete and to decide whether your circumstances match GAU program requirements.

(1) We require a written medical report to determine incapacity. The report must:

- (a) Contain sufficient information as described under WAC 388-448-0030;
- (b) Be written by an authorized medical professional;
- (c) Document the existence of a potentially incapacitating condition; and
- (d) Indicate an impairment is expected to last ninety days or more from the application date.

(2) If the information received is not clear, we may require more information before we decide your ability to be gainfully employed. As examples, we may require you to get more medical tests or be examined by a medical specialist.

(3) We deny incapacity when:

- (a) There is only one impairment with a severity rating less than three;
- (b) A reported impairment is not expected to last ninety days (twelve weeks) or more from the date of application;
- (c) The practitioner is not able to determine that the physical or mental impairment would remain incapacitating after at least sixty days of abstinence from alcohol and drugs; or

(d) We do not have clear and objective medical evidence to approve incapacity.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090.00-16-113, § 388-448-0040, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0050 PEP step II—How we determine the severity of mental impairments.** If you are diagnosed with a mental impairment, we use information from the provider to determine if your impairment prevents you from being gainfully employed. We review the psychological evidence to determine the severity of your mental impairment.

(1) The severity of your mental impairment is based on:

- (a) Psychosocial and treatment history;
- (b) Clinical findings;
- (c) Results of psychological tests; and
- (d) Symptoms observed by the examining practitioner that show impairment of your ability to perform basic work-related activities.

(2) If you are diagnosed with mental retardation, the diagnosis must be based on the Wechsler Adult Intelligence Scale (WAIS). The following test results determine the severity rating:

Intelligence Quotient (IQ) Score	Severity Rating
85 or above	1
71 to 84	3
70 or lower	5

(3) If you are diagnosed with a mental impairment with physical causes, we assign a severity rating based on the most severe of the following three areas of impairment:

- (a) Memory defect for recent events;
- (b) Impoverished, slowed, perseverative thinking, with confusion or disorientation; or
- (c) Labile, shallow, or coarse affect.
- (4) We base the severity of the functional psychotic or nonpsychotic disorder, excluding alcoholism or drug addiction, on:

(a) Clinical assessment of these twelve symptoms: depressed mood, suicidal trends, verbal expression of anxiety or fear, expression of anger, social withdrawal, motor agitation, motor retardation, paranoid behavior, hallucinations, thought disorder, hyperactivity, preoccupation with physical complaints; and

(b) Clinical assessment of the intensity and pervasiveness of your symptoms and their effect on work activities.

(5) We base the severity rating for a functional mental impairment on accumulated severity ratings for the twelve symptoms in subsection (4)(a) of this section as follows:

Symptom Ratings or Condition	Severity Rating
(a) The functional mental impairment is diagnosed with psychotic features; (b) You have had two or more hospitalizations for psychiatric reasons in the past two years; (c) You have had more than six months of continuous psychiatric hospital or residential treatment in the past two years; (d) The overall assessment of symptoms is rated three; or (e) At least three symptoms are rated three or higher.	3
(f) The overall assessment of symptoms is rated four; or (g) At least three symptoms are rated four or five.	4
(h) The overall assessment of symptoms is rated five; or (i) At least three symptoms are rated five.	5

(6) If you have more than one type of mental impairment, we assign a severity rating as follows:

Condition	Severity Rating
(a) Two or more disorders with ratings of three; or (b) One or more disorders rated three; and one rated four.	4
(c) Two or more disorders rated four.	5

(7) We deny incapacity when you do not have a significant physical impairment and your overall mental severity rating is one or two;

(8) We approve incapacity when you have an overall mental severity rating of five, regardless of whether you have a physical impairment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0050, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0060 PEP step III—How we determine the severity of physical impairments.** We must decide if your physical impairment is serious enough to limit your ability to be gainfully employed. "Severity of a physical impairment" means the degree that an impairment restricts you from performing basic work-related activities (see WAC 388-448-0010). Severity ratings range from one to five, with five being the most severe. We will assign severity ratings according to the table in WAC 388-448-0035.

(1) We assign to each physical impairment a severity rating that is supported by medical evidence.

(2) If your physical impairment is rated two, and there is no mental impairment or a mental impairment that is rated one, we deny incapacity.

(3) If your physical impairment is consistent with a severity rating of five, we approve incapacity.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0060, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0070 PEP step IV—How we determine the severity of multiple impairments.** (1) If you have more than one impairment we decide the overall severity rating by deciding if your impairments have a combined effect on your ability to be gainfully employed. Each diagnosis is grouped by affected organ or function into one of 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.	3
(iii) All impairments are in different body systems, are rated two and there is a cumulative effect on basic work activities.	

Your Condition	Severity Rating
(iv) Two or more impairments are in different body systems and are rated three.	4
(v) Two or more impairments are in different body systems; one is rated three and one is rated four.	
(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 388-448-0080 PEP step V—How we determine your ability to function in a work environment if you have a mental impairment.** If you have a mental impairment we evaluate your cognitive and social functioning in a work setting. Functioning means your ability to perform the tasks that would be required of you on the job and your ability to get along with your co-workers, supervisors and other people you would be in contact with while on the job.

(1) We evaluate cognitive factors by assessing your ability to:

- (a) Understand, remember, and follow simple, one- or two-step instructions;
- (b) Understand, remember, and follow complex instructions, with three or more steps;
- (c) Learn new tasks;
- (d) Exercise judgment and make decisions; and
- (e) Perform routine tasks without undue supervision.

(2) We approve incapacity when the practitioner's evaluation shows you are:

(a) At least moderately impaired in your ability to understand, remember, and follow simple instructions and at least moderately limited in your ability to:

- (i) Learn new tasks, exercise judgment, and make decisions; and
- (ii) Perform routine tasks without undue supervision; or
- (b) Able to understand, remember, and follow simple instructions, but are:

(i) At least moderately impaired in the ability to understand, remember, and follow instructions with three or more steps; and

(ii) Markedly impaired in the ability to learn new tasks, exercise judgment and make decisions, and perform routine tasks without undue supervision.

(3) The practitioner's evaluation reports your social factors after assessing your ability to:

- (a) Relate appropriately to coworkers and supervisors;
- (b) Relate appropriately in contacts with the public;
- (c) Tolerate the pressures of a work setting;
- (d) Perform self-care activities, including personal hygiene; and
- (e) Maintain appropriate behavior in a work setting.

(4) We approve incapacity if you are rated at least two in one area of social functioning and at least three in all other areas of social functioning.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0080, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0090 PEP step V—How we determine your ability to function in a work environment if you have a physical impairment.** In Step V of the PEP we review the medical evidence you provide and make a determination of how your physical impairment prevents you from working. This determination is then used in Steps VI and VII of the PEP to determine your ability to perform either work you have done in the past or other work.

(1) "Exertion level" means the ability to lift, carry, stand and walk with the strength needed to fulfill job duties in the following work categories. For this section, "occasionally" means less than one-third of the time and "frequently" means one-third to two-thirds of the time. We only consider your strength, mobility, and flexibility. We review any work limits you have in the following areas, and then assign an exertion level and determine exertional limitations.

The following table is used to determine your exertion level. Included in this table is a strength factor, which is your ability to perform physical activities, as defined in Appendix C of the Dictionary of Occupational Titles (DOT), Revised Edition, published by the U.S. Department of Labor.

If you	Then we assign this exertion level
(a) Can not lift at least two pounds or stand and/or walk.	Severely limited
(b) Can lift ten pounds maximum and frequently lift and/or carry lightweight articles. Walking and standing are only required for brief periods.	Sedentary
(c) Can lift twenty pounds maximum and frequently lift and/or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday, with sitting and pushing/ pulling arm or leg movements most of the day.	Light
(d) Can lift fifty pounds maximum and frequently lift and/or carry up to twenty-five pounds.	Medium
(e) Can lift one hundred pounds maximum and frequently lift and/or carry up to fifty pounds.	Heavy

(2) "Exertionally-related limitation" means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. If you have exertionally-related limitations, we consider them in determining your ability to work.

(3) "Functional physical capacity" means the degree of strength, agility, flexibility, and mobility you can apply to work-related activities. We consider the effect of the physical

impairment on the ability to perform work-related activities when the physical impairment is assigned an overall severity rating of three or four. We determine functional physical capacity based on your exertional, exertionally related and non-exertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(4) "Nonexertional physical limitation" means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Examples are:

(a) Environmental restrictions which could include, among other things, your inability to work in an area where you would be exposed to chemicals; and

(b) Workplace restrictions, such as impaired hearing or speech, which would limit the types of work environments you could work in.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0090, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0100 PEP step VI—How we evaluate capacity to perform relevant past work.** If your overall severity rating is three or four and we have reached this stage of the PEP and have not approved or denied your application, we decide if you can do the same or similar work as you have done in the past. We look at your current physical and/or mental limitations and vocational factors to make this decision. Vocational factors are education, relevant work history, and age.

(1) We evaluate education in terms of formal schooling or other training that enables you to meet job requirements. We classify education as:

If you	Then your education level is
(a) Can not read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b) Have no formal schooling beyond the eleventh grade; or (c) Have participated in special education.	Limited education
(d) Have received a high school diploma or general equivalency degree (GED); or (e) Have received skills training and were awarded a certificate, degree or license.	High school and above level of education

(2) We evaluate your work experience to determine if you have relevant past work. "Relevant past work" means work that:

(a) Is normally done for pay or profit. We exclude work done in a sheltered workshop, a job where you were given special consideration, or activities you may have performed as a student or homemaker;

(b) Has been performed in the past five years; and

(c) You have done long enough for you to have acquired the knowledge and skills to continue performing the job. You must meet the specific vocational preparation level as defined in Appendix C of the Dictionary of Occupational Titles.

(3) For each relevant past work situation you have had, we determine:

(a) The exertional or skill requirements of the job; and

(b) Current cognitive, social, or nonexertional factors that significantly limit your ability to perform past work.

(4) After considering vocational factors, we approve or deny incapacity based on the following:

If you	Then we take this action on incapacity
(a) Have the physical or mental ability to perform past work and there is no significant cognitive, social or nonexertional limitation.	Deny
(b) Have recently acquired specific work skills through completion of vocational training, enabling you to work within your current physical or mental capacities.	Deny
(c) Are fifty-five years of age or older and have an impairment that is assigned an overall severity rating of at least three and do not have the physical or mental ability to perform past work or do not have work experience.	Approve

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0100, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0110 PEP step VII—How we evaluate your capacity to perform other work.** If we decide you cannot do work that you've done before, we then decide if you can do any other work. In making this decision, we again consider vocational factors of age, education and limited English proficiency (LEP).

(1) We approve incapacity if you have a physical impairment only and meet the vocational factors below:

Highest work level assigned by the practitioner	Your age	Your education level	Other vocational factors
Sedentary	Any age	Any level	Does not apply
Light	Fifty and older	Any level	Does not apply
Light	Thirty-five and older	Illiterate or LEP	Does not apply
Light	Eighteen and older	Limited education	Does not have any past work
Medium	Fifty and older	Limited education	Does not have any past work
Medium	Fifty-five and older	Any level	Does not apply
Heavy	Fifty-five and older	Any level	Environmental restrictions apply

(2) We approve incapacity when you have a mental impairment only and meet the age and social functioning limitations below:

Social limitation	Age
(a) Can not appropriately relate to coworkers and supervisors (rated three); and (b) Can not tolerate the pressures of a work setting (rated four).	Fifty years and older
(c) Can not tolerate the pressures for a work setting (rated five).	Eighteen to fifty-four
(d) A mental disorder severity rated four; (e) One or more symptoms from WAC 388-448-0050(4) (rated five); (f) Can not appropriately relate to coworkers and supervisors (rated three); and (g) Can not tolerate the pressures of a work setting (rated four).	Eighteen to forty-nine

(3) We approve incapacity when you have both mental and physical impairments and vocational factors interfere with working as follows:

Your age	Your education	Your other restrictions
Any age	Any level	(a) Can not appropriately relate to coworkers and supervisors (rated three); and (b) Can not tolerate pressures of a work setting (rated four).
Fifty or older	Limited education	(c) Restricted to medium work level or less.
Eighteen to forty-nine	Limited education	(d) Restricted to light work level.

(4) If we do not find that you are incapacitated by the end of Step VII of the PEP, an administrative review team (ART) makes the incapacity decision. The review team consists of two or more persons within the community service office (CSO) who are not in the position of providing direct eligibility or incapacity services to you. The ART reviews the medical evidence and your vocational factors.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0110, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0120 How we decide how long you are incapacitated.** We 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 accommoda-

tion (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 388-448-0150 Penalty for refusing medical treatment or other agency referrals.** (1) If you refuse required treatment or agency referral without having good cause, we will stop your GAU benefits.

(2) We stop your GAU benefits until you agree to accept and pursue the required treatment service or referral.

(3) If you reapply, you must wait for a penalty period to pass before you begin getting benefits. The penalty is based on how often you have refused:

Refusal	Penalty
First	One week
Second within six months	One month
Third and subsequent within one year	Two months

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0150, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0160 Review of your incapacity.** (1) In order to review your incapacity, we must have sufficient written medical information based on an examination within the last sixty days. We may also require information about your progress with required treatment or agency referrals according to WAC 388-448-0130.

(2) We cannot extend GAU eligibility beyond the current eligibility end date if we do not receive current medical evidence that we decide is enough to show that you continue to be incapacitated.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0160, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0170 Termination requirement—How we determine you are no longer incapacitated.** (1) Before we can decide you are no longer incapacitated, we must demonstrate that at least one of the following conditions exists:

(a) The incapacitating condition has clearly improved since incapacity was established. **"Clear improvement"** means that since incapacity was established:

(i) The physical or mental impairment that incapacity was based on has decreased in severity to the point where you are capable of gainful employment;

(ii) The effect of that impairment on work-related activities has been significantly decreased through treatment or rehabilitation, and you are now capable of gainful employment; or

(iii) We decide you are gainfully employed.

(b) There was a previous error in the eligibility decision. **"Previous error"** means incapacity was previously established based on:

(i) Faulty or insufficient information; or

(ii) We made a procedural error in one of our previous determinations, based on a rule in effect at the time.

(2003 Ed.)

(2) If we decide you are clearly improved but are receiving services through the division of vocational rehabilitation (DVR), we have the option of approving continued GAU through an exception to rule (ETR).

(3) We do not apply the clear improvement or previous error criteria when:

(a) You have a break in assistance of over thirty days and do not meet the criteria for retroactive reinstatement as required under WAC 388-448-0190; or

(b) You do not meet the categorical eligibility requirements for the general assistance unemployable program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0170, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0180 How 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 388-448-0190 Reinstating your eligibility after termination due to lack of medical evidence.** If your assistance was terminated due to lack or insufficiency of medical evidence, we reinstate your eligibility the day following the termination date if the following conditions are met:

(1) The termination was not due to your failure to cooperate in gathering the evidence;

(2) You provided the medical evidence within thirty days after the termination, establishing that you have been incapacitated since the date of termination; and

(3) The medical evidence substantiates incapacity.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0190, filed 8/2/00, effective 9/1/00.]

**WAC 388-448-0200 Eligibility for general assistance unemployable pending SSI eligibility.** If 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.]

**WAC 388-448-0210 Assignment and recovery of interim assistance.** You can get assistance to meet your basic needs from only one government source at a time. When you are approved for SSI, you may receive a payment going back to the date you applied for SSI. This means you are being paid a back payment for your basic needs. When you have received GAU during that time period, the amount paid to you in the form of GAU must be reimbursed to the state.

(1) **"Assign"** means that the Social Security Administration (SSA) will pay DSHS directly from your reimbursement amount. The assignment will be up to the amount of interim assistance we provide to you.

(2) **"Interim assistance"** means the state funds we provide to you to meet basic needs during:

(a) The time between your SSI application date and the month recurring SSI payments begin; or

(b) The period your SSI payments were suspended or terminated, and later reinstated for that period.

(3) We pay up to twenty-five percent of the interim assistance reimbursement that we receive from the SSA to the attorney who has successfully represented you in your effort to receive SSI.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0210, filed 8/2/00, effective 9/1/00.]

### Chapter 388-450 WAC INCOME

#### WAC

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388-450-0190	How does the department figure my shelter cost income deduction for food assistance?
388-450-0195	Utility allowances for food assistance programs.
388-450-0200	Medical expenses may be used as an income deduction for food assistance households containing an elderly or disabled household member.
388-450-0210	Countable income for medical programs.
388-450-0215	How the department estimates income to determine your eligibility and benefits.
388-450-0225	How the department calculates the benefit amount for the first month of eligibility for cash assistance.
388-450-0230	What income does the department count in the month I apply for food assistance when my assistance unit is destitute?
388-450-0245	When are my benefits suspended?

### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-450-0060	Lump sum payments. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0060, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0060, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0075	Income from time-loss compensation. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0075, filed 7/31/98, effective 9/1/98.] Repealed by 02-20-069, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 74.08.090 and 74.04.510.
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.
388-450-0180	Effect of countable income on eligibility and benefit level for cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0180, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0205	Budgeting income deductions for food assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0205, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

- 388-450-0220 Retrospective budgeting. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0220, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0220, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-450-0235 Discontinued income. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0235, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0235, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-450-0240 Effect of net lump sum payments for cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0240, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-450-0250 Income of a new assistance unit member. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0250, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0250, filed 7/31/98, effective 9/1/98.] Repealed by 00-01-012, filed 12/3/99, effective 1/1/00. Statutory Authority: RCW 74.04.510.

**WAC 388-450-0005 Income—Ownership and availability.** This section applies to cash assistance, medical programs for children, pregnant women and families, and food assistance.

(1) The department counts all available income owned or possessed by a client to figure the client's eligibility and benefit level when:

- (a) You get or expect to get the income in the month.
- (b) It is income we must count under chapter 388-450 WAC.
- (c) You own the income. We use applicable state and federal laws pertaining to property ownership to determine if you actually own the income. For married persons, ownership of separate and community income is determined according to chapter 26.16 RCW.
- (d) You have control over the income, which means the income is actually available to you.
- (e) You can use the income to meet your current needs. We count the gross amount of available income in the month it is received:

(i) If the income is usually available on a specific day, we consider it to be available on that date.

(ii) If you usually get the income monthly or semi-monthly and your pay date changes due to a reason beyond your control, such as a weekend or holiday, we count it in the month you actually get it.

(iii) If you usually get the income weekly or bi-weekly and your pay date changes due to a reason beyond your control, we count it in the month you get it.

(2) We consider the income that is legally yours as available income, even if it is paid to someone else for you. For example, the father of your child has a court order to pay you two hundred fifty dollars per month in child support. Instead of giving the money directly to you (as required in the court order), he gives the money to your landlord to pay part of your rent. We still count the two hundred fifty dollars as income even though you never actually got the money.

(2003 Ed.)

(3) We may also count the income of certain people who live in your home, even if they are not getting assistance. Their income counts as part of your income.

(a) For cash assistance, we count the income of ineligible, disqualified, or financially responsible people as defined in WAC 388-405-0100.

(b) For food assistance, we count the income of ineligible assistance unit members as defined in WAC 388-408-0035.

(c) For family and SSI-related medical assistance, we count the income of financially responsible people as defined in WAC 388-408-0055 and chapter 388-475 WAC.

(d) For long-term care services, we count the income of financially responsible people as defined in WAC 388-506-0620.

(4) If you have a joint bank account with someone who is not in your AU, we consider any money deposited into that account as your income unless:

(i) You can show that all or part of the funds belong exclusively to the other account holder and are held or used solely for the benefit of that holder; or

(ii) Social Security Administration (SSA) used that money to determine the other account holder's eligibility for SSI benefits.

(5) Potential income is income you may have access to that can be used to reduce the need for assistance. If we determine that a potential income source exists, you must make a reasonable effort to make the income available in order to get cash or medical assistance.

(a) We do not count that income until you actually get it; and

(b) You can choose whether to receive TANF/SFA or Supplemental Security Income (SSI) benefits.

(6) The income of an alien's sponsor is considered available to the alien under the rules of this chapter when determining the alien's eligibility and benefit level.

(7) For SSI-related medical:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the clients needs for food, clothing and shelter, except as provided in WAC 388-511-1130.

(b) Loans and certain other receipts are not defined as income for SSI-related medical purposes as described in 20 C.F.R. Sec. 416.1103.

(8) For medical programs, see WAC 388-561-0100 for more information about trusts.

(9) You may give us proof about an income source anytime, including when we ask for it or if you disagree with a decision we made, about:

(a) Who owns the income;

(b) Who has legal control of the income;

(c) The amount of the income; or

(d) The availability of the income.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-450-0005, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590 and 388-506-0610.]

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**WAC 388-450-0010** The department takes some or all of your time-loss benefits if you get cash assistance while waiting for your claim to be processed. (1) Some people who are hurt on the job can get time-loss benefits because of their injury. The time-loss benefits are paid by an agency, such as the department of labor and industries or a private insurance company.

(2) If you are an adult or minor child who gets cash assistance while waiting for your time-loss benefit claim to be processed, you are required to let the department take some or all of your time-loss benefits as repayment for your cash assistance. We will take our portion of the time-loss benefits before you get yours. You agree to this when you sign the application and accept your cash benefits.

(3) The amount of your time-loss benefits that we take will not be more than the total amount of cash assistance you got while waiting for your claim to be approved.

(4) If your assistance unit includes another adult to whom you are not married, the amount of your time-loss benefits we take may be less than the amount of cash assistance you received.

(5) Each time we take our portion from your time-loss benefits, the office of financial recovery (OFR) will send you a letter telling you how much we are taking.

(6) If you or your attorney claim that you are getting more time-loss benefits because of the help of your attorney, OFR will:

(a) First, figure out:

(i) How much of your time-loss benefits are a direct result of your attorney's work; and

(ii) Our proportionate share of your attorney's fees and costs for the amount we are taking; and

(b) Then, either:

(i) Subtract our share of your attorney's fees and costs from the amount we are taking; or

(ii) Send your attorney their share of the time-loss benefits we have taken.

(c) Send a copy of the account summary to you.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-20-069, § 388-450-0010, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0015** What types of income are not used when figuring out my benefits? This section applies to cash assistance, medical programs for children, pregnant women and families, and food assistance.

(1) There are some types of income that we (the department) do not count when figuring out if you can get benefits and the amount you can get. Some examples of income we do not count are:

(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 your 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;

(i) Child support payments received by TANF/SFA recipients; and

(j) Payments issued under the Department of State or Department of Justice Reception and Replacement Programs, such as Voluntary Agency (VOLAG) payments.

(2) For medical programs for children, pregnant women, or families, we also do not count any insurance proceeds or other income you have recovered as a result of being a Holocaust survivor.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-14-022, § 388-450-0015, filed 6/21/02, effective 6/22/02. 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 388-450-0020** Income exclusions for SSI-related medical. This section describes the types of income which are excluded or not counted when determining how much of a client's income is compared to the income standards in WAC 388-478-0065 through 388-478-0085 to determine eligibility.

(1) The first twenty dollars per month of a client's earned or unearned income, which is not otherwise excluded in this section, is excluded. This exclusion:

(a) Can only be allowed once for a husband and wife; and

(b) Does not apply to income paid on the basis of an eligible person's needs, which is funded totally or partially by the federal government or a private agency.

(2) The first sixty-five dollars per month of a client's earned income, plus one-half of the remainder is considered a work incentive and is deducted from the earned income. This deduction does not apply to income already excluded in this section.

(3) Income a client does not reasonably anticipate or which a client receives infrequently or irregularly is excluded when it is:

(a) Unearned and does not exceed twenty dollars per month; or

(b) Earned and does not exceed ten dollars per month.

(4) A client's work related expenses including child care are excluded when they specifically enable:

(a) A blind client to work; or

(b) A permanently or totally disabled client to continue to work.

(5) Any portion of self-employment income normally allowed as an income deduction by the Internal Revenue Service (IRS) is excluded.

(6) Any payment a client receives for the foster care of a child who lives in the same household, is excluded when the child:

(a) Was placed in the client's home by a public or non-profit child placement or child care agency; and

(b) Is not SSI eligible.

(7) One-third of any payment for child support a client receives from an absent parent for a minor child, who is not institutionalized, is excluded.

(8) A portion of an SSI-related person's income to meet the needs of an ineligible minor child living in the household is excluded when:

(a) The SSI-related parent is single; or

(b) If married, the spouse does not have income (see WAC 388-450-0150 if the spouse has income); and

(c) The excluded amount is:

(i) One-half of the one person federal SSI benefit rate, as described in WAC 388-478-0055; and

(ii) Minus any income of the child.

(9) Unless income is specifically contributed to the client, all earned income of an ineligible or nonapplying person, under twenty-one years of age, is excluded when this person is a student:

(a) Attending a school, college, or university; or

(b) Pursuing a vocational or technical training program designed to prepare the student for gainful employment.

(10) A client's veteran's benefits are excluded when they are designated for the veteran's:

(a) Dependent; or

(b) Aid and attendance/household allowance and unreimbursed medical expense allowance (UME). For an institutional client see WAC 388-513-1345.

(11) Any federal SSI income or state supplement payment (SSP), which is based on financial need is excluded.

(12) COLA increases in Title II Social Security Administration benefits are excluded for a noninstitutionalized client when:

(a) Received by the client after the client's termination from SSI/SSP or;

(b) Received by the client's spouse or other financially responsible person living in the household during the time period after the SSI/SSP termination.

(13) Income which causes a client to lose SSI eligibility due solely to the reduction in the SSP is excluded.

(14) Increases in a client's burial funds, established on or after November 1, 1982, are excluded if these increases are the result of:

(a) Interest earned on excluded burial funds;

(b) Appreciation in the value of an excluded burial arrangement which is left to accumulate and become part of separately identified burial funds.

(15) An essential expense incurred by a client to receive unearned income is excluded.

(16) A client's refund by any public agency of taxes paid on real property or on food is excluded.

(17) Tax rebates or special payments excluded under other statutes are excluded.

(18) The amount of a client's EITC payment is excluded.

(19) A fee a guardian or representative payee charges as reimbursement for providing services, when such services are a requirement for the client to receive payment of the income are excluded.

(20) Income a client's ineligible or nonapplying spouse receives from a governmental agency for services provided to an eligible client, such as chore services, are excluded.

(21) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services are excluded.

(22) Payments to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act are excluded. Any interest earned on this income is considered as unearned income, under WAC 388-450-0025.

(23) Payments to a client under section 500 through 506 of the Austrian General Social Insurance Act are excluded. Any interest earned on this income is considered unearned income under WAC 388-450-0025.

(24) Payments to a client from the Dutch government, under the Netherlands' Act on Benefits for Victims of Persecution (WUV) are excluded. Any interest earned on this income is considered unearned income under WAC 388-450-0025.

(25) Other payments excluded under federal or state law, including but not limited to those described in WAC 388-450-0015 (1)(b) through (g).

(26) Payments from *Susan Walker v. Bayer Corporation, et al.*, 96-c-5024 (N.D. Ill.) (May 8, 1997) settlement funds are excluded as income. Any interest earned on this income is considered unearned income under WAC 388-450-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140 and 388-519-1910.]

**WAC 388-450-0025 What is unearned income?** This section applies to cash assistance, food assistance, and medical programs for families, children, and pregnant women.

(1) Unearned income is income you get from a source other than employment or self-employment. Some examples of unearned income are:

(a) Railroad Retirement;

(b) Unemployment Compensation;

(c) Social Security benefits (including retirement benefits, disability benefits, and benefits for survivors);

(d) Time loss benefits as described in WAC 388-450-0010, such as benefits from the department of labor and industries (L&I); or

(e) Veteran Administration benefits.

(2) For food assistance we also count the total amount of cash benefits due to you before any reductions caused by your failure (or the failure of someone in your assistance unit) to perform an action required under a federal, state, or local means-tested public assistance program, such as TANF/SFA, GA, and SSI.

(3) When we count your unearned income, we count the amount you get before any taxes are taken out.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 02-20-069, § 388-450-0025, filed 9/30/02, effective 10/31/02; 99-17-025, § 388-450-0025,

filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0025, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0030 What is earned income?** This section applies to cash assistance, food assistance, and medical programs for families, children, and pregnant women.

(1) Earned income money you get from working. This includes:

- (a) Wages;
- (b) Tips;
- (c) Commissions;
- (d) Profits from self-employment activities as described in WAC 388-450-0080; and

(e) One-time payments for work you did over a period of time.

(2) For cash and medical assistance, we also consider you to have earned income if you work for something other than money, such as your rent.

(3) When we count your earned income, we count the amount you get before any taxes are taken out.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-20-069, § 388-450-0030, filed 9/30/02, effective 10/31/02; 99-17-025, § 388-450-0030, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0030, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0035 Educational benefits.** This section applies to cash assistance, medical programs for children, pregnant women and families, and food assistance.

(1) We do not count:

(a) Educational assistance in the form of grants, loans or work study, issued from Title IV of the Higher Education Amendments (Title IV - HEA) and Bureau of Indian Affairs (BIA) education assistance programs. Examples of Title IV - HEA and BIA educational assistance include but are not limited to:

- (i) College work study (federal and state);
- (ii) Pell grants; and
- (iii) BIA higher education grants.

(b) Educational assistance in the form of grants, loans or work-study made available under any program administered by the Department of Education (DOE) to an undergraduate student. Examples of programs administered by DOE include, but are not limited to:

- (i) Christa McAuliffe Fellowship Program;
- (ii) Jacob K. Javits Fellowship Program; and
- (iii) Library Career Training Program.

(2) For assistance in the form of grants, loans or work-study under the Carl D. Perkins Vocational and Applied Technology Education Act, P.L. 101-391:

(a) If you are attending school half-time or more, we subtract the following expenses:

- (i) Tuition;
- (ii) Fees;
- (iii) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study;
- (iv) Books;
- (v) Supplies;
- (vi) Transportation;

(vii) Dependent care; and  
(viii) Miscellaneous personal expenses.  
(b) If you are attending school less than half-time, we subtract the following expenses:

- (i) Tuition;
- (ii) Fees; and
- (iii) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study.

(c) For cash assistance and medical programs for children, pregnant women and families, we also subtract the difference between the appropriate need standard and payment standard for your family size.

(d) Any remaining income is unearned income and budgeted using the appropriate budgeting method for the assistance unit.

(3) If you are participating in WorkFirst work study, that work study income is:

- (a) Not counted for cash and medical assistance;
- (b) Counted as earned income for food assistance.

(4) If you are participating in a work study program that is not excluded in subsection (1), of this section, we count that work study income as earned income:

- (a) You get any applicable earned income disregards;
- (b) For cash assistance, and medical programs for children, pregnant women and families, we also subtract the difference between the need standard and payment standard for your family size as described in chapter 388-478 WAC; and

(c) Budgeting remaining income using the appropriate budgeting method for the assistance unit.

(5) If you get Veteran's Administration Educational Assistance:

- (a) All applicable attendance costs as subtracted; and
- (b) The remaining unearned income is budgeted using the appropriate budgeting method for the assistance unit.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-450-0035, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 00-18-057, § 388-450-0035, filed 9/1/00, effective 9/4/00. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0035, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0040 Native American benefits and payments.** This section applies to TANF/SFA, RCA, GA medical and food assistance programs.

(1) The following types of income are not counted when a client's benefits are computed:

(a) Up to two thousand dollars per individual per calendar year received under the Alaska Native Claims Settlement Act, P.L. 92-203 and 100-241;

(b) Income received from Indian trust funds or lands held in trust by the Secretary of the Interior for an Indian tribe or individual tribal member. Income includes:

- (i) Interest; and
- (ii) Investment income accrued while such funds are held in trust.

(c) Income received from Indian judgement funds or funds held in trust by the Secretary of the Interior distributed per capita under P.L. 93-134 as amended by P.L. 97-458 and 98-64. Income includes:

- (i) Interest; and
- (ii) Investment income accrued while such funds are held in trust.
- (d) Up to two thousand dollars per individual per calendar year received from leases or other uses of individually owned trust or restricted lands, P.L. 103-66;
- (e) Payments from an annuity fund established by the Puyallup Tribe of Indians Settlement Act of 1989, P.L. 101-41, made to a Puyallup Tribe member upon reaching twenty-one years of age; and
- (f) Payments from the trust fund established by the P.L. 101-41 made to a Puyallup Tribe member.

(2) Other Native American payments and benefits that are excluded by federal law are not counted when determining a client's benefits. Examples include but are not limited to:

- (a) White Earth Reservation Land Settlement Act of 1985, P.L. 99-264, Section 16;
- (b) Payments made from submarginal land held in trust for certain Indian tribes as designated by P.L. 94-114 and P.L. 94-540; and
- (c) Payments under the Seneca Nation Settlement Act, P.L. 101-503.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140.]

**WAC 388-450-0045 How do we count income from employment and training programs?** This section applies to cash assistance, food assistance, and medical programs for families, children, and pregnant women.

(1) We treat payments issued under the Workforce Investment Act (WIA) as follows:

- (a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.
- (b) For food assistance:
  - (i) We exclude OJT earnings for children who are eighteen years of age or younger and under parental control as described in WAC 388-408-0035.
  - (ii) We count OJT earnings as earned income for people who are:
    - (A) Age nineteen and older; or
    - (B) Age eighteen or younger and not under parental control.
  - (iii) We exclude all other payments.

(2) We treat payments issued under the National and Community Service Trust Act of 1993 (AmeriCorps) as follows:

- (a) We exclude OJT earnings for children who are eighteen years of age or younger and under parental control as described in WAC 388-408-0035 (2)(c).
- (b) We count OJT earnings as earned income for people who are:
  - (i) Age nineteen and older; or
  - (ii) Age eighteen or younger and not under parental control.
- (c) We exclude all other payments.

(3) We exclude payments issued under Title II of the Domestic Volunteer Act of 1973, such as Retired Senior Volunteer Program (RSVP).

(2003 Ed.)

(4) We treat payments issued under Title I of the Domestic Volunteer Act of 1973, such as VISTA, as follows:

- (a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.
- (b) For food assistance, we count most payments as earned income. We exclude the payments if you get:
  - (i) Food assistance or cash assistance at the time you joined the Title I program; or
  - (ii) You were participating in the Title I program and got an income disregard at the time of conversion to the Food Stamp Act of 1977. We will continue to exclude the payments you get even if you do not get food assistance every month.

(5) We count training allowances from vocational and rehabilitative programs as earned income when:

- (a) The program is recognized by federal, state, or local governments; and
- (b) The allowance is not a reimbursement.
- (6) When GAU clients receive training allowances we allow:

- (a) The earned income incentive and work expense deduction specified under WAC 388-450-0175, when applicable; and
- (b) The actual cost of uniforms or special clothing required for the course as a deduction, if enrolled in a remedial education or vocational training course.

(7) We exclude support service payments received by or made on behalf of WorkFirst participants.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-03-019, § 388-450-0045, filed 1/4/02, effective 2/1/02; 99-16-024, § 388-450-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0045, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0050 How are your cash assistance and food assistance benefits determined when you are participating in the community jobs (CJ) program?** (1) 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.

[Title 388 WAC—p. 723]



(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 388-450-0055 How does money from other agencies or organizations count against my benefits? (1)** For cash assistance and medical programs for children, pregnant women, and families:

(a) We do not count money given to you by other agencies or organizations if the money is given to you for reasons other than ongoing living expenses. Ongoing living expenses include the following items:

- (i) Clothing;
- (ii) Food;
- (iii) Household supplies;
- (iv) Medical supplies (nonprescription);
- (v) Personal care items;
- (vi) Shelter;
- (vii) Transportation; and
- (viii) Utilities (e.g., lights, cooking fuel, the cost of heating or heating fuel).

(b) If the money given to you is supposed to be used for ongoing living expenses, we count the amount remaining after we subtract the difference between the need standard and the payment standard for your family size as described in chapter 388-478 WAC.

(2) For food assistance:

(a) We do not count money given to you if:

- (i) It is given to you by a private, nonprofit, charitable agency or organization; and
- (ii) The amount of money you get is no more than three hundred dollars in any one of the following calendar quarters:
  - (A) January - February - March,
  - (B) April - May - June,
  - (C) July - August - September,
  - (D) October - November - December.

(b) We count the entire amount if the requirements in (a) of this subsection are not met.

(3) For cash assistance, food assistance, and medical programs for children, pregnant women, and families, if we do count the money you get, we treat it as unearned income under WAC 388-450-0025.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-14-022, § 388-450-0055, filed 6/21/02, effective 6/22/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0055, filed 7/31/98, effective 9/1/98.]

[Title 388 WAC—p. 724]

**WAC 388-450-0065 Gifts—Cash and noncash.** A gift is an item furnished to a client without work or cost on his or her part.

(1) A cash gift is a gift that is furnished as money, cash, checks or any other readily negotiable form.

(a) For cash assistance and medical programs for children, pregnant women and families, cash gifts totaling no more than thirty dollars per calendar quarter for each assistance unit member are disregarded as income.

(b) For food assistance programs:

- (i) Cash gifts to the assistance unit are excluded if they total thirty dollars or less per quarter;
- (ii) Cash gifts in excess of thirty dollars per quarter are counted in full as unearned income.

(2) For cash assistance and medical programs for children, pregnant women and families, and food assistance, a noncash gift is treated as a resource.

(a) If the gift is a countable resource, its value is added to the value of the client's existing countable resources and the client's eligibility is redetermined as specified in chapter 388-470 WAC.

(b) If the gift is an excluded or noncountable resource, it does not affect the client's eligibility or benefit level.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-450-0065, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0065, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0065, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0070 How do we count the earned income of a child? (1)** For food assistance and medical programs for families, children, and pregnant women, we do not count the earnings of a child if the child is:

- (a) In school;
- (b) Age seventeen or younger;
- (c) Not married; and
- (d) Not emancipated.

(2) For cash assistance, we do not count the earnings of a child if the child is:

- (a) In school; and
- (b) Meets the age and attendance requirements in WAC 388-404-0005.

(3) School includes:

- (a) Participating in a home-school program that is approved by the superintendent of public instruction; or
- (b) On break between school terms when the child:
  - (i) Was enrolled during the previous school term; and
  - (ii) Plans to return to school when it reopens.

(4) For medical programs, if we count the earnings of the child, we put the child in a separate MAU as described in WAC 388-408-0055.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-03-020, § 388-450-0070, filed 1/4/02, effective 2/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0070, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0080 What is self-employment income?** This section applies to TANF/SFA, GA, RCA, food assistance, and medical programs for children, pregnant women and families.

(2003 Ed.)

(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 388-450-0095 Allocating income—General.**

This section applies to TANF/SFA, RCA, and GA assistance programs.

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit.

(2) In-bound allocation means income possessed by a financially responsible person outside the assistance unit which is considered available to meet the needs of legal dependents in the assistance unit.

(3) Out-bound allocation means income possessed by a financially responsible assistance unit member which is set aside to meet the needs of a legal dependent outside the assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0095, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0100 Allocating income—Definitions.**

The following definitions apply to the allocation rules for TANF/SFA, RCA, and GA programs:

(1) **"Dependent"** means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) **"Financially responsible person"** means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) A **"disqualified assistance unit member"** means a person who is:

(a) An unmarried pregnant or parenting minor under age eighteen who has not completed a high school education or general education development (GED) certification and is not participating in those educational activities which would lead to the attainment of a high school diploma or GED;

(b) An unmarried pregnant or parenting minor under age eighteen who is not living in a department-approved living situation;

(c) The financially responsible person who does not report to the department within five days of the date it becomes reasonably clear that the absence of a child will exceed ninety days;

(d) A person who has been convicted in federal or state court of having made a fraudulent statement or representation about their place of residence in order to receive assistance

from two or more states at the same time as defined in WAC 388-446-0010; and

(e) A person who has been convicted of unlawfully receiving public assistance as defined under WAC 388-446-0005.

(4) **"Ineligible assistance unit member"** means an individual who is:

(a) Ineligible for cash assistance due to citizenship/alien status requirement in WAC 388-424-0005;

(b) Ineligible to receive assistance under WAC 388-442-0010 for having been convicted after August 21, 1996, under federal or state law, of possession, use or distribution of a controlled substance;

(c) Ineligible to receive assistance under WAC 388-442-0010 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime;

(d) Ineligible to receive assistance under WAC 388-442-0010 for violating a condition of probation or parole which was imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction;

(e) The spouse of a woman who receives cash benefits from the GA-S program; or

(f) The adult parent of a minor parent's child.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0100, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0100, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0105 Allocating the income of a financially responsible person included in the assistance unit.** This section applies to TANF/SFA, RCA, and RMA. Refer to WAC 388-408-0055 for the rules concerning the treatment of income of financially responsible person for medical programs. The income of a financially responsible person included in the assistance unit is countable to meet the needs of the assistance unit after the income is reduced by the following:

(1) Any applicable earned income incentive and work expense or deduction for the financially responsible person in the assistance unit, if that person is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-450-0105, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0105, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0106 How does the department count my income if someone in my family cannot get assistance because of their alien status?** This section applies to TANF/SFA, RCA, and RMA. We count your income differently if you are applying for medical assistance only. See WAC 388-408-0055.

If you are included in the assistance unit and you are financially responsible for someone, as defined in WAC 388-450-0100, who does not meet the alien requirements

described in WAC 388-424-0005, we do not count all of your income. We subtract some of it so that you can use that part to help support the people who cannot get assistance. To figure out how much we count, we take the following seven steps:

(1) We start by only counting fifty percent of your earned income, as defined in WAC 388-450-0030;

(2) We add all of your unearned income, as defined in WAC 388-450-0025.

(3) We subtract the difference between the following payment standards (payment standards can be found in WAC 388-478-0020):

(a) One that includes both eligible assistance unit members and those who cannot get assistance because of their alien status; and

(b) One that includes only the eligible assistance unit members.

(4) We subtract the payment standard for the number of people who are ineligible for reasons other than alien status, as defined in WAC 388-450-0100 (4)(b) through (f).

(5) We subtract any court or administratively ordered child support you pay for legal dependents. This includes both current and back support. The amount cannot be more than the need standard in WAC 388-478-0015 for the number of dependents.

(6) We subtract any employment-related child care expenses you have.

(7) Then, we count whatever is left as unearned income.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-21-097, § 388-450-0106, filed 10/21/02, effective 10/24/02; 99-16-024, § 388-450-0106, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0106, filed 11/24/98, effective 12/25/98.]

**WAC 388-450-0110 Allocating the income of a GA-U client to legal dependents.** This section applies to the GA-U program.

(1) The income of a GA-U client is reduced by the following:

(a) The GA-U earned income disregard and work expense disregard, as specified in WAC 388-450-0175; and

(b) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(2) When a GA-U client in a medical institution, alcohol or drug treatment center, congregate care facility or adult family home has income, the income is countable to meet the client's needs after the income is reduced by the following:

(a) The payment standard amount for the nonapplying spouse and legal dependents living in the home; and

(b) The standard of assistance the client is eligible for while in an alternative care facility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1910.]

**WAC 388-450-0115 Allocating the income of a financially responsible person excluded from the assistance unit.** This section applies to TANF/SFA, RCA and GA-S programs.

The income of a financially responsible person excluded from the assistance unit is available to meet the needs of the assistance unit after the income is reduced by the following:

(1) A ninety dollar work expense deduction from the financially responsible person(s) excluded from the assistance unit who is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0115, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0116 How does the department count my income if I cannot get assistance because I am an alien?** This section applies to TANF/SFA, RCA, and RMA programs. We count your income differently if you are applying for medical assistance only. See WAC 388-408-0055.

Some people cannot get assistance because they do not meet the alien requirements described in WAC 388-424-0005. If you do not meet those requirements but you are financially responsible for someone in the assistance unit, as defined in WAC 388-450-0100, we count some of your income as part of the assistance unit's income. To figure out how much we count, we take the following seven steps:

(1) We start by only counting fifty percent of your earned income, as described in WAC 388-450-0030.

(2) We add all of your unearned income, as described in WAC 388-450-0025.

(3) We subtract the difference between the following payment standards:

(a) One that includes both eligible assistance unit members and those who cannot get assistance because of their alien status; and

(b) One that includes only the eligible assistance unit members.

(4) We subtract the payment standard for the number of people who are ineligible for reasons other than alien status, as defined in WAC 388-450-0100 (4)(b) through (f).

(5) We subtract any court or administratively ordered child support you pay for legal dependents. This includes both current and back support. The amount cannot be more than the need standard in WAC 388-478-0005 for the number of dependents.

(6) We subtract any employment-related childcare expenses you have.

(7) Then, we count whatever is left as unearned income.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-14-021, § 388-450-0116, filed 6/21/02, effective 6/22/02; 99-16-024, § 388-450-0116, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0116, filed 11/24/98, effective 12/25/98.]

**WAC 388-450-0120 Allocating the income of financially responsible parents to a pregnant or parenting minor.** This section applies to TANF/SFA, RCA and GA-S programs.

The income of nonapplying financially responsible parent(s) of a pregnant or parenting minor is countable to meet

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the needs of the minor and the child(ren) after the income is reduced by the following:

(1) A ninety dollar work expense from the financially responsible parent's gross income from employment;

(2) An amount not to exceed the department's standard of need for:

(a) The financially responsible parent and dependent living in the home who are not applying for or receiving cash benefits and not a disqualified individual; and

(b) Court or administratively ordered current or back support for legal dependents.

(3) Spousal maintenance payments made to meet the needs of individuals not living in the home.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0120, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0130 Allocating the income of a non-applying spouse to a caretaker relative.** This section applies to TANF/SFA and RCA programs.

(1) The community income of the nonapplying spouse and applying spouse is combined. See WAC 388-450-0005 to determine what income is available as community income.

(2) Subtract a one person payment standard as specified in WAC 388-478-0020.

(3) The remainder is allocated to the caretaker relative.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0130, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0135 Allocating income of an ineligible spouse to a GA-U client.** (1) This section applies to the GA-U program.

(2) When a GA-U client is married and lives with the nonapplying spouse, the following income is available to the client:

(a) The remainder of the client's wages, retirement benefits or separate property after reducing the income by:

(i) The GA-U work incentive and work expense deduction, as specified in WAC 388-450-0175; and

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(b) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(i) The GA-U work expense deduction;

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents; and

(iii) The payment standard amount as specified under WAC 388-478-0030 which includes ineligible assistance unit members.

(c) One-half of all other community income, as provided in WAC 388-450-0005.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0135, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0140 How does the income of an ineligible assistance unit member affect my eligibility and benefits for food assistance?** The department decides who

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must be in your assistance unit (AU) under WAC 388-408-0035. If an AU member is ineligible for food assistance under WAC 388-408-0035, this affects your AU's eligibility and benefits as follows:

(1) We do not count the ineligible member(s) 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 an 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 an AU member is an ineligible ABAWD under WAC 388-444-0030, is ineligible due to their alien status, failed to sign the application to state their citizenship or alien status, or refused to get or provide us a Social Security number:

(a) We allow the twenty percent earned income disregard for the ineligible member's earned income;

(b) We prorate the remaining income of the ineligible member among all the AU members by excluding the ineligible member's share and counting the remainder to the eligible members; and

(c) We divide the ineligible member's allowable expenses evenly among all members of the AU when the ineligible member has income.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 02-06-089, § 388-450-0140, filed 3/1/02, effective 3/26/02; 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 388-450-0145 Income of a person who is not a member of a food assistance unit.** (1) A cash payment made to a food assistance unit from a person who is not a member of the assistance unit is counted as unearned income.

(2) The following types of income are not available to the assistance unit:

(a) The nonmember's income; and

(b) Payments made by a nonmember to a third party for the benefit of the assistance unit.

(3) When the nonmember's earnings are not clearly separate from the earnings of food assistance unit members, the earnings are:

(a) Divided equally among the working persons, including the nonmember; and

(b) The portion of the nonmember is not counted.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0145, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0150 SSI-related medical income allocation.** (1) When a client is applying for SSI-related categorically needy (CN) or medically needy (MN) medical assistance, a portion of the income of a spouse or parent is allo-

cated to the needs of the applicant. This occurs when the spouse or parent is:

(a) Financially responsible for the SSI-related person as described in chapter 388-408 WAC; and

(b) Lives in the same household; and

(c) Is not receiving SSI; and

(d) Is either not related to SSI or is not applying for medical assistance.

(2) If the conditions in subsection (1) of this section are met, the income exclusions listed below are applied and the remainder of the parent's income is allocated to their SSI-related minor child applying for either (CN) or (MN) medical assistance:

(a) Income exclusions as described in WAC 388-450-0020; and

(b) One-half of the federal benefit rate (FBR), as described in WAC 388-478-0055, for each SSI ineligible child in the household, minus any income of that child; and

(c) A one person FBR for a single parent, or two person FBR for two parents.

(3) The income of the financially responsible spouse of an SSI-related client applying for CN or MN medical assistance is allocated to the applicant's needs.

(a) The income exclusions in WAC 388-450-0020 (3) through (26) are allowed to reduce the nonapplying spouse's income; and

(b) One-half of the FBR for any non-SSI eligible child in the household, minus any income of that child, is allowed as a deduction; and

(c) Allocate the applying spouse:

(i) Zero income when the financially responsible spouse's income equals or is less than one-half of the FBR after allowing the income exclusions in WAC 388-450-0020 (1) and (2); or

(ii) All of the financially responsible spouse's income when the income exceeds one-half of the FBR after allowing the income exclusions in WAC 388-450-0020 (1) and (2).

(4) If the income of the financially responsible spouse described in subsection (3) of this section is less than the MNIL, a portion of the SSI-related applicant's income is added to the financially responsible spouse's income to raise it to the MNIL.

(5) If an alien client is ineligible for SSI cash assistance because of income or resources of a sponsor allocated or deemed available to the client, the SSI-related client is still considered eligible for CN or MN medical assistance. Only the income or resources actually contributed to the alien client are considered available to that client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0150, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0630 and 388-519-1910.]

**WAC 388-450-0155 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 388-450-0162 The department uses countable income to determine if you are eligible and the amount of your cash and food assistance benefits.** The department uses countable income to determine if the client is eligible and the amount of the cash and food assistance benefits.

(1) Countable income is all income that remains after we subtract the following:

(a) Excluded or disregarded income under WAC 388-450-0015;

(b) Deductions or earned income incentives under WAC 388-450-0170 through 388-450-0200;

(c) Allocations to someone outside of the assistance unit under WAC 388-450-0095 through 388-450-0160.

(2) Countable income includes all income that must be deemed or allocated from financially responsible persons who are not members of your assistance unit.

(3) For cash assistance:

(a) We compare your countable income to the payment standard in WAC 388-478-0020 and 388-478-0030.

(b) You are not eligible for benefits when your assistance unit's countable income is equal to or greater than the payment standard plus any authorized additional requirements.

(c) Your benefit level is the payment standard and authorized additional requirements minus your assistance unit's countable income.

(4) For food assistance:

(a) We compare your countable income to the monthly net income standard specified in WAC 388-478-0060.

(b) You are not eligible for benefits when your assistance unit's income is equal to or greater than the monthly net income standard.

(c) Your benefit level is the maximum allotment in WAC 388-478-0060 minus thirty percent of your countable income.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0162, filed 11/19/99, effective 1/1/00.]

**WAC 388-450-0165 Gross earned income limit for TANF/SFA.** When applying the gross earned income limit as required under WAC 388-478-0035:

(1) "Family" means:

(a) All adults and children who would otherwise be included in the assistance unit under WAC 388-408-0015, but who do not meet TANF/SFA eligibility requirements;

(b) The unborn child of a woman in her third trimester of pregnancy; and

(c) The husband of a woman in her third trimester of pregnancy, when residing together.

(2) "Gross earned income" does not include excluded income, as provided in WAC 388-450-0015.

(3) The following amounts are disregarded when determining a family's gross earned income:

(a) Court or administratively ordered current or back support paid to meet the needs of legal dependents, up to:

- (i) The amount actually paid; or
- (ii) A one-person need standard for each legal dependent.

(b) Authorized ongoing additional requirement payment as defined in WAC 388-255-1050 through 388-255-1250.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0165, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0170 TANF/SFA earned income incentive and deduction.** This section applies to TANF/SFA, RCA, and medical programs for children, pregnant women, and families except as specified under WAC 388-450-0210.

(1) If a client works, the department only counts some of the income to determine eligibility and benefit level.

(2) We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

(3) If you pay for care before we approve your benefits, we subtract the amount you pay for those dependent children or incapacitated adults who get cash assistance with you.

(a) The amount we subtract is:

(i) Prorated according to the date you are eligible for benefits;

(ii) Cannot be more than your gross monthly income; and

(iii) Cannot exceed the following for each dependent child or incapacitated adult:

Dependent Care Maximum Deductions

Hours Worked Per Month	Child Under Two	Child Over Two
	Years of Age	Years of Age or Incapacitated Adult
0 - 40	\$ 43.75	\$ 50.00
41 - 80	\$ 87.50	\$ 100.00
81 - 120	\$ 131.25	\$ 150.00
121 or More	\$ 175.00	\$ 200.00

(b) In order to get this deduction:

(i) The person providing the care must be someone other than the parent or stepparent of the child or incapacitated adult; and

(ii) You must verify the expense.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-450-0170, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0170, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0175 GA-U earned income incentive and deduction.** This section applies to the GA-U cash assistance program.

(1) When a client's countable income is determined, eighty-five dollars plus one half of the remainder of a client's monthly gross earned income is disregarded as an incentive to employment.

(2) In addition to the work incentive provided in subsection (1) of this section, work expenses are disregarded in an

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amount equal to twenty percent of the gross earned income; or

(3) At the option of the client, actual verified work expenses, including:

(a) Mandatory deductions required by law or as a condition of employment, such as FICA, income tax, and mandatory retirement contributions;

(b) Union dues when union membership is required for employment;

(c) Clothing costs when the clothing is necessary for employment;

(d) Tools necessary for employment;

(e) Other expenses reasonably associated with employment, such as legally binding contracts with employment agencies; and

(f) Transportation expenses as follows:

(i) If public transportation (other than for-hire vehicles such as taxis) is available and practical, the actual monthly cost, based on a commuter's pass, ticket book, or tokens at reduced quantity rates, even if the client does not use public transportation; or

(ii) If public transportation is not available or practical, the actual amount if the client pays another person to drive; or

(iii) If public transportation is not available or practical and the client uses his or her own vehicle, the costs, based on the percentage of work-related miles driven, for service and repairs, replacement of worn parts, registration and license fees, the interest on car payments, and either eight cents per mile or the actual cost for gas, oil, fluids, and depreciation.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0175, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0185 Does the department count all of my income to determine my eligibility and benefits for food assistance?** We subtract the following amounts from your assistance unit's (AU's) countable income before we determine your food assistance benefit amount:

(1) A standard deduction based on the number of people in your AU under WAC 388-408-0035:

Eligible and ineligible AU members	Standard deduction
1	\$134
2	\$134
3	\$134
4	\$134
5	\$147
6 or more	\$168

(2) Twenty percent of your AU's gross earned income (earned income deduction);

(3) Your AU's expected monthly dependent care expense as described below:

(a) The dependent care must be needed for AU member to:

(i) Keep work, look for work, or accept work;

(ii) Attend training or education to prepare for employment; or

(iii) Meet employment and training requirements under chapter 388-444 WAC.

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(b) We subtract allowable dependent care expenses that are payable to someone outside of your AU:

- (i) Up to two hundred dollars for each dependent under age two; and
- (ii) Up to one hundred seventy-five dollars for each dependent age two or older.

(4) Medical expenses over thirty-five dollars a month owed or anticipated by an elderly or disabled household member as described under WAC 388-450-0200.

(5) Legally obligated current or back child support paid to someone outside of your AU:

- (a) For a person who is not in your AU; or
- (b) For a person who is in your AU to cover a period of time when they were not living with you.

(6) A portion of your shelter costs as described in WAC 388-450-0190.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and H.R. 2646 Farm Security and Rural Investment Act of 2002. 02-22-044, § 388-450-0185, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0185, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0185, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0190 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 association or condo fees;
- (d) Homeowner's insurance for the building only;
- (e) Utility allowance your AU is eligible for under WAC 388-450-0195;

(f) 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;

(g) 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 sixty-seven 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

- (b) The entire amount if someone in your AU is elderly or disabled, even if the amount is over three hundred sixty-seven dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-22-045, § 388-450-0190, filed 10/30/02, effective 12/1/02. 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.

(a) 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	\$ 275
2	\$ 283
3	\$ 291
4	\$ 300
5	\$ 308
6 or more	\$ 316

(b) 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 two hundred fifteen dollars.

(c) If your AU has only telephone costs and no other utility costs, you get a telephone utility allowance (TUA) of thirty-five dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-22-045, § 388-450-0195, filed 10/30/02, effective 12/1/02. 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 74.04.510 [74.04.510]. 99-24-052, § 388-450-0195, filed 11/29/99, effective 12/1/99. Statutory Authority: RCW 74.04.510. 99-09-055, § 388-450-0195, filed 4/19/99, effective 5/20/99. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6). 99-01-069, § 388-450-0195, filed 12/14/98, effective 1/14/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0195, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0200 Medical expenses may be used as an income deduction for food assistance households containing an elderly or disabled household member.** (1) Food assistance households can use medical expenses in

excess of thirty-five dollars monthly as an income deduction for members that are:

- (a) Age sixty or older; or
- (b) Disabled as defined in WAC 388-400-0040.

(2) The department allows deductions for expenses to cover services, supplies, or medication prescribed by a state licensed practitioner or other state certified, qualified, health professional, such as:

(a) Medical, psychiatric, naturopathic physician, dental, or chiropractic care;

- (b) Prescription drugs;
- (c) Over the counter drugs;
- (d) Eye glasses;
- (e) Medical supplies other than special diets;
- (f) Medical equipment.

(g) Hospital and outpatient treatment including:

- (i) Nursing care; or
- (ii) Nursing home care including payments made for a

person who was an assistance unit member at the time of placement.

(h) Health insurance premiums paid by the client including:

- (i) Medicare premiums or cost sharing; and
- (ii) Insurance deductibles and co-payments.

(i) Spenddown expenses as defined in WAC 388-519-0010. Spenddown expenses are allowed as a deduction as they are estimated to occur or as the expense become due;

(j) Dentures, hearing aids, and prosthetics;

(k) Cost of obtaining and caring for a seeing eye or hearing animal, including food and veterinarian bills. We do not allow the expense of guide dog food as a deduction if you receive ongoing additional requirements under WAC 388-255-1050 to pay for this need;

(l) Reasonable costs of transportation and lodging to obtain medical treatment or services;

(m) Attendant care necessary due to age, infirmity, or illness. If your household provides most of the attendant's meals, we allow an additional deduction equal to a one-person allotment.

(3) There are two types of deductions:

(a) One-time expenses are expenses that cannot be estimated to occur on a regular basis. You can choose to have us:

(i) Allow the one-time expense as a deduction when it is billed or due; or

(ii) Average the expense through your certification period.

(b) Recurring expenses are expenses that happen on a regular basis. We estimate your monthly expenses for the certification period.

(4) We do not allow a medical deduction if:

- (a) The expense has already been paid;
- (b) The expense is repaid by someone else;
- (c) The expense is paid or will be paid by another agency;

(d) The expense is covered by medical insurance;

(e) You claim the expense later than the first billing, even if:

(i) You did not claim the expense the first time it was billed;

(ii) The expense is included in the current billing; and

(iii) You paid the bill.

(f) We previously allowed the expense, and you did not pay it. We do not allow the expense again even if it is part of a repayment agreement;

(g) You included the expense in a repayment agreement after failing to meet a previous agreement for the same expense;

(h) You claim the expense after you have been denied for presumptive SSI; and you are not considered disabled by any other criteria; or

(i) The provider considers the expense overdue.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0200, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0200, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0200, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0210 Countable income for medical programs.** (1) For purposes of medical program eligibility, a client's countable income is income which remains when:

(a) The income cannot be specifically excluded; and

(b) All appropriate deductions and disregards allowed by a specific program, have been applied.

(2) A client's countable income cannot exceed the income standard for the specific medical programs described in WAC 388-478-0065, 388-478-0070, 388-478-0075, 388-478-0080, or 388-513-1305, 388-513-1315, or 388-513-1395 unless the program allows for those limits to be exceeded.

(3) Unless modified by subsection (4) of this section, the TANF/SFA income rules, as described in this chapter, are used to determine a client's countable income for the following programs:

(a) Family medical program as described in WAC 388-505-0220;

(b) Medical extensions as described in chapter 388-523 WAC;

(c) Pregnant women's program as described in WAC 388-462-0015;

(d) Children's medical program as described in WAC 388-505-0210;

(e) Medically Indigent (MI) program as described in WAC 388-438-0100.

(4) Exceptions to the TANF/SFA cash assistance methodology apply as follows:

(a) The financial responsibility of relatives when a client is applying for medical for families, children, pregnant women or for the medically indigent program is specified in WAC 388-408-0055;

(b) Actual work-related child and dependent care expenses, which are the client's responsibility, are income deductions (the limits on this deduction in WAC 388-450-0170 (3) and (4) do not apply);

(c) Court or administratively ordered current or back support paid to meet the needs of legal dependents, are income deductions;

(d) Only income actually contributed to an alien client from the alien's sponsor is countable unless the sponsor signed the affidavit of support I-864 or I-864A. See subsection (5) of this section;

(e) TANF/SFA gross earned income limits as described in WAC 388-450-0165 do not apply;

(f) The fifty percent earned income deduction is not used to calculate countable income for CN programs with income levels based upon the Federal Poverty Level (FPL). These programs are listed in subsection (3)(c), and (d) of this section. The only work related income deductions for these programs are:

(i) Ninety dollars; and

(ii) Actual work-related child and dependent care expenses, as described in (b) of this subsection; and

(iii) Child support as described in (c) of this subsection.

(g) When determining medically needy (MN) or MN scope of care coverage for children or pregnant women for the programs described in subsection (3)(c) and (d), the exception described in subsection (4)(f) is not used as the MN income standards are not based on the FPL;

(h) A nonrecurring lump sum payment is considered as income in the month the client receives payment, and a resource if the client retains the payment after the month of receipt;

(i) Diversion cash assistance (DCA), is not countable income;

(j) Effective April 1, 2002, the department will disregard an increase in earned income when:

(i) A family is receiving benefits under the family medical program; and

(ii) The increase occurs during the second or third month of eligibility. The disregard stops the last day of the third month of eligibility for a family medical program.

(5) When an alien's sponsor has signed the affidavit of support I-864 or I-864A, the sponsor's income and resources are counted as described in WAC 388-450-0155, 388-450-0156, 388-450-0160, and 388-470-0060.

(6) Except when this state has adopted more liberal rules, SSI income rules are used to determine a client's countable income for the following programs:

(a) SSI-related CN or MN; and

(b) Medicare savings programs. Refer to chapter 388-475 WAC.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-450-0210, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.08A.100, and Title XIX State Plan amendment 00-008. 02-03-009, § 388-450-0210, filed 1/4/02, effective 2/4/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580, 388-505-0590 and 388-519-1910.]

**WAC 388-450-0215 How the department estimates income to determine your eligibility and benefits.** The department uses prospective budgeting to determine eligibility and benefits.

(1) The department determines the amount of benefits an assistance unit can receive each month based on an estimate of your income and circumstances for that month. This is known as prospective budgeting.

(2) We base this estimate on what can be reasonably expected based on your current, past and future circumstances.

(3) We determine if our estimate is reasonable by looking at documents, statements, and other verification.

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(4) There are two methods of estimating a client's income:

(a) Anticipating monthly income: We estimate the actual amount of income you expect to receive in the month; and

(b) Averaging income: We estimate your income based on adding the total income you expect to receive for a period of time and dividing by the number of months in the time period.

(5) We must use the anticipating monthly method in the following circumstances:

(a) If you are a destitute migrant or destitute seasonal farmworker as defined in WAC 388-406-0021;

(b) If you are receiving SSI, Social Security, or SSI-related medical benefits;

(c) If you have income allocated to someone receiving SSI-related medical benefits under WAC 388-450-0150; or

(d) If you have already received income in the month that you apply for benefits.

(6) When using the anticipating monthly method, we estimate the actual amount of income you expect to receive in the month. Your benefits will vary based on the income that is expected for that month.

(7) When using the averaging method, the expected changes in your income are taken into consideration so your benefits do not change as much:

(a) Clients that receive their income weekly or every other week will have their income converted to a monthly amount. If you are paid:

(i) Weekly, we multiply your expected pay by 4.3; or

(ii) Every other week, we multiply your expected pay by 2.15.

(b) Clients that receive their income other than weekly or every other week will have their monthly income estimated by:

(i) Adding the total amount of income expected to be received for the period of time; and

(ii) Dividing by the number of months in the period of time.

(8) We will not make you repay an overpayment or increase your benefits if your actual income is different than your estimated income unless:

(a) The information you provided was incomplete or false; or

(b) We made an error in calculating your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0215, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0215, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0215, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

**WAC 388-450-0225 How the department calculates the benefit amount for the first month of eligibility for cash assistance.** (1) To determine the client's benefit amount for the first month of eligibility for cash assistance, the department compares the countable income to the payment standard as described in WAC 388-450-0162.

(2) Even if your countable income exceeds the payment standard, you can still receive additional requirements.

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(3) When your countable income is less than the payment standard, we prorate your grant amount based on the date you are eligible.

(4) We do not prorate the approved additional requirements.

(5) We prorate your grant by:

(a) Dividing the grant amount by the number of days in the first month of eligibility; and

(b) Multiplying the figure in (5)(a) of this section by the number of days from the date of eligibility to the last day of the month.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0225, filed 11/19/99, effective 1/1/00; 99-16-024, § 388-450-0225, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0225, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0230 What income does the department count in the month I apply for food assistance when my assistance unit is destitute?** (1) If your assistance unit (AU) includes a migrant or seasonal farmworker and your AU is destitute under WAC 388-406-0021, we may exclude some of your income in the month you apply for food assistance.

(2) In the month of application, we:

(a) Count only income received between the first of the month and the date you apply for food assistance; and

(b) Disregard any income from a new source that you expect to receive after the date you apply for food assistance.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, and 7 C.F.R. 273.10. 02-17-028, § 388-450-0230, filed 8/12/02, effective 10/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0230, filed 11/19/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0230, filed 7/31/98, effective 9/1/98.]

**WAC 388-450-0245 When are my benefits suspended?** (1) In the TANF/SFA, RCA, GA and food assistance programs, the word "suspend" means that the department stops your benefits for one month.

(2) We suspend your benefits for one month when your expected countable income as defined in WAC 388-450-0162:

(a) Exceeds the dollar limits for your household size; and

(b) Exceeds those limits for only that one month.

(3) We end your benefits when your expected countable income exceeds the limits for your household size for two or more consecutive months.

(4) If your expected income drops below the limits for your household size, you may be eligible if you reapply for benefits.

[Statutory Authority: RCW 74.04.510. 00-01-012, § 388-450-0245, filed 12/3/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0245, filed 7/31/98, effective 9/1/98.]

## Chapter 388-452 WAC INTERVIEW REQUIREMENTS

### WAC

388-452-0005

Do I have to be interviewed in order to get benefits?

(2003 Ed.)

388-452-0010

What does the family violence amendment mean for TANF/SFA recipients?

**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 deny your application for cash or food assistance because you did not appear for an interview, we 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 just one 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;

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(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, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-452-0005, filed 6/21/02, effective 7/1/02. 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.]

**WAC 388-452-0010 What does the family violence amendment mean for TANF/SFA recipients?** The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), also known as the Welfare Reform Act, gave every state the option to have a program to address issues of family violence for temporary assistance for needy families (TANF) and state family assistance (SFA) recipients.

(1) For TANF/SFA, it is family violence when a recipient, or family member or household member has been subjected by another family member or household member as defined in RCW 26.50.010(2) to one of the following:

- (a) Physical acts that resulted in, or threatened to result in, physical injury;
- (b) Sexual abuse;
- (c) Sexual activity involving a dependent child;
- (d) Being forced as the caretaker relative or a dependent child to engage in nonconsensual sexual acts or activities;
- (e) Threats of or attempts at, physical sexual abuse;
- (f) Mental abuse;
- (g) Neglect or deprivation of medical care; or
- (h) Stalking.

(2) DSHS shall:

- (a) Screen and identify TANF/SFA recipients for a history of family violence;
- (b) Notify TANF/SFA recipients about the family violence amendment both verbally and in writing;
- (c) Maintain confidentiality as stated in RCW 74.04.060;
- (d) Offer referral to social services or other resources for clients who meet the criteria in subsection (1) of this section;
- (e) Waive WorkFirst requirements that unfairly penalize victims of family violence, would make it more difficult to escape family violence or place victims at further risk. Requirements to be waived may include:

(i) Time limits for TANF/SFA recipients, for as long as necessary (after fifty-two months of receiving TANF/SFA);

(ii) Cooperation with the division of child support.

(f) Develop specialized work activities for instances where participation in regular work activities would place the recipient at further risk of family violence.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0010, filed 7/31/98, effective 9/1/98.]

[Title 388 WAC—p. 736]

## Chapter 388-454 WAC LIVING WITH A RELATIVE

### WAC

- 388-454-0005 Can I get TANF or SFA benefits for the child living with me?
- 388-454-0006 The department makes background checks on adults who are acting in place of a parent without court-ordered custody.
- 388-454-0010 Do I have to be related to a child in order to get TANF or SFA for the child?
- 388-454-0015 Temporary absence from the home.
- 388-454-0020 Temporary absence to attend school or training.
- 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.

**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

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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.]

(2003 Ed.)

**WAC 388-454-0015 Temporary absence from the home.** The child or the caretaker is temporarily absent from the home as long as the caretaker continues to be responsible for the care and control of the child. Temporary absences cannot exceed ninety days except as described below. A caretaker must report a child's absence in excess of ninety days as required under WAC 388-418-0005. Temporary absences include:

(1) Receiving care in a hospital or public or private institution. If the temporary care exceeds ninety days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(2) Receiving care in a substance abuse treatment facility. If the care exceeds ninety days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(3) Visits in which the child or parent will be away for ninety days or less, including visits of a child to a parent who does not reside in the child's home.

(4) Placement of a child in foster care when the child's caretaker is receiving care in a residential treatment facility or for other reasons as determined by the division of children and family services (DCFS). DCFS must determine that the child is expected to return to the home within ninety days of the foster care placement.

(5) Placement of a child in foster care or in the temporary care of a relative, when:

(a) A parent or other relative applies for TANF or SFA on behalf of the child;

(b) DCFS has determined the child will be placed in the care of the applying relative within thirty days following the authorization of assistance; and

(c) No concurrent TANF or SFA payments are made for the child while in the temporary care of a relative.

(6) The child or caretaker is attending school or training as described in WAC 388-454-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-454-0015, filed 7/31/98, effective 9/1/98.]

**WAC 388-454-0020 Temporary absence to attend school or training.** A child or caretaker is temporarily absent from the home to attend school or training when:

(1) The child's caretaker is attending a department approved vocational training program; or

(2) The child attends school or training away from home, as long as:

(a) The child returns to the family home during a year's period, at least for summer vacation; and

(b) The absence is necessary because:

(i) Isolation of the child's home makes it necessary for the child to be away to attend school;

(ii) The child is enrolled in an Indian boarding school administered through the Bureau of Indian Affairs; or

(iii) Specialized education or training is not available in the child's home community and is recommended by local school authorities.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-454-0020, filed 7/31/98, effective 9/1/98.]

[Title 388 WAC—p. 737]

**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 388-455 WAC LUMP SUM INCOME

### WAC

388-455-0005	How lump sum payments affect benefits.
388-455-0010	How the department treats lump sum payments as a resource for cash assistance and TANF/SFA-related medical assistance.
388-455-0015	How the department treats lump sum payments as income for cash assistance and TANF/SFA-related medical assistance.

**WAC 388-455-0005 How lump sum payments affect benefits.** (1) For the purpose of determining benefits for cash assistance, temporary assistance for needy families (TANF)/state family assistance (SFA)-related medical assistance, and food assistance, a lump sum payment is money that the client receives but does not expect to receive on a continuing basis.

(2) For cash assistance and TANF/SFA-related medical assistance:

(a) The department counts payments awarded for wrongful death, personal injury, damage, or loss of property as resources as described in WAC 388-455-0010.

(b) We count all other lump sum payments as income as described in WAC 388-455-0015.

(3) For food assistance, all lump sum payments are counted as resources as described in WAC 388-470-0055.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-24-008, § 388-455-0005, filed 11/19/99, effective 1/1/00.]

**WAC 388-455-0010 How the department treats lump sum payments as a resource for cash assistance and TANF/SFA-related medical assistance.** This section applies to cash assistance and TANF/SFA-related medical assistance.

(1) In the month the payment is received, the department does not count any amount of a lump sum payment awarded for:

- (a) Wrongful death;
- (b) Personal injury;

(c) Damage; or

(d) Loss of property.

(2) In the month following the month of receipt, we count the entire amount as a resource except for the portion of the payment designated for:

- (a) Repair or replacement of damaged or lost property; or
- (b) Medical bills.

(3) We do not count the portion described in subsection (2) of this section for sixty days following the month the payment is received. At the end of the sixty-day period, we count any amount that remains as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-24-008, § 388-455-0010, filed 11/19/99, effective 1/1/00.]

**WAC 388-455-0015 How the department treats lump sum payments as income for cash assistance and TANF/SFA-related medical assistance.** For cash assistance and TANF/SFA-related medical assistance, lump sum payments not awarded for wrongful death, personal injury, damage, or loss of property are counted as income. They are budgeted against the client's benefits according to the effective dates in WAC 388-418-0020. The rules in this section describe what portion is countable and when the department counts it. For rules on how lump sum payments awarded for wrongful death, personal injury, damage, or loss of property affect benefits, see WAC 388-450-0010.

(1) To identify what portion of the lump sum the department will count as income, we take the following steps:

(a) First, we subtract the value of your existing resources from the resource limit as described in WAC 388-470-0005;

(b) Then, we subtract the difference in (1)(a) from the total amount of the lump sum; and

(c) The amount left over is the countable amount of the lump sum.

(2) For cash assistance, the amount of the lump sum that is countable may change if any or all of the lump sum becomes unavailable for reasons beyond your control. See WAC 388-450-0005. When the countable amount of the lump sum is:

(a) Less than your payment standard plus additional requirements, we consider it as income in the month it is received.

(b) More than one month's payment standard plus additional requirements but less than two months:

(i) We consider the portion equal to one month's payment standard plus additional requirements as income in the month it is received; and

(ii) We consider the remainder as income the following month.

(c) Equal to or greater than the total of the payment standard plus additional requirements for the month of receipt and the following month, we consider the payment as income for those months.

(3) If you are ineligible or disqualified from receiving cash benefits and you receive a one-time lump sum payment:

(a) We allocate the payment to meet your needs as specified in WAC 388-450-0105; and

(b) The remainder is treated as a lump sum payment available to the eligible assistance unit members according to the rules of this section.

(4) You can avoid having the lump sum budgeted against your benefits if you request termination of your cash assistance the month before you receive the lump sum.

(5) For TANF/SFA-related medical assistance:

(a) We consider lump sum payments as income in the month of receipt.

(b) We consider any money that remains on the first of the next month as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0015, filed 11/19/99, effective 1/1/00.]

**Chapter 388-458 WAC  
NOTICES TO CLIENTS**

**WAC**

- 388-458-0002 The department of social and health services (DSHS) sends you letters to tell you about your case.
- 388-458-0006 DSHS sends you a letter when you withdraw your application.
- 388-458-0011 DSHS sends you a denial letter when you can't get benefits.
- 388-458-0016 DSHS sends you an approval letter when you can get benefits.
- 388-458-0020 You get a request letter when we need more information.
- 388-458-0025 We send you a change letter if the amount of benefits you are getting is changing.
- 388-458-0030 We send you a termination letter when your benefits stop.
- 388-458-0035 Why do you give me ten days notice before you reduce or stop my benefits?
- 388-458-0040 What happens if I ask for a fair hearing before the change happens?
- 388-458-0045 Will I get other kinds of letters?

**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 388-458-0002 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.

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(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 388-458-0006 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 388-458-0011 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 388-458-0016 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.

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- (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.

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(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;
- (e) We got returned mail from the post office that says you have moved and we do not have a forwarding address; or
- (f) 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, 74.04.057, and 74.04.510. 02-14-086, § 388-458-0030, filed 6/28/02, effective 7/1/02. 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.
- (c) 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) 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.

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(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 388-460 WAC**

**PAYEES ON BENEFIT ISSUANCES**

**WAC**

388-460-0001	Who may be issued cash, child care, medical and food assistance benefits?
388-460-0005	Authorized representative for food assistance benefits.
388-460-0010	Food assistance authorized representative—Treatment centers and group homes.
388-460-0015	Persons who may not be an authorized representative for a food assistance unit.
388-460-0020	Who is a protective payee?
388-460-0025	Who can be a protective payee?
388-460-0030	When is an emergency or temporary protective payee (TANF/SFA) used?
388-460-0035	When is a protective payee assigned for mismanagement of funds?
388-460-0040	When is a protective payee assigned to TANF/SFA pregnant or parenting minors?
388-460-0045	Are clients in WorkFirst sanction status assigned protective payees?
388-460-0050	When is a client transferred from a protective payee to guardianship?
388-460-0055	What are the protective payee's responsibilities?
388-460-0060	When are protective payee plans done?
388-460-0065	When is the protective payee status ended and how is a protective payee changed?
388-460-0070	What are your fair hearing rights regarding protective payment?

**WAC 388-460-0001 Who may be issued cash, child care, medical and food assistance benefits? (1) Cash and**

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child care assistance may be issued in the name of the following persons:

(a) A client who is the recipient of the benefits;

(b) An ineligible parent or other relative getting benefits on behalf of an eligible child;

(c) A person, facility, organization, institution or agency acting as a protective payee or representative payee for a client;

(d) A guardian or agent acting on behalf of a client; or

(e) A vendor of goods or services supplied to an eligible client.

(2) When medical coverage accompanies cash assistance, the medical identification (MAID) card for the assistance unit members is issued in the name of the person listed as payee for the cash benefit.

(3) For other medical assistance units, the MAID card is issued to the person named as the head of the assistance unit.

(4) Food assistance benefits are issued to the person named as the head of the food assistance unit.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0001, filed 6/28/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0001, filed 7/31/98, effective 9/1/98.]

**WAC 388-460-0005 Authorized representative for food assistance benefits.** An authorized representative is an adult who is not a member of the food assistance unit but has the knowledge and consent of the assistance unit to act on their behalf.

(1) A responsible member of the food assistance unit can name, in writing, an authorized representative. An authorized representative has authority to:

(a) Apply for food assistance on behalf of the food assistance unit;

(b) Redeem the food coupon authorization (FCA) card for the unit; and

(c) Purchase food for the food assistance unit using the unit's authorized benefit allotment.

(2) A responsible member of the food assistance unit can name, in writing, an emergency authorized representative to transact a particular FCA card when no responsible member is able to transact the card. Both the responsible member of the food assistance unit and the person named must sign the written statement.

(3) The food assistance unit members are liable for any over-issuance that may result from information supplied to the department by the authorized representative.

(4) An authorized representative may act on behalf of more than one food assistance unit when approved by the CSO administrator.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0005, filed 7/31/98, effective 9/1/98.]

**WAC 388-460-0010 Food assistance authorized representative—Treatment centers and group homes.** (1) Residents in group homes may choose to have food assistance benefits authorized as follows:

(a) On their own behalf;

(b) Through an authorized representative of their choosing; or



(c) Through a facility acting as authorized representative.

(2) Residents in chemical dependency treatment centers are required to have a designated employee of the facility act as an authorized representative.

(3) The authorized representative for residents in a chemical dependency treatment center or a group home must:

(a) Be aware of the resident's circumstances;

(b) Notify the department of any changes in income, resources or circumstances within ten days of the change;

(c) Use the resident's food assistance benefit allotment for meals served to the resident; and

(d) Maintain enough benefits in the facility electronic benefits transfer (EBT) account to allow the department to transfer one-half of a client's monthly allotment to the client's own account. The client is entitled to one-half of the food assistance benefits when the client leaves the facility on or before the fifteenth of the month.

(4) When assigning an employee as the authorized representative for residents, a facility accepts responsibility for:

(a) Any misrepresentation or intentional program violation; and

(b) Liability for food assistance benefits held at the facility on behalf of the resident.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-460-0010, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-460-0015 Persons who may not be an authorized representative for a food assistance unit.** (1) A person acting as an authorized representative for a food assistance unit will be disqualified for one year when that person:

(a) Knowingly provides false information to the department;

(b) Misrepresents the food assistance unit's circumstances; or

(c) Misuses the food assistance benefits.

(2) The authorized representative and the head of the food assistance unit are notified thirty days prior to the disqualification taking effect.

(3) The following persons may act as an authorized representative for a food assistance unit only with written approval of the CSO administrator and only when no one else is available:

(a) An employee of the department;

(b) Any person disqualified from the food assistance program because of an intentional program violation;

(c) A retailer authorized to accept coupons;

(4) A public or private nonprofit organization providing meals for homeless persons may not be an authorized representative under any conditions.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0015, filed 7/31/98, effective 9/1/98.]

**WAC 388-460-0020 Who is a protective payee?** (1) A protective payee is a person or an employee of an agency who manages client cash benefits to provide for basic needs -

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housing, utilities, clothing, child care, and food. They may also provide services such as training clients how to manage money.

(2) Clients are assigned to protective payees for the following reasons:

(a) Emergency or temporary situations where a child is left without a caretaker (TANF/SFA) per WAC 388-460-0030;

(b) Mismanagement of money (TANF/SFA, GA, or WCCC) per WAC 388-460-0035;

(c) Noncooperation with WorkFirst program requirements per WAC 388-310-1600 or 388-310-1650; or

(d) Pregnant or parenting minors per WAC 388-460-0040.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0020, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0025 Who can be a protective payee?**

(1) Clients may ask for a particular protective payee, but the department makes the final choice.

(2) Protective payees must contract with the department, except for employees of the department who are assigned this function as part of their job duties.

(3) The contracted protective payee and their staff must pass a criminal background check according to the criteria in WAC 388-06-0170, 388-06-0180 and 388-06-0190.

(4) A departmental employee acting as a protective payee must pass a criminal background check and cannot:

(a) Have the client in their caseload,

(b) Have the client in the caseloads of other employees under their supervision,

(c) Be responsible for determining or issuing benefits for the client,

(d) Be the office administrator, or

(e) Be a special investigator.

(5) For TANF/SFA, a department employee cannot act as a protective payee when the department has legal custody or responsibility for placement and care of the child.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0025, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0030 When is an emergency or temporary protective payee (TANF/SFA) used?** An emergency or temporary protective payee is assigned when a caretaker relative or adult acting in loco parentis per WAC 388-454-0005 is not available to take care of and supervise a child due to an emergency.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0030, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0035 When is a protective payee assigned for mismanagement of funds?** (1) The decision to assign a person to a protective payee because of mismanagement of funds must be based on law or with proof the client is unable to manage their cash benefits. The proof must be current and show how this threatens the well being of a child or client on TANF/SFA, GA or WCCC. Examples of proof are:

(2003 Ed.)

(a) Department employees or others observe that the client or client's children are hungry, ill, or not adequately clothed;

(b) Repeated requests from the client for extra money for basic essentials such as food, utilities, clothing, and housing;

(c) A series of evictions or utility shut off notices within the last twelve months;

(d) Medical or psychological evaluations showing an inability to handle money;

(e) Persons having had an ADATSA assessment and who are participating in ADATSA-funded chemical dependency treatment;

(f) Not paying an in home child care provider for services when payment has been issued to the client by the department for that purpose;

(g) A complaint from businesses showing a pattern of failure to pay bills or rent;

(h) Using public assistance electronic benefits transfer (EBT) card or cash obtained through EBT to purchase or pay for lottery tickets, pari-mutuel wagering, or any of the activities authorized under chapter 9.46 RCW.

(2) A lack of money or a temporary shortage of money because of an emergency does not constitute mismanagement.

(3) When a client has a history of mismanaging money, benefits can be paid through a protective payee or directly to a vendor.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0035, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0040 When is a protective payee assigned to TANF/SFA pregnant or parenting minors?** Pregnant or parenting minors who are not emancipated under court order must be assigned to protective payees if the clients are:

- (1) Head of a household;
- (2) Under age eighteen;
- (3) Unmarried; and
- (4) Pregnant or have a dependent child.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0040, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0045 Are clients in WorkFirst sanction status assigned protective payees?** (1) Clients in sanction status for noncooperation or nonparticipation in WorkFirst work activities are assigned to protective payees following the rules in WAC 388-310-1600 and 388-310-1650.

(2) Clients in sanction status remain in protective payee status until they cooperate with WorkFirst and the sanction is removed, as long as they are receiving assistance.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0045, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0050 When is a client transferred from a protective payee to guardianship?** (1) In emergency cases where a person is physically or mentally unable to manage their own funds, the client is referred to other divisions of the department for full care, including guardianship.

(2003 Ed.)

(2) In cases where a child is eligible for TANF/SFA and the caretaker relative does not use the benefits for adequate care of the child, the case can be referred to the attorney general to establish a limited guardianship.

(3) Guardianships are used only if it appears there is a need for services that are expected to last longer than two years.

(4) These guardianships are limited to management of DSHS benefits.

(5) The protective payee plan is changed if a guardian is appointed. The guardian is designated as the payee.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0050, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0055 What are the protective payee's responsibilities?** The protective payee's responsibilities are to:

(1) Manage client cash and child care assistance benefits to pay bills for basic needs, such as housing and utilities, or as directed in the protective payee plans;

(2) Provide money management for client if this item is included in the protective payee plans;

(3) Encourage clients to comply with WorkFirst and other program requirements, such as getting a job or attending school; and

(4) Provide reports to the department on client progress.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0055, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0060 When are protective payee plans done?** A protective payee plan may be developed when a case is assigned to a protective payee.

(1) A copy of the plan is provided to the protective payee and the client.

(2) All cases must be reviewed:

(a) After an initial three-month period; and

(b) At least every six months beyond the initial period for on going cases.

(3) Reviews include evaluation of:

(a) The need for the client to continue in protective payee status; or

(b) The need to change the plan; or

(c) The client's potential to assume control of their funds (or be removed from protective payee status); and

(d) Protective payee performance.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0060, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0065 When is the protective payee status ended and how is a protective payee changed?** A client may be removed from a protective payee status when a:

(1) Protective payee requests the client be reassigned;

(2) The department assigns a different protective payee; or

(3) Protective payee is no longer required.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0065, filed 6/28/02, effective 7/1/02.]

**WAC 388-460-0070 What are your fair hearing rights regarding protective payment?** You have the right for a fair hearing if you disagree with the department's decision to:

- (1) Assign payment of benefits through a protective payee,
- (2) Continue the assignment,
- (3) Change the protective payee selected for you, or
- (4) Change the contents of your protective payee plan.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-14-083, § 388-460-0070, filed 6/28/02, effective 7/1/02.]

## Chapter 388-462 WAC

### PREGNANCY

#### WAC

388-462-0010	Temporary assistance for needy families (TANF) or state family assistance (SFA) eligibility for pregnant women.
388-462-0011	Post adoption cash benefit.
388-462-0015	Medical programs for pregnant women.
388-462-0020	Breast and cervical cancer treatment program (BCCTP) for women—Client eligibility.

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

388-462-0005	Pregnancy requirement for GA-S. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-045, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
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**WAC 388-462-0010 Temporary assistance for needy families (TANF) or state family assistance (SFA) eligibility for pregnant women.** (1) If you are already receiving TANF or SFA benefits, your pregnancy will not change your eligibility or benefit level.

(2) If you are not currently receiving TANF or SFA benefits, you may be eligible for these benefits if your pregnancy and expected date of delivery has been verified by a licensed medical practitioner.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0010, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-462-0011 Post adoption cash benefit.** (1) Under RCW 74.04.005 (6)(g) recipients of TANF or SFA who lose their eligibility solely because of the birth and relinquishment of the qualifying child may receive general assistance through the end of the month in which the period of six weeks following the birth of the child falls.

(2) The department will consider income and resources when determining eligibility and benefit amount for post adoption cash benefit in the same manner as TANF. Refer to chapters 388-450, 388-470, and 388-488 WAC.

(3) To receive the post adoption cash benefit, a client must have been receiving TANF or SFA in Washington state.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0011, filed 6/30/99, effective 8/1/99.]

**WAC 388-462-0015 Medical programs for pregnant women.** (1) A pregnant woman is eligible for medical services described in this chapter only when her pregnancy is confirmed by a licensed medical practitioner, licensed laboratory, community clinic, family planning clinic, or health department clinic.

(2) A pregnant woman is eligible for CN Medicaid coverage if she meets the following requirements as described in WAC 388-503-0505:

(a) Citizenship or immigration status (chapter 388-424 WAC); and

(b) Social security account number (chapter 388-474 WAC); and

(c) Washington state residence (chapter 388-468 WAC); and

(d) Countable income meets the standard described in WAC 388-478-0075.

(3) A pregnant woman is considered for medically needy (MN) program coverage if she meets the requirements in subsection (2)(a) through (c) of this section and:

(a) Her countable income is greater than the standard in subsection (2)(d) of this section; and

(b) Her countable resources do not exceed the standard in WAC 388-478-0070.

(4) A pregnant woman is eligible for CN scope of care under the state-funded pregnant woman program if she is not eligible for programs in subsection (2) of this section due to citizenship, immigrant or social security number requirements.

(5) A pregnant woman is considered for MN scope of care under the state-funded pregnant woman program if:

(a) She is not eligible for the program under subsection (4) of this section because her income exceeds the standard; and

(b) Her resources do not exceed the standard in WAC 388-478-0070.

(6) A pregnant woman is considered for the medically indigent (MI) program if her resources exceed the standards in WAC 388-478-0070.

(7) Only the income of an unmarried father of an unborn child that is actually contributed to a pregnant woman is considered as income to her.

(8) There are no resource limits for the programs described in subsections (2) and (4) of this section.

(9) The assignment of child support and medical support rights as described in chapter 388-422 WAC do not apply to pregnant women.

(10) Unless stated otherwise, this section contains the only eligibility requirements for pregnant women to qualify for medical coverage.

(11) A woman who was eligible for and received medical coverage on the last day of pregnancy is eligible for extended medical benefits for postpartum care through the end of the month:

(a) Which includes the sixtieth day from the end of the pregnancy, for a pregnant woman receiving medical in any program except medically indigent (MI); or

(b) The pregnancy ends, for a pregnant woman receiving MI benefits.

(12) A woman who was eligible for a medical program on the last day of pregnancy is eligible for family planning services for twelve months from the end of the pregnancy.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-462-0015, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0820, 388-508-0830, 388-522-2230 and 388-508-0835.]

**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 388-464 WAC  
QUALITY ASSURANCE**

**WAC**

388-464-0001 Requirement to cooperate with quality assurance.

**WAC 388-464-0001 Requirement to cooperate with quality assurance.** (1) To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or federal food stamp benefits, the following clients are required to cooperate in the quality assurance review process:

(a) All adult recipients or payees in a TANF or SFA assistance unit; or

(b) All household members in a food assistance unit.

(2) Assistance units become ineligible for benefits upon a determination of noncooperation by quality assurance and remain ineligible until the client meets quality assurance requirements or:

(2003 Ed.)

(a) For TANF/SFA clients, one hundred twenty days from the end of the annual quality assurance review period; or

(b) For food assistance household members, ninety-five days from the end of the annual quality assurance review period.

(3) The quality assurance review period covers the federal fiscal year which runs from October 1st of one calendar year through September 30th of the following year.

(4) Individuals reapplying for TANF, SFA, or federal food stamps after the sanction period has ended must provide verification of all eligibility requirements. However, individuals meeting expedited service criteria only need to provide expedited service verification requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-464-0001, filed 7/31/98, effective 9/1/98.]

**Chapter 388-466 WAC  
REFUGEE PROGRAM**

**WAC**

388-466-0005 Immigration status requirement for refugee assistance.  
388-466-0120 Refugee cash assistance (RCA).  
388-466-0130 Refugee medical assistance (RMA).  
388-466-0140 Income and resources for refugee assistance eligibility.  
388-466-0150 Refugee employment and training services.

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

388-466-0010 Treatment of income and resources for refugee assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0010, filed 7/31/98, effective 9/1/98.] Repealed by 02-04-057, filed 1/30/02, effective 2/1/02. Statutory Authority: RCW 74.08.090, 74.08A.320.

388-466-0015 Work and training requirements for refugee cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0015, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.

388-466-0020 Exemptions to work and training requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0020, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.

388-466-0025 Penalties for not complying with work and training requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0025, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.

**WAC 388-466-0005 Immigration status requirement for refugee assistance.** (1) To be eligible for refugee cash assistance (RCA) and refugee medical assistance (RMA), a person must prove, by providing documentation issued by the Immigration and Naturalization Service (INS), that he or she was:

(a) Admitted as a refugee under section 207 of the Immigration and Nationalities Act (INA);

(b) Paroled into the U.S. as a refugee or asylee under section 212 (d)(5) of the INA;

(c) Granted conditional entry under section 203 (a)(7) of the INA;

(d) Granted asylum under section 208 of the INA;

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(e) Admitted as an Amerasian Immigrant from Vietnam through the orderly departure program, under section 584 of the Foreign Operations Appropriations Act, incorporated in the FY88 Continuing Resolution P.L. 100-212;

(f) A Cuban-Haitian entrant who was admitted as a public interest parolee under section 212 (d)(5) of the INA.

(2) A permanent resident alien meets the immigration status requirements for RCA and RMA if the individual was previously in one of the statuses described in subsections (1)(a) through (f) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0005, filed 7/31/98, effective 9/1/98.]

### **WAC 388-466-0120 Refugee cash assistance (RCA).**

#### **(1) Who can apply for refugee cash assistance (RCA)?**

Any individual can apply to the department of social and health services (DSHS) for refugee cash assistance and have their eligibility determined within thirty days.

#### **(2) How do I know if I qualify for RCA?**

You may be eligible for RCA if you meet all of the following conditions:

(a) You have resided in the United States for less than eight months;

(b) You meet the immigration status requirements of WAC 388-466-0005;

(c) You meet the income and resource requirements under chapters 388-450 and 388-470 WAC;

(d) You meet the work and training requirements of WAC 388-466-0150; and

(e) You provide the name of the voluntary agency (VOLAG) which helped bring you to this country.

#### **(3) What are the other reasons for not being eligible for RCA?**

Even if you meet the eligibility requirements named in subsection (2) above you may be not eligible if you:

(a) Are eligible for temporary assistance for needy families (TANF) or Supplemental Security Income (SSI); or

(b) Have been denied TANF due to your refusal to meet TANF eligibility requirements; or

(c) Are employable and have voluntarily quit or refused to accept a bona fide offer of employment within thirty consecutive days immediately prior to your application for RCA; or

(d) Are a full-time student in a college or university.

#### **(4) If I am an asylee, what date will be used as an entry date?**

If you are an asylee, your entry date will be the date that your asylum status is granted. For example: You entered the United States on December 1, 1999 as a tourist, then applied for asylum on April 1, 2000, interviewed with the asylum office on July 1, 2000 and were granted asylum on September 1, 2000. Your entry date is September 1, 2000. On September 1, 2000, you may be eligible for refugee cash assistance.

#### **(5) If I am a victim of human trafficking, can I be eligible for RCA?**

(a) If you are an adult victim you are eligible for RCA to the same extent as a refugee, if you provide the original certification letter from the U.S. Department of Health and Human Services (DHHS) and meet eligibility requirements

in subsection (2)(c) and (d) of this section. You do not have to provide any other documentation of your immigration status. Your entry date will be the date on your certification letter.

(b) If you are a child victim under eighteen years old you are eligible for benefits to the same extent as a refugees and do not need to be certified. DHHS issues a special letter for children. Children also have to meet income eligibility requirement.

#### **(6) Does getting a onetime cash grant from a voluntary agency (VOLAG) affect my eligibility for RCA?**

No. In determining your eligibility for RCA DSHS does not count a onetime resettlement cash grant provided to you by your VOLAG.

#### **(7) What is the effective date of my eligibility for RCA?**

The date DSHS has sufficient information to make eligibility decision is the date your RCA begins.

#### **(8) When does my RCA end?**

(a) Your RCA ends on the last day of the eighth month starting from the month of your arrival to the United States. Count the eight months from the first day of the month of your entry into the United States. For example, if you entered the United States on May 28, 2000, May is your first month and December 2000 is your last month of RCA.

(b) If you get a job, your income will affect your RCA based on the TANF rules (chapter 388-450 WAC). If you earn more than is allowed by WAC 388-478-0035, you are no longer eligible for RCA. Your medical coverage may continue for up to eight months from your month of arrival in the United States (WAC 388-466-0130).

#### **(9) Are there other reasons why RCA may end?**

Your RCA also ends if:

(a) You move out of Washington state;

(b) Your unearned income and/or resources go over the maximum limit (WAC 388-466-0140); or

(c) You, without good cause, refuse to meet refugee employment and training requirements (WAC 388-466-0150).

#### **(10) Will my spouse be eligible for RCA, if he/she arrives in the U.S. after me?**

When your spouse arrives in the United States, DSHS determines his/her eligibility for RCA and/or other income assistance programs. Your spouse may be eligible for up to eight months of RCA based on his/her date of arrival into the United States. If you live together you and your spouse are part of the same assistance unit and your spouse's eligibility for RCA is determined based on your and your spouse's combined income and resources (WAC 388-466-0140).

#### **(11) Can I get additional money in an emergency?**

If you have an emergency and need a cash payment to get or keep your housing or utilities, you may apply for the DSHS program called additional requirements for emergent needs (AREN). To receive AREN, you must meet the requirements in WAC 388-436-0002.

#### **(12) What can I do if I disagree with a decision or action that has been taken by DSHS on my case?**

If you disagree with a decision or action taken on your case by the department, you have the right to request a review

of your case or a fair hearing (WAC 388-02-0090). Your request must be made within ninety days of the decision or action.

[Statutory Authority: RCW 74.08.090, 74.08A.320. 02-04-057, § 388-466-0120, filed 1/30/02, effective 2/1/02.]

**WAC 388-466-0130 Refugee medical assistance (RMA). (1) Who can apply for refugee medical assistance?**

Any individual can apply for refugee medical assistance (RMA) and have eligibility determined by the department of social and health services (DSHS).

**(2) Who is eligible for refugee medical assistance?**

(a) You are eligible for RMA if you meet all of the following conditions:

(i) Immigration status requirements of WAC 388-466-0005;

(ii) Income and resource requirements of WAC 388-466-0010;

(iii) Monthly income standards up to two hundred percent of the federal poverty level (FPL). Spenddown is available for applicants whose income exceeds two hundred percent of FPL (see WAC 388-519-0110); and

(iv) Provide the name of the voluntary agency (VOLAG) which helped bring you to this country, so that DSHS can promptly notify the agency (or sponsor) about your application for RMA.

(b) You are eligible for RMA if you meet one of the following conditions:

(i) Receive refugee cash assistance (RCA) and are not eligible for Medicaid or children's health insurance program (CHIP); or

(ii) Choose not to apply for or receive RCA and are not eligible for Medicaid or CHIP, but still meet RMA eligibility requirements.

**(3) Who is not eligible for refugee medical assistance?**

You are not eligible to receive RMA if you are:

(a) Already eligible for Medicaid or CHIP;

(b) A full-time student in an institution of higher education unless the educational activity is part of a department-approved individual responsibility plan (IRP);

(c) A nonrefugee spouse of a refugee.

**(4) If I have already received a cash assistance grant from voluntary agency (VOLAG), will it affect my eligibility for RMA?**

No. A cash assistance payment provided to you by your VOLAG is not counted in determining eligibility for RMA.

**(5) If I get a job after I have applied but before I have been approved for RMA, will my new income be counted in determining my eligibility?**

No. Your RMA eligibility is determined on the basis of your income and resources on the date of the application.

**(6) Will my sponsor's income and resources be considered in determining my eligibility for RMA?**

Your sponsor's income and resources are not considered in determining your eligibility for RMA unless your sponsor is a member of your assistance unit.

**(7) How do I find out if I am eligible for RMA?**

DSHS will send you a letter in both English and your primary language informing you about your eligibility. DSHS will also let you know in writing every time there are any changes or actions taken on your case.

**(8) Will RMA cover my medical expenses that occurred after I arrived in the U.S. but before I applied for RMA?**

You may be eligible for RMA coverage of your medical expenses for three months prior to the first day of the month of your application. Eligibility determination will be made according to Medicaid rules.

**(9) If I am an asylee, what date will be used as an entry date?**

If you are an asylee, your entry date will be the date that your asylum status is granted. For example, if you entered the United States on December 1, 1999 as a tourist, then applied for asylum on April 1, 2000, interviewed with the asylum office on July 1, 2000 and granted asylum on September 1, 2000, your date of entry is September 1, 2000. On September 1, 2000 you may be eligible for refugee medical assistance.

**(10) When does my RMA end?**

Your refugee medical assistance will end on the last day of the eighth month from the month of your entry into the United States. Start counting the eight months from the first day of the month of your entry into the U.S. For example, if you entered the U.S. on May 28, 2000, your last month is December 2000.

**(11) What happens if my earned income goes above the income standards?**

(a) If you are getting RMA, your medical eligibility will not be effected by the amount of your earnings;

(b) If you were getting Medicaid and it was terminated because of your earnings, we will transfer you to RMA for the rest of your RMA eligibility period. You will not need to apply.

**(12) Will my spouse also be eligible for RMA, if he/she arrives into the U.S. after me?**

When your spouse arrives in the U.S., we will determine his/her eligibility for Medicaid and other medical programs. Your spouse may be eligible for RMA; if so, he/she would have a maximum of eight months of RMA starting on the first day of the month of his/her arrival.

**(13) What do I do if I disagree with a decision or action that has been taken by DSHS on my case?**

If you disagree with the decision or action taken on your case by department you have the right to request a review of your case or request a fair hearing (see WAC 388-02-0090). Your request must be made within ninety days of the decision or action).

**(14) What happens to my medical coverage after my eligibility period is over?**

We will determine your eligibility for other medical programs. You may have to complete an application for another program.

[Statutory Authority: RCW 74.08.090, 74.08A.320. 00-21-065, § 388-466-0130, filed 10/16/00, effective 11/1/00.]

**WAC 388-466-0140 Income and resources for refugee assistance eligibility. (1) How does DSHS count my**



**income and resources when determining my eligibility for refugee cash assistance?**

We determine your eligibility for RCA using the TANF rules about income and resources in chapters 388-450 and 388-470 WAC, except we do not count a onetime resettlement cash payment provided to you by your voluntary agency (VOLAG).

**(2) How does DSHS count my income and resources when determining my eligibility for refugee medical assistance?**

We determine your eligibility for RMA using the TANF rules about income and resources in chapters 388-450 and 388-470 WAC, except as it stated below:

(a) Your monthly income can be up to two hundred percent of the Federal Poverty Level (FPL);

(b) A onetime resettlement cash payment provided to you by your VOLAG is not counted in determining your eligibility for RMA;

(c) Your RMA eligibility is determined on the basis of your income and resources on the date of your application (WAC 388-466-0130).

[Statutory Authority: RCW 74.08.090, 74.08A.320, 02-04-057, § 388-466-0140, filed 1/30/02, effective 2/1/02.]

**WAC 388-466-0150 Refugee employment and training services. (1) What are refugee employment and training services?**

Refugee employment and training services provided to eligible refugees may include information and referral, employment oriented case management, job development, job placement, job retention, wage progression, skills training, on-the-job training, counseling and orientation, English as a second language, and vocational English training.

**(2) Am I required to participate in refugee employment and training services?**

If you are receiving refugee cash assistance (RCA) you are required to participate in refugee employment and training services, unless you are exempt.

**(3) How do I know if I am exempt from mandatory employment and training requirements?**

(a) You may be exempt from participation in employment and training requirements if:

(i) You are needed in the home to personally provide care for your child under three months of age (see WAC 388-310-0300);

(ii) You are sixty years of age or older.

(b) You can not be exempt from work and training requirements solely because of an inability to communicate in English.

**(4) If I am required to participate, what do I have to do?**

You are required to:

(a) Register with your employment service provider;

(b) Accept and participate in all employment opportunities, training or referrals, determined appropriate by the department.

**(5) What happens if I do not follow these requirements?**

If you refuse without good reason to cooperate with the requirements, you are subject to the following penalties:

(a) If you are applying for refugee cash and medical assistance, you will be ineligible for thirty days from the date of your refusal to accept work or training opportunity; or

(b) If you are already receiving refugee cash and medical assistance, your cash benefits will be subject to financial penalties.

(c) The department will notify your voluntary agency (VOLAG) if financial penalties take place.

**(6) What are the penalties to my grant?**

The penalties to your grant are:

(a) If the assistance unit includes other individuals as well as yourself, the cash grant is reduced by the sanctioned refugee's amount for three months after the first occurrence. For the second occurrence the financial penalty continues for the remainder of the sanctioned refugee's eight-month eligibility period.

(b) If you are the only person in the assistance unit your cash grant is terminated for three months after the first occurrence. For the second occurrence, your grant is terminated for the remainder of your eight-month eligibility period.

**(7) How can I avoid the penalties?**

You can avoid the penalties, if you accept employment or training before the last day of the month in which your cash grant is closed.

**(8) What is considered a good reason for not being able to follow the requirements?**

You have a good reason for not following the requirements if it was not possible for you to stay on the job or to follow through on a required activity due to an event outside of your control. See WAC 388-310-1600(3) for examples.

[Statutory Authority: RCW 74.08.090, 00-22-085, § 388-466-0150, filed 10/31/00, effective 12/1/00.]

**Chapter 388-468 WAC  
RESIDENCY****WAC**

388-468-0005 Residency.

**WAC 388-468-0005 Residency.** (1) A resident is an individual who:

(a) Currently lives in Washington and intends to continue living here; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) With the exception of subsection (4) of this section, a client can temporarily be out of the state for more than one month. If so, they must supply the department with adequate information to demonstrate their intent to continue to reside in the state of Washington.

(4) Noncategorically eligible food assistance households remaining out of the state more than one calendar month lose their state residence status.

(5) Residency is not a requirement for the following:

(a) The medically indigent (MI) program; or

(b) Detoxification services.

(6) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency, prior to entering the facility.

(7) A person who enters Washington state temporarily just to get medical care does not meet the definition of a resident and is not eligible for those services.

(8) For purposes of medical programs a client's residence is the state:

(a) Making a state Supplemental Security Income (SSI) payment; or

(b) Making federal payments for foster or adoption assistance under Title IV-E of the Social Security Act; or

(c) Of residence of the parent or legal guardian, if appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(d) Where a client is residing if the person becomes incapable before reaching twenty-one years of age; or

(e) Making a placement in an out-of-state institution.

(9) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

(10) A former resident of the state can apply for the GA-U program while living in another state if:

(a) The person:

(i) Plans to return to this state; and

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in subsection (10)(i), (ii), and (iii) being met, the absence must be the result of one of the following:

(i) Is enforced and beyond the person's control; or

(ii) Is essential to the person's welfare and is due to physical or social needs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-468-0005, filed 7/31/98, effective 9/1/98.]

## Chapter 388-470 WAC RESOURCES

### WAC

388-470-0005	Resource eligibility and limits.
388-470-0010	How to determine who owns a resource.
388-470-0012	How do the resources of an ineligible or disqualified person effect eligibility for cash assistance?
388-470-0015	Availability of resources.
388-470-0020	Excluded resources.
388-470-0025	Excluded resources for cash assistance.
388-470-0026	Excluded resources for family medical programs.
388-470-0030	Excluding a home as a resource.
388-470-0035	Excluded resources for food assistance.
388-470-0040	Additional excluded resources for SSI-related medical assistance.
388-470-0045	Resources that are counted toward the resource limits for cash, food assistance and TANF/SFA-related medical programs.
388-470-0050	Resources that count.
388-470-0055	Resources that are counted for food assistance.
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?
388-470-0065	Individual development accounts for TANF recipients.

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388-470-0070 How vehicles are counted toward the resource limit for cash assistance and family medical programs.

388-470-0075 How is my vehicle counted for the Washington basic food program?

### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-470-0080 Compensatory award or related settlement lump sum payments. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0080, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

### WAC 388-470-0005 Resource eligibility and limits.

(1) A resource is personal property or real property or certain types of payments that are not considered income that is owned by and available to a client.

(2) A client may own and keep excluded resources or countable resources up to the resource limit.

(3) For SSI-related medical a resource is considered available when the client or spouse:

(a) Owns the resource; and

(b) Has the authority to convert the resource to cash; and

(c) Is not legally restricted from using the resource for the person's support and maintenance.

(4) For an SSI-related client a resource is available on the first day of the month following receipt of the resource.

(5) Available resources may be:

(a) Excluded which means it is not counted toward the resource limit;

(b) Partially excluded:

(i) The resource is not counted up to a specified dollar amount; but

(ii) Any amount over that amount is counted toward the resource limit; or

(c) Countable which means the entire value is counted toward the resource limit.

(6) For medical programs, if the household consists of more than one medical assistance unit (MAU), the resources for each MAU are considered according to the related program.

(7) An assistance unit's resources are determined by:

(a) Disregarding all excluded resources;

(b) Adding the value of:

(i) Resources that are in excess of the excluded dollar amounts; and

(ii) Resources that are countable; and

(c) Comparing the total countable resources to the applicable resource limit for the assistance unit;

(d) If the total resources exceed the applicable resource limit, the assistance unit's benefits are denied or terminated except for institutional medical programs as described in WAC 388-513-1395.

(8) The value of a resource is the equity value. The equity value is the amount a person could receive for the resource (fair market value) minus the legal amount still owing. Limits for countable resources are:

(a) For cash assistance and TANF-related medical, an eligible assistance unit's countable resources must be at or below one thousand dollars;

(b) For food assistance, an eligible assistance unit's countable resources must be at or below:

- (i) Three thousand dollars for any household with an elderly member; or
- (ii) Two thousand dollars for all other households.

(9) For food assistance, assistance units in which all members are receiving cash assistance or SSI do not have to meet the resource limits in subsection (8)(b) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0005, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0010 How to determine who owns a resource.** Unless specifically stated, this section applies to all cash, TANF-related medical and food assistance programs.

(1) A client owns a resource when the client holds the title to real or personal property or has possession of the property but there is no title.

(2) A client may provide evidence to clarify ownership when doubt exists about:

- (a) Ownership (full or partial);
- (b) Legal control; or
- (c) Value.

(3) Community property is an available resource unless the client can provide proof to the contrary.

(4) Real or personal property is considered to be community property when it is in the name of either the husband or wife or both and can be disposed of by either of them.

(5) For cash assistance, community property owned by the husband or wife or both will be used to determine eligibility for the assistance unit, regardless that one or both are clients.

(6) Resources are considered separate property rather than community property when the property was:

- (a) Acquired and paid for by either spouse before marriage;
- (b) Acquired and paid for entirely out of income from separate property; or
- (c) Received by one of the spouses as a gift or inheritance.

(7) Property is no longer considered separate when both community and separate properties are used to purchase or improve real or personal property.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0012 How do the resources of an ineligible or disqualified person effect eligibility for cash assistance?** (1) As used in this section; ineligible, disqualified and financially responsible persons are defined in WAC 388-450-0100.

(2) When determining the cash eligibility of an assistance unit, the department includes the countable resources of a financially responsible person who lives in the home even when the person is ineligible or disqualified from receiving cash assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-09-053, § 388-470-0012, filed 4/19/99, effective 5/20/99.]

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**WAC 388-470-0015 Availability of resources.** (1) A resource is considered available when a cash, TANF/SFA-related medical or food assistance program client has:

- (a) Actual title;
- (b) Control over and can legally dispose of it; and
- (c) The ability to transfer it to a buyer or convert it into cash.

(2) Only resources that are actually available will affect eligibility. However, for cash assistance only, the client must take reasonable action to make the resource available.

(3) A client may provide evidence that a resource is unavailable.

(4) For medical programs a resource is considered unavailable when the client or spouse:

- (a) Does not own the resource;
- (b) Does not have the authority to convert the resource to cash;
- (c) Is legally restricted from using the resources for the person's support and maintenance;
- (d) Cannot convert the resource to cash within twenty work days; and
- (e) Makes a reasonable effort to convert noncash resources to cash.

(5) Resources of persons residing in a shelter for battered women and children are not considered available when:

- (a) The resource is owned jointly with members of the former household; and
- (b) Availability of the resource depends on an agreement of the joint owner.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-507-0730.]

**WAC 388-470-0020 Excluded resources.** Resources that do not count toward a cash, medical or food assistance client's resource limit are:

- (1) Burial plot:
  - (a) For cash assistance and TANF/SFA-related medical programs other than SSI-related, one burial plot for each assistance unit member is excluded.
  - (b) For food assistance, one burial plot for each assistance unit member including ineligible members is excluded.
  - (c) For SSI-related medical the limits are described in WAC 388-470-0040 (14) and (15).

- (2) Energy assistance payments;
- (3) Household goods such as furniture;
- (4) Noncash resources are excluded for categorically needy (CN) and medically needy (MN) medical programs when the client:

- (a) Cannot convert the noncash resource to cash within twenty work days; and
- (b) Makes an ongoing attempt to convert the noncash resources to cash.

(5) Personal items such as clothing is excluded. For cash assistance programs, personal property of "great sentimental value" can be excluded due to personal attachment or hobby interest, without consideration to its value;

(6) The value of a sales contract is excluded for TANF-related medical. Sales contracts for SSI-related medical are described in WAC 388-470-0040;

(7) Resources excluded by federal law;

(8) Trust accounts when not available to the assistance unit except as specified in WAC 388-470-0015(2).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580.]

**WAC 388-470-0025 Excluded resources for cash assistance.** The following resources do not count toward the resource limits for cash assistance:

(1) Adoption support payments when the adopted child is excluded from the assistance unit.

(2) Bona fide loans which means the loan is a debt a client owes and has an obligation to repay.

(3) Earned income tax credit and advanced earned income tax credit in the month received and the following month.

(4) Excess real property on which a client is not living:

(a) When, for a period not to exceed nine months, a client:

(i) Makes a good-faith effort to sell the excess property; and

(ii) Signs an agreement to repay the amount of benefits received or the net proceeds of the sale, whichever is less.

(b) Upon cash assistance approval, the agreement to repay is sent to office of financial recovery to file a lien without a specified amount; or

(c) Is used in a self-employment enterprise and meets the criteria in subsection (10) of this section.

(5) Food coupon allotment from the food assistance programs.

(6) Food service payments provided for children under the National School Lunch Act of 1966, PL 92-433 and 93-150.

(7) Foster care payments provided under Title IV-E and/or state foster care maintenance payments.

(8) Housing and Urban Development (HUD) community development block grant funds.

(9) Income tax refunds are excluded in the month the refund is received.

(10) A bank account jointly owned with an SSI recipient when SSA counted the funds to determine the SSI recipient's eligibility.

(11) Real and personal property used in a self-employment enterprise if:

(a) The property is necessary to restore the client's independence or will aid in rehabilitating the client or the client's dependents; and

(b) The client has an approved self-employment plan; and

(c) For WorkFirst participants, the self-employment enterprise is a component of the participant's approved individual responsibility plan (IRP).

(12) Retroactive cash benefits or TANF benefits resulting from a court order modifying a department policy.

(13) Self-employment-accounts receivable that a client bills to the client's customer but has been unable to collect.

(14) SSI recipient's income and resources.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0025, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW

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74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0025, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0026 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, a family medical program includes the medical extension benefits as described in WAC 388-523-0100.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-470-0026, filed 8/12/02, effective 9/12/02. 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 388-470-0030 Excluding a home as a resource.**

(1) For cash and TANF-related medical assistance programs a home with a reasonable amount of surrounding property is excluded when the home is owned and used as a resident by the client or the client's dependents.

(2) If a client and his or her dependents are absent from the home for more than ninety consecutive days, the total value of the home will count toward the resource limit, unless the absence is due to:

(a) Hospitalization; or

(b) Other health reasons; or

(c) A natural disaster.

(3) If the absence is due to hospitalization or other health reasons the client may be absent for more than ninety days and continue to have the home excluded as a resource when:

(a) At least one of three physicians provides a written statement that in their medical opinion, the client can return to the home during the client's lifetime; or

(b) The home continues to be occupied by a spouse or dependent children or children with disabilities.

(4) If the absence is due to a natural disaster the client may be absent for more than ninety days and continue to have the home excluded as a resource when:

(a) The home is not fit to live in; and

(b) The home will become fit to live in with reasonable effort and expense to the client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-470-0030, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0035 Excluded resources for food assistance.** The following resources do not count toward a client's resource limit.

(1) Earned income tax credit is excluded:

(a) In the month it is received and the following month if the person was not a food assistance recipient when the credit was received; or

(b) For twelve months when the person:

(i) Was a food assistance recipient when the credit was received; and

(ii) Remains a food assistance recipient continuously during this period.

(2) Essential property needed for employment or self-employment of a household member is excluded. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(3) Excluded funds that are deposited in a bank account with countable funds continue to be excluded up to six months from the date of deposit.

(4) Governmental disaster payments to repair a damaged home when the household can be sanctioned if the funds are not used for this purpose.

(5) A home a client is living in including the surrounding property that is not separated by property owned by others is excluded. Public right of ways do not affect this exclusion;

(6) A home that the household is not living in and surrounding property is excluded if the household:

(a) Is making a good faith effort to sell; or

(b) Is planning to return to the home and it is not occupied due to:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Unlivable conditions caused by a natural disaster or casualty.

(7) Any other property is excluded if the household:

(a) Has offered the property for sale through a professional real estate broker; and

(b) Has not declined an offer equivalent to fair market value.

(8) Indian lands that are held jointly by the tribe or can be sold only with the approval from the Bureau of Indian Affairs (BIA) are excluded;

(9) Installment contracts:

(a) Installment contracts or agreements for the sale of land or property are excluded when they are producing income consistent with their fair market value;

(b) Value of property sold under an installment contract or held for security is excluded if the purchase price is consistent with fair market value.

(10) Insurance policies and pension funds:

(a) Cash value of life insurance policies and pension funds, except IRAs and Keogh Plans, are excluded.

(b) Prepaid burial plans are excluded when the plan:

(i) Is death insurance as opposed to a bank account; and

(ii) Requires repayment for allowable withdrawals.

(11) Land. Where a client plans to build a permanent home or is excluded where their property is not separated by land owned by others. The land is countable if the assistance unit owns another home.

(12) A resource is excluded when it is owned by an assistance unit member who receives TANF/SFA or SSI.

(13) Resources that are owned by persons who are not members of the household are excluded.

(14) A resource is excluded when, if it is sold, would only result in a gain to the household of one-half of the applicable resource limit as defined under WAC 388-470-0005. The resource must be something other than stocks, bonds, negotiable financial instruments, or a vehicle.

(15) Prorated income for self-employed persons or ineligible students. These monies retain their exclusion for the period of time the income is prorated even when commingled with other funds.

(16) Real or personal property when:

(a) It produces yearly income that is equal to its fair market value even when used only on a seasonal basis;

(b) Secured by a lien for a business loan and the lien prevents the household from selling it; or

(c) It is directly related to the maintenance or use of a vehicle excluded in WAC 388-470-0075.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-470-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-470-0035, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0040 Additional excluded resources for SSI-related medical assistance.** In addition to other SSI-related resource exclusions in this chapter the resources in this section are excluded when a client's eligibility for SSI-related medical assistance is determined.

(1) A client's household goods and personal effects are excluded.

(2) One home, which may be any shelter in which the client has ownership interest, is excluded when:

(a) The client uses the home as the principal place of residence;

(b) The client's spouse resides in the home; or

(c) The client does not currently live in the home and the client:

(i) Intends to return to the home; and

(ii) Provides the department with an oral or written statement of their intent to return; or

(d) A relative resides in the home when:

(i) The relative is financially or medically dependent on the client; and

(ii) The client or dependent relative provides the department with a written statement of the dependency.

(3) Proceeds, including cash or a sales contract, from the sale of the home described in subsection (2) of this section are excluded when the client purchases another home within three months of receipt of the proceeds of the sale. Only the portion of the sales contract payment which represents interest is counted as unearned income. See WAC 388-450-0040.

(4) The value of a sales contract is excluded:

(a) When the current market value of the contract is zero or the contract is unsalable; or

(b) When combined with other resources, it exceeds the resource limit, and the sales contract was executed:

(i) On or before November 30, 1993; or

(ii) On or after December 1, 1993, and:

(A) Was received as compensation for the sale of the client's principal place of residence;

(B) Provides interest within the prevailing interest rate at the time of the sale;

(C) Requires the repayment of a principal amount equal to the fair market value of the property; and

(D) Payment on the amount owed does not exceed thirty years.

The income a client receives which represents the principle and interest portion of a sales contract meeting the definition of this subsection is counted as unearned income. See WAC 388-450-0040.

(5) A sales contract is a nonexcluded resource when:

(a) It does not meet the conditions in subsection (4); or

(b) The client transferred it to someone other than the client's spouse. See WAC 388-513-1365.

(6) When a client owns a sales contract as described in subsection (5), the portion of the payment which represents the:

(a) Principle is counted as an available resource; and

(b) Interest is counted as unearned income.

(7) The equity value of one vehicle up to five thousand dollar is excluded. The five thousand dollars limitation does not apply when the client or a member of the client's household, uses the vehicle which is:

(a) Necessary for employment; or

(b) Necessary for the treatment of specific or regular medical problem; or

(c) Modified for operation by, or transportation of, a person with disabilities; or

(d) Necessary due to climate, terrain, distance, or similar factors to provide the client transportation to perform essential daily activities.

(8) Property which is essential to self-support is excluded when:

(a) The client uses the property for an income producing activity:

(i) In a trade or business; or

(ii) As an employee for work.

(b) The client uses nonbusiness property with a value up to six thousand dollars in equity, to produce:

(i) Goods or services essential to daily activities, solely for the client's household;

(ii) An annual income return of six percent or more of the exempt equity; or

(iii) A six percent return within a twenty-month period when the client uses the property, or is expected to resume

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using the property within twelve months, for the activities described in this subsection.

(9) Resources necessary for a client, who is blind or disabled, to enable them to fulfill an approved self-sufficiency plan are excluded.

(10) Alaska Native Claims Settlement Act benefits are excluded, including:

(a) Shares of stock held in a regional or village corporation;

(b) Cash or dividends on stock received from a native corporation up to two thousand dollars per person per year;

(c) Stock issued by a native corporation as a dividend;

(d) A partnership interest;

(e) Land or an interest in land; and

(f) An interest in a settlement trust.

(11) The total cash surrender value (CSV) of a life insurance policy or policies when the total face value of all policies held by the client is fifteen hundred dollars or less are not counted. The CSV of a client's policies in excess of fifteen hundred dollars is applied to the client's resource limit as described in WAC 388-478-0070 and 388-478-0080.

(12) Restricted allotted land owned by an enrolled tribal member and spouse, if the land cannot be disposed of without the permission of the other person, the tribe, or an agency of the federal government is not counted.

(13) A settlement the client receives for the purpose of repairing or replacing a specific excluded resource is not counted for a period of:

(a) Nine months when the client uses the total amount of the cash to repair or replace the excluded resource;

(b) Nine additional months when:

(i) Circumstances beyond the control of the client prevent the repair or replacement of the excluded resource; and

(ii) The client uses the total amount of the cash to repair or replace the excluded resource.

(c) Twelve additional months, for a maximum of thirty months, when:

(i) The settlement is a result of a catastrophe which is declared a major disaster by the President of the United States;

(ii) The excluded resource is geographically within the disaster area as defined by the presidential order;

(iii) The client intends to repair or replace the excluded resource; and

(iv) Circumstances beyond the control of the client prevented the repair or replacement of the excluded resource in the time frames described under subsection (13)(a) and (b) of this section.

(d) Except, any settlement excluded and not used within the allowable time period as described under this subsection as an available resource.

(14) Burial spaces for the client and any member of the client's immediate family, as described in subsection (16) are not counted. Burial spaces include:

(a) Conventional grave sites;

(b) Crypts;

(c) Mausoleums; or

(d) Urns and other repositories customarily used for the remains of deceased persons.



(15) A burial space purchase agreement is also defined as a burial space. The value of the purchase agreement is excluded, as well as any interest accrued on the purchase agreement, which is left to accumulate as part of the value of the burial space purchase agreement.

(16) Immediate family, for purposes of subsection (14) of this section includes the client's:

- (a) Spouse;
- (b) Minor and adult children, including adopted and stepchildren;
- (c) Siblings;
- (d) Parents and adoptive parents;
- (e) Spouses of any of the above.

None of the family members listed above need to be dependent upon or living with the client, to be considered immediate family members.

(17) The following types of burial funds are excluded as resources:

- (a) Up to fifteen hundred dollars each for a client or a client's spouse when funds are specifically set aside solely for burial expenses;
- (b) A revocable burial contract, burial trust, cash, account, or other financial instrument with a definite cash value; and
- (c) Any interest earned and appreciation in the value of excluded burial funds when left to accumulate and become part of the burial fund.

(18) Funds which a client has specifically set aside solely for burial expenses, as described in subsection (17) of this section are funds which:

- (a) Are kept separate from all other resources except nonexcluded funds the client intends to use solely for burial related items or services and identified as a burial fund; and
- (b) May be designated as burial funds back to the first day of the month in which the person intended the funds to be set aside for burial.

(19) The limitation described under subsection (17)(a) of this section is reduced by:

- (a) The face value of insurance policies owned by the client or spouse if the policies have been excluded as provided in subsection (11) of this section; and
- (b) Amounts in an irrevocable burial trust.

(20) A client's burial funds lose excluded status when:

- (a) They are mixed with other resources; or
- (b) The burial funds, interest, or appreciated values are used for other purposes. These funds are then considered available income:

- (i) On the first of the month of use; if
- (ii) When added to other nonexcluded resources, the amount exceeds the resource limit as described in WAC 388-478-0080.

(21) All resources specifically excluded by federal statute are not counted.

(22) Retroactive SSI payments, including benefits a client receives under the interim assistance reimbursement agreement with the Social Security Administration, or Social Security Disability Insurance (OASDI) payments are excluded for six months following the month of receipt. This exclusion applies to:

(a) Payments received by the client, spouse, or any other person the client is financially responsible for;

(b) SSI payments made to the client for benefits due for a month before the month of payment;

(c) OASDI payments made to the client for benefits due for a month that is two or more months before the month of payment; and

(d) Payments held as cash, in a checking account, or in a saving account. This exclusion does not apply once the payments have been converted to any other type of resource.

(23) Cash payments an SSI recipient receives from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(24) Payments from the Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV) are excluded. Interest earned on these payments is counted as unearned income as specified under chapter 388-450 WAC.

(25) Payments to survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act are excluded. Interest earned on these payments is counted as unearned income as specified under chapter 388-450 WAC.

(26) Earned income tax credit refunds and payments are excluded as resources during the month of receipt and the following month.

(27) Payments from a state administered victim's compensation program are excluded for a period of nine calendar months after the month of receipt.

(28) Payments under section 500 through 506 of the Austrian General Social Insurance Act are not counted as a resource or income when a client's eligibility or post-eligibility (for institutionalized clients) is determined. A post-eligibility determination is the process of determining a client's share of the cost of institutional or waived services care.

Any interest earned on the payments in this subsection is counted as unearned income as specified under WAC 388-450-0025.

(29) Payments from *Susan Walker v. Bayer Corporation*, et al., 96-c-5024 (N.D. Ill.) (May 8, 1997) settlement funds are excluded. Any interest earned on these payments is counted as unearned income as specified under WAC 388-450-0025.

(30) Cash received from the sale of an excluded resource is not counted when it is:

- (a) Used to replace an excluded resource; or
- (b) Invested in an excluded resource within the same month, unless specified differently under this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-511-1160.]

**WAC 388-470-0045 Resources that are counted toward the resource limits for cash, food assistance and TANF/SFA-related medical programs.** (1) The following resources are counted toward the resource limits for cash, food assistance and TANF/SFA-related medical programs:

- (a) Liquid resources such as cash on hand, monies in checking or savings accounts; or

(b) Stocks or bonds minus any early withdrawal penalty.

(2) For TANF/SFA, GA, and TANF/SFA-related medical, the entire value of a motor home is counted as a resource when not used as a residence. For food assistance, a motor home is treated as a vehicle as described in WAC 388-470-0075.

(3) A resource owned with a person other than a spouse, contract vendor, mortgage or lien holder (jointly owned) is counted as follows:

(a) For cash assistance and TANF-related medical, the client's share of the equity value; or

(b) For food assistance, resources jointly owned by separate assistance units are considered available in their entirety to each assistance unit.

(4) A client may provide evidence that all or a portion of a jointly owned resource:

(a) Belongs to the other owner; and

(b) Is held for the benefit of the other owner.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0045, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0050 Resources that count.** Unless otherwise specified the following resources count toward a cash or TANF-related medical assistance unit's resource limit:

(1) Burial insurance and term insurance: The cash surrender value in excess of fifteen hundred dollars.

(2) Child's irrevocable educational trust: Trust funds in excess of four thousand dollars per child.

(3) Life insurance: The cash surrender value of life insurance policies.

(4) Sales contracts, real estate mortgages, security interest: With the exception of sales contracts for the purposes of TANF-related medical, countable cash discount values.

(5) Savings accounts: For recipient's only, value in excess of three thousand dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0050, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0055 Resources that are counted for food assistance.** The net value of the following resources are counted toward an assistance unit's resource limit:

(1) Excluded funds that are deposited in an account with countable funds (commingled) for more than six months from the date of deposit.

(2) Lump sums such as insurance settlements, refunded cleaning and damage deposits.

(3) Resources of ineligible household members, as described in WAC 388-408-0035(9).

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0055, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0055, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0060 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 388-470-0065 Individual development accounts for TANF recipients.** (1) A TANF recipient's individual development account (IDA) established under RCW 74.08A.220 is excluded when determining TANF eligibility.

(2) When a TANF recipient withdraws funds from an IDA, for a purpose other than specified in RCW 74.08A.220, the funds are a countable resource, as specified under WAC 388-470-0015(2).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0065, filed 7/31/98, effective 9/1/98.]

**WAC 388-470-0070 How vehicles are counted toward the resource limit for cash assistance and family medical programs.** (1) A vehicle is any device for carrying persons and objects by land, water, or air.

(2) The entire value of a licensed vehicle needed to transport a physically disabled assistance unit member is excluded.

(3) The equity value of one vehicle up to five thousand dollars is excluded when the vehicle is used by the assistance unit or household as a means of transportation. Each separate medical assistance unit is allowed this exclusion.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-470-0070, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610.]

**WAC 388-470-0075 How is my vehicle counted for the Washington basic food program?** This rule applies to the Washington basic food program only.

(1) A vehicle is a motorized device that the client can use as a regular means of transportation.

(2) If you own a licensed vehicle we (the department) do not count its entire value if the vehicle:

(a) Has an equity value (fair market value (FMV) minus what you owe on the vehicle) of one thousand five hundred dollars or less.

(b) Is used over fifty percent of the time to make income. This includes vehicles such as a taxi, truck, or fishing boat. If you are a self-employed farmer or fisher and your self-employment ends, we still exclude your vehicle for one year from the date you end your self-employment.

(c) Is used to make income each year that is consistent with its FMV, even if used on a seasonal basis.

(d) Is needed for long-distance travel, other than daily commuting, for the employment of an assistance unit (AU).

(e) Is used as your AU's home.

(f) Is used to carry fuel for heating or water for home use when this is the primary source of fuel or water for your AU.

(g) Is needed to transport a physically disabled AU member, no matter if the disability is permanent or temporary.

(3) For licensed vehicles we did not exclude in subsection (2) above, we subtract four thousand six hundred fifty dollars from the vehicle's FMV and count the remaining amount toward the resource limit for:

(a) One vehicle for each adult AU member no matter how it is used; and

(b) Any vehicle an AU member under age eighteen uses to drive to work, school, training, or to look for work.

(4) If you have other licensed vehicles, we count the larger value of the following toward your AU's resource limit:

(a) FMV greater than four thousand six hundred fifty dollars; or

(b) Equity value (FMV minus what is owed on the vehicle).

(5) If you are a tribal member and drive an unlicensed vehicle on a reservation that does not require vehicle licensing, we count or exclude your vehicle as if it was a licensed vehicle.

(6) For all other unlicensed vehicles we count the equity value towards your AU's resource limit unless the vehicle is:

(a) Used to make income each year that is consistent with its FMV, even if used on a seasonal basis; or

(b) Work-related equipment needed for employment or self-employment of a member of your AU.

(7) We do not add the equity values of different vehicles together to perform the equity test. We look at each vehicle separately. If a vehicle passes the equity test, we do not count it towards the resource maximum.

(8) After we determine the countable value of each vehicle, we add those values to your other countable resources to see if your resources are below your resource limit.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-23-028, § 388-470-0075, filed 11/12/02, effective 12/1/02; 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

388-472-0005	What are my rights and responsibilities?
388-472-0010	What are necessary supplemental accommodation services?
388-472-0020	How does the department decide if I am eligible for NSA services?

388-472-0030	How can I get NSA services?
388-472-0040	What are the department's responsibilities in giving NSA services to me?
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?

**WAC 388-472-0005 What are my rights and responsibilities?** For the purposes of this chapter, "we" and "us" refer to the department and "you" refers to the applicant or recipient.

(1) If you apply for or get cash, food or medical assistance benefits you have the right to:

(a) Have your rights and responsibilities explained to you and given to you in writing;

(b) Be treated politely and fairly no matter what your race, color, political beliefs, national origin, religion, age, gender, disability or birthplace;

(c) Request benefits by giving us an application form using any method listed under WAC 388-406-0010. You can ask for and get a receipt when you give us an application or other documents;

(d) Have your application processed as soon as possible. Unless your application is delayed under WAC 388-406-0040, we process your application for benefits within thirty days, except:

(i) If you are eligible for expedited services under WAC 388-406-0015, you get food assistance within five days. If we deny you expedited services, you have a right to ask that the decision be reviewed by the department within two working days from the date we denied your application;

(ii) If you are pregnant and otherwise eligible, you get medical within fifteen working days.

(iii) General assistance (GAU), alcohol or drug addiction treatment (ADATSA), or medical assistance may take up to forty-five days; and

(iv) Medical assistance requiring a disability decision may take up to sixty days.

(e) Be given at least ten days to give us information needed to determine your eligibility and be given more time if you ask for it. If we do not have the information needed to decide your eligibility, then we may deny your request for benefits;

(f) Have the information you give us kept private. We may share some facts with other agencies for efficient management of federal and state programs;

(g) Ask us not to collect child support or medical support if you fear the noncustodial parent may harm you, your children, or the children in your care;

(h) Ask for extra money to help pay for temporary emergency shelter costs, such as an eviction or a utility shutoff, if you get TANF;

(i) Get a written notice, in most cases, at least ten days before we make changes to lower or stop your benefits;

(j) Ask for a fair hearing if you disagree with a decision we make. 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 given to you at no cost 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; and

(m) Get help from us to register to vote.

(2) If you get cash, food, or medical assistance, you are responsible to:

(a) Tell us if you are pregnant, in need of immediate medical care, experiencing an emergency such as having no money for food, or facing an eviction so we can process your request for benefits as soon as possible;

(b) Report the following expenses so we can decide if you can get more food assistance:

(i) Shelter costs;

(ii) Child or dependent care costs;

(iii) Child support that is legally obligated;

(iv) Medical expenses; and

(v) Self-employment expenses.

(c) Report changes as required under WAC 388-418-0005 and 388-418-0007. If you get:

(i) Cash or food assistance, changes must be reported within ten days from the date you learn of the change; or

(ii) Medical assistance, changes must be reported within twenty days from the date you learn of the change.

(d) Give us the information needed to determine eligibility;

(e) Give us proof of information when needed. If you have trouble getting proof, we help you get the proof or contact other persons or agencies for it;

(f) Cooperate in the collection of child support or medical support unless you fear the noncustodial parent may harm you, your children, or the children in your care;

(g) Apply for and get any benefits from other agencies or programs prior to getting cash assistance from us;

(h) Complete reports and reviews when asked;

(i) Look for, get, and keep a job or participate in other activities if required for cash or food assistance;

(j) Give your medical identification card or letter of eligibility from us to your medical care provider; and

(k) Cooperate with the quality control review process.

(3) If you are eligible for necessary supplemental accommodation (NSA) services under chapter 388-472 WAC, we help you comply with the requirements of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-472-0005, filed 6/21/02, effective 7/1/02; 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:

(2003 Ed.)

(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.

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(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 388-473 WAC

### ONGOING ADDITIONAL REQUIREMENTS

#### WAC

388-473-0010 General provisions for ongoing additional requirements.  
388-473-0020 Restaurant meals as an ongoing additional requirement.

388-473-0030 Home-delivered meals as an ongoing additional requirement.  
388-473-0040 Food for service animals as an ongoing additional requirement.  
388-473-0050 Telephone services as an ongoing additional requirement.  
388-473-0060 Laundry as an ongoing additional requirement.

**WAC 388-473-0010 General provisions for ongoing additional requirements.** For the purposes of this chapter, "we" and "us" refers to the department of social and health services. "You" refers to the applicant or recipient. An "ongoing additional requirement" is a continuing need that you have for which you require additional financial benefits in order to continue living independently.

(1) We may authorize ongoing additional requirement benefits if you are:

(a) Eligible for temporary assistance for needy families (TANF), Tribal TANF, state family assistance (SFA), refugee or general assistance cash, or SSI payments; and

(b) Aged: You are age sixty-five or older;

(c) Blind: You have central visual acuity of 20/200 or less in the better eye with the use of a correcting lens or limited fields of vision so the widest diameter of the visual field subtends an angle of no greater than twenty degrees; or

(d) Disabled: You are unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment that:

(i) Can be expected to result in death; or

(ii) Has lasted or can be expected to last for a continuous period of not less than twelve months..

(2) You may apply for ongoing additional requirement benefits by asking for it from staff that maintain your cash or medical assistance.

(3) We authorize ongoing additional requirement benefits only when we determine the item is essential to you. In deciding if you are eligible for ongoing additional requirement benefits, we consider and verify:

(a) The circumstances that created the need; and

(b) Your health, safety and ability to continue to live independently.

(4) When we determine ongoing additional requirement benefits are needed, we:

(a) Increase your cash assistance benefit to provide the additional benefits by monthly payment;

(b) Periodically review whether you continue to need the additional benefits. We conduct this review at least:

(i) Twice a year for TANF and refugee cash assistance recipients;

(ii) Yearly for general assistance or SSI recipients when we decide the need is not likely to change; or

(iii) More frequently if we expect your circumstances to change.

(5) Monthly payment standards for ongoing additional requirements are described under WAC 388-478-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 01-01-070, § 388-473-0010, filed 12/12/00, effective 2/1/01; 00-15-053, § 388-473-0010, filed 7/17/00, effective 9/1/00.]

**WAC 388-473-0020 Restaurant meals as an ongoing additional requirement.** We authorize benefits for restaurant meals when we decide you are:

## Chapter 388-474 WAC

## SUPPLEMENTAL SECURITY INCOME

- (1) Physically or mentally unable to prepare meals;
- (2) A roomer and meals are not provided or your housing arrangement does not provide for or allow cooking; or
- (3) Homeless.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0020, filed 7/17/00, effective 9/1/00.]

**WAC 388-473-0030 Home-delivered meals as an ongoing additional requirement.** We authorize benefits for home-delivered meals, such as meals on wheels, when we decide the following conditions are all true:

- (1) You cannot prepare all of your meals, and home-delivered meals are available;
- (2) You require help in preparing meals and getting home-delivered meals would ensure your nutrition or health;
- (3) Help in preparing meals is not available without cost to you; and
- (4) Board (or board and room) is not available to you or would cost you more than home-delivered meals.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0030, filed 7/17/00, effective 9/1/00.]

**WAC 388-473-0040 Food for service animals as an ongoing additional requirement.** (1) A "service animal" is one that has been trained at a recognized school or training facility to provide you with assistance that is necessary for your health and safety, and that supports your ability to continue to live independently.

(2) We authorize benefits for food for a service animal if we decide the animal assists you in your daily living as described in WAC 388-473-0040(1).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0040, filed 7/17/00, effective 9/1/00.]

**WAC 388-473-0050 Telephone services as an ongoing additional requirement.** We authorize benefits for telephone services when we decide:

- (1) Without a telephone, your life would be endangered, you could not live independently, or you would require a more expensive type of personal care; and
- (2) You have applied for the Washington telephone assistance program (WTAP) through your local telephone company.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0050, filed 7/17/00, effective 9/1/00.]

**WAC 388-473-0060 Laundry as an ongoing additional requirement.** We authorize benefits for laundry when we decide:

- (1) You are not physically able to do your own laundry; or
- (2) You do not have laundry facilities that are accessible to you due to your physical limitations.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0060, filed 7/17/00, effective 9/1/00.]

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WAC	
388-474-0001	What is Supplemental Security Income (SSI) and who can get it?
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388-474-0015	What happens to my categorically needy (CN) medical coverage when my Supplemental Security Income (SSI) cash payment is terminated?
388-474-0020	What can a general assistance-unemployable (GA-U) client expect when Supplemental Security Income (SSI) benefits begin?

**WAC 388-474-0001 What is Supplemental Security Income (SSI) and who can get it?** (1) SSI is a federal cash benefit program administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

(2) You can get SSI if you have limited income and resources and if you are:

- (a) Aged (sixty-five and older);
- (b) Blind; or
- (c) Disabled.

(3) The SSI program replaced state programs for aged, blind and disabled persons beginning in January 1974. If you received state assistance in December 1973 and you became eligible for SSI in January 1974, you are called a grandfathered client by the state and a mandatory income level (MIL) client by SSI. You 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), see <http://policy.ssa.gov/poms.nsf>.

(4) If you are needed in the home to care for an eligible person, you are called an essential person. You are also called a grandfathered client.

(5) If you are an essential person you must have lived continuously with the eligible person since January 1974.

(6) If you are an SSI recipient and you have a spouse who does not qualify for SSI in their own right, you may be eligible for a state supplemental payment for your spouse (also referred to as an ineligible spouse).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0001, filed 5/7/02, effective 6/7/02. 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 388-474-0005 What medical coverage does a Supplemental Security Income client, essential person, and an ineligible spouse get?** (1) If you are an SSI client you automatically get categorically needy (CN) medical coverage (WAC 388-505-0110) unless you:

- (a) Refuse to provide private medical insurance information; or
- (b) Refuse to assign the right to recover insurance funds to the department (WAC 388-505-0540).

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(2) If you are an essential person as described in WAC 388-474-0001 you get CN medical coverage as long as you continue to live with the SSI client.

(3) If you are an ineligible spouse you are not considered an SSI recipient. You must have your medical assistance determined separately.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0005, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0005, filed 7/31/98, effective 9/1/98.]

**WAC 388-474-0010 How does being a Supplemental Security Income (SSI) client affect your cash assistance eligibility?** (1) If you are married to an SSI recipient but do not get SSI in your own right, you are called an "ineligible spouse."

(2) If you are an ineligible spouse you cannot get the SSI state supplement when 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 (see WAC 388-408-0015; or

(c) Receiving refugee assistance.

(3) If you are an ineligible spouse and get an SSI state supplement (WAC 388-474-0012), you cannot get general assistance (GA).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0010, filed 5/7/02, effective 6/7/02. 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.]

**WAC 388-474-0015 What happens to my categorically needy (CN) medical coverage when my Supplemental Security Income (SSI) cash payment is terminated?** (1) Your CN medical coverage (WAC 388-505-0110) continues after an SSI cash payment ends when:

(a) Countable income exceeds the SSI income standard due solely to the annual cost-of-living adjustment (COLA); or

(b) A timely request for a hearing has been filed. CN medical coverage is continued until Social Security Administration (SSA) makes a final decision on the hearing request and on any subsequent timely appeals.

(2) If your SSI ends your CN medical coverage continues for a period of up to one hundred twenty days while the department reviews your eligibility for other cash or medical programs.

(3) If you are a terminated SSI or SSI-related client, the department will review your disability status when:

(a) You present new medical evidence;

(b) Your medical condition changes significantly; or

(c) Your termination from SSI was not based on a review of current medical evidence.

(4) Children terminated from SSI due to loss of disabled status may be eligible for medical benefits under WAC 388-505-0210.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-20-070, § 388-474-0015, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-

[Title 388 WAC—p. 760]

11-033, § 388-474-0015, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-524-2405.]

**WAC 388-474-0020 What can a general assistance-unemployable (GA-U) client expect when Supplemental Security Income (SSI) benefits begin?** You can only get assistance to meet your basic needs from one government source at a time (WAC 388-448-0210). If you are a GA-U client who begins setting SSI, you should know that:

(1) If you got advance, emergency or retroactive SSI cash assistance for any period where you got GA-U, you must repay the department the amount of GA-U paid to you for the matching time period.

(2) When you apply for GA-U you must sign DSHS 18-235(X), interim assistance reimbursement agreement (IARA) to get GA-U assistance.

(3) You cannot use your GA-U money to replace money deducted from your SSI check to repay an SSI overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0020, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0020, filed 7/31/98, effective 9/1/98.]

## Chapter 388-475 WAC

### HEALTHCARE FOR WORKERS WITH DISABILITIES (HWD) PROGRAM

#### WAC

388-475-1000	Healthcare for workers with disabilities (HWD)—Program description.
388-475-1050	Healthcare for workers with disabilities (HWD)—Program requirements.
388-475-1100	Healthcare for workers with disabilities (HWD)—Retroactive coverage.
388-475-1150	Healthcare for workers with disabilities (HWD)—Disability requirements.
388-475-1200	Healthcare for workers with disabilities (HWD)—Employment requirements.
388-475-1250	Healthcare for workers with disabilities (HWD)—Premium payments.

**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 chapters 388-513 and 388-515 WAC. LTC services include institutional, waived, 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

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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:

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- (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.

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(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 388-476 WAC SOCIAL SECURITY NUMBER

### WAC

388-476-0005 Social Security number requirements.

**WAC 388-476-0005 Social Security number requirements.** (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

- (a) Apply for the SSN;
- (b) Provide proof that the SSN has been applied for; and
- (c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) A newborn may receive benefits for up to six months from the date of birth if the household is unable to provide proof of application for an SSN at the time of birth.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

- (a) The consolidated emergency assistance program;
- (b) The refugee cash and medical assistance program;
- (c) The medically indigent program;

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- (d) The alien emergency medical program;
- (e) The state-funded pregnant woman program;
- (f) The children's health program; and
- (g) Detoxification services.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-476-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-476-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0530.]

### Chapter 388-478 WAC STANDARDS FOR PAYMENTS

#### WAC

388-478-0005	Cash assistance need and payment standards and grant maximum.
388-478-0010	Households with obligations to pay shelter costs.
388-478-0015	Need standards for cash assistance.
388-478-0020	Payment standards for TANF, SFA, GA-S, GA-H and RCA.
388-478-0030	Payment standards for GA-U and ADATSA.
388-478-0035	Maximum earned income limits for TANF and SFA.
388-478-0040	Payment standard for persons in medical institutions.
388-478-0045	Payment standard for persons in certain group living facilities.
388-478-0050	Payment standards for ongoing additional requirements.
388-478-0055	SSI payment standards for eligible recipients.
388-478-0057	Year-end adjustments to the SSI state supplement.
388-478-0060	What are the income limits and maximum benefit amounts for food assistance?
388-478-0065	Categorically needy income level (CNIL) and resource standards for families.
388-478-0070	Monthly income and countable resource standards for medically needy (MN) and medically indigent (MI) programs.
388-478-0075	Medical programs—Monthly income standards based on the federal poverty level (FPL).
388-478-0080	SSI-related categorically needy income level (CNIL) and countable resource standards.
388-478-0085	Medicare cost sharing programs—Monthly income and countable resources standards.

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

388-478-0025	TANF payment standards for recent arrivals to Washington state. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0025, filed 7/31/98, effective 9/1/98.] Repealed by 99-16-024, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-478-0026	Excluded resources for family medical programs. [Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530 and 2000 c 218. 00-21-063, § 388-478-0026, filed 10/16/00, effective 12/1/00.] Repealed by 02-05-004, filed 2/7/02, effective 3/10/02. Statutory Authority: RCW 74.08.090.
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 388-478-0005 Cash assistance need and payment standards and grant maximum.** (1) Need standards for cash assistance programs represent the amount of income required by individuals and families to maintain a minimum and adequate standard of living. Need standards are based on assistance unit size and include basic requirements for food, clothing, shelter, energy costs, transportation, household maintenance and operations, personal maintenance, and necessary incidentals.

(2) Payment standards for assistance units in medical institutions and other facilities are based on the need for

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clothing, personal maintenance, and necessary incidentals (see WAC 388-478-0040 and 388-478-0045).

(3) Need and payment standards for persons and families who do not reside in medical institutions and other facilities are based on their obligation to pay for shelter.

(a) Eligibility and benefit levels for persons and families who meet the requirements in WAC 388-478-0010 are determined using standards for assistance units with an obligation to pay shelter costs.

(b) Eligibility and benefit levels for all other persons and families are determined using standards for assistance units who have shelter provided at no cost.

(c) For recent arrivals to Washington state who apply for temporary assistance for needy families (TANF), see WAC 388-478-0025.

(4) The monthly grant for an assistance unit containing eight or more persons cannot exceed the grant maximum of one thousand seventy-five dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0005, filed 7/31/98, effective 9/1/98.]

**WAC 388-478-0010 Households with obligations to pay shelter costs.** The monthly need and payment standards for cash assistance are based on a determination of assistance unit size and whether the assistance unit has an obligation to pay shelter costs.

Eligibility and benefit level is determined using standards for assistance unit with obligations to pay shelter costs. An assistance unit has an obligation to pay shelter costs if one of the members:

(1) Owns, purchases or rents their place of residence, even if costs are limited to property taxes, fire insurance, sewer, water, or garbage;

(2) Resides in a lower income housing project which is funded under the United States Housing Act of 1937 or Section 236 of the National Housing Act, if the household either pays rent or makes a utility payment instead of a rental payment; or

(3) Is homeless. Homeless households include persons or families who:

(a) Lack a fixed, regular, and adequate nighttime residence; or

(b) Reside in a public or privately operated shelter designed to provide temporary living accommodations; or

(c) Live in temporary lodging provided through a public or privately funded emergency shelter program.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0010, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0010, filed 7/31/98, effective 9/1/98.]

**WAC 388-478-0015 Need standards for cash assistance.** The need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard
1	\$ 944
2	1,194
3	1,474

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4	1,740
5	2,005
6	2,271
7	2,624
8	2,905
9	3,185
10 or more	3,465

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard
1	\$ 492
2	623
3	769
4	907
5	1,046
6	1,184
7	1,369
8	1,515
9	1,661
10 or more	1,807

[Statutory Authority: RCW 74.08.090, 74.04.510, and 74.04.770. 02-23-029, § 388-478-0015, filed 11/12/02, effective 12/1/02. 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 388-478-0020 Payment standards for TANF, SFA, GA-S, GA-H and RCA.** (1) The payment standards for temporary assistance for needy families (TANF), state family assistance (SFA), general assistance for pregnant women (GA-S), general assistance for children (GA-H) and refugee cash assistance (RCA) assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	\$349	6	\$ 841
2	440	7	971
3	546	8	1,075
4	642	9	1,180
5	740	10 or more	1,283

(2) The payment standards for TANF, SFA, GA-S, GA-H and RCA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	\$212	6	\$ 511
2	268	7	591
3	332	8	654
4	391	9	718
5	451	10 or more	780

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710.]

**WAC 388-478-0030 Payment standards for GA-U and ADATSA.** (1) The payment standards for general assistance - unemployable (GA-U) and alcohol and drug addiction

[Title 388 WAC—p. 764]

treatment and support act (ADATSA) program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	\$ 339
2	428

(2) The payment standards for GA-U and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	\$ 206
2	261

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0030, filed 7/31/98, effective 9/1/98.]

**WAC 388-478-0035 Maximum earned income limits for TANF and SFA.** To be eligible for temporary assistance for needy families (TANF) or state family assistance (SFA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Earned Income Level
1	\$ 698	6	\$1,682
2	880	7	1,942
3	1,092	8	2,150
4	1,284	9	2,360
5	1,480	10 or more	2,566

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0035, filed 7/31/98, effective 9/1/98.]

**WAC 388-478-0040 Payment standard for persons in medical institutions.** (1) "Medical institutions" include skilled nursing homes, public nursing homes, general hospitals, tuberculosis hospitals, intermediate care facilities, and psychiatric hospitals approved by the joint commission on accreditation of hospitals (JCAH).

(2) The monthly payment standard for eligible persons in medical institutions is forty-one dollars and sixty-two cents. The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0040, filed 7/31/98, effective 9/1/98.]

**WAC 388-478-0045 Payment standard for persons in certain group living facilities.** (1) A monthly grant payment of thirty-eight dollars and eighty-four cents will be made to eligible persons in the following facilities:

- (a) Congregate care facilities (CCF);
- (b) Adult residential rehabilitation centers/adult residential treatment facilities (AARC/ARTF); and
- (c) Division of developmental disabilities (DDD) group home facilities.

(2) The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0045, filed 7/31/98, effective 9/1/98.]

**WAC 388-478-0050 Payment standards for ongoing additional requirements.** An "ongoing additional requirement" is a continuing need that you have for which you require additional financial benefits in order to continue living independently. The "payment standard" for ongoing additional requirement benefits is the amount of money needed to pay for these items or services. We use the following payment standards for ongoing additional requirements approved under WAC 388-473-0020 through 388-473-0060:

- (1) Restaurant meals: \$187.09 per month (or \$6.04 per day with the payment rounded down to the nearest dollar amount);
- (2) Laundry: \$11.13 per month;
- (3) Service animal food: \$33.66 per month;
- (4) Home delivered meals: The amount charged by the agency providing the meals;
- (5) Telephone: The local telephone flat rate for the area; or the Washington telephone assistance program (WTAP) rate, whichever is less.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-052, § 388-478-0050, filed 7/17/00, effective 9/1/00; 98-16-044, §

388-478-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

**WAC 388-478-0055 SSI 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:	\$ 797.00	\$ 19.90	\$ 816.90
One essential person			
Individual with:	\$531 for the eligible individual plus \$266 for each essential person (no state supplement)		
Multiple essential persons			
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:	\$ 797.00	\$ 0.00	\$ 797.00
One essential person			
Individual with:	\$531 for the eligible individual plus \$266 for each essential person (no state supplement)		
Multiple essential persons			
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:	\$ 531.34	\$ 4.20	\$ 535.54
One essential person			
Individual with:	\$354.00 for the eligible individual plus \$177.00 for each essential person (no state supplement)		
Multiple essential persons			
Individual with an ineligible spouse	\$ 354.00	\$ 101.66	\$ 455.66
Couple	\$ 530.67	\$ 4.20	\$ 534.87



	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
SHARED LIVING - In the home of another person 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 Individual	Federal Benefit Level \$ 30.00	State Supplement Benefit Level \$ 11.62	Combined Benefit Level \$ 41.62
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(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 388-478-0057 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 the income limits and maximum benefit amounts 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. The maximum monthly food assistance benefit your AU could receive is listed in column D.

EFFECTIVE 10-1-2002

Column A	Column B Maximum Gross Monthly Income	Column C Maximum Net Monthly Income	Column D Maximum Allotment	Column E 165% of Poverty Level
Number of Eligible AU Members				
1	\$960	\$739	\$139	\$1,219
2	1,294	995	256	1,642
3	1,628	1,252	366	2,066
4	1,961	1,509	465	2,489
5	2,295	1,765	553	2,913
6	2,629	2,022	663	3,336
7	2,962	2,279	733	3,760
8	3,296	2,535	838	4,183
9	3,630	2,792	943	4,607
10	3,964	3,049	1,048	5,031
Each Additional Member	+334	+257	+105	+424

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. 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 74.04.050, 74.04.055, 74.04.057, 74.08.090, 02-21-050, § 388-478-0060, filed 10/14/02, effective 12/1/02. 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, 2002, the medically needy income level (MNIL) and MI monthly income standards are as follows:

(a) One person	\$571.00
(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 42 U.S.C. 1396r-5, 02-10-116, § 388-478-0070, filed 4/30/02, effective 5/31/02. 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**

(2003 Ed.)

**(FPL).** (1) The department bases the income standard upon the Federal Poverty Level (FPL) for the following medical programs:

(a) Pregnant women's program up to one hundred eighty-five percent of FPL;

(b) Children's categorically needy program up to two hundred percent of FPL;

(c) Healthcare for workers with disabilities (HWD) up to two hundred twenty percent of FPL; and

(d) The state children's health insurance program (SCHIP) is over two hundred percent of FPL but under two hundred fifty percent of FPL.

(2) Beginning April 1, 2002, the monthly FPL standards are:

FAMILY SIZE	100% FPL	185% FPL	200% FPL	220% FPL	250% FPL
1	\$739	\$1366	\$1477	\$1625	\$1846
2	\$995	\$1841	\$1990	\$2189	\$2488
3	\$1252	\$2316	\$2504	\$2754	\$3130
4	\$1509	\$2791	\$3017	\$3319	\$3771
5	\$1765	\$3266	\$3530	\$3883	\$4413
6	\$2022	\$3741	\$4044	\$4448	\$5055
7	\$2279	\$4215	\$4557	\$5013	\$5696
8	\$2535	\$4690	\$5070	\$5577	\$6338
9	\$2792	\$5165	\$5584	\$6142	\$6980
10	\$3049	\$5640	\$6097	\$6707	\$7621
Add to the ten person standard for each person over ten:					
	\$257	\$475	\$514	\$565	\$642

(3) There are no resource limits for the programs under this section.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-478-0075, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.500, 74.09.510, and Section 1902 (a)(10)(A)(ii)(XV) and (XVI) of the Social Security Act, 02-07-090, § 388-478-0075, filed 3/19/02, effective 4/1/02. 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, 2002, the CNIL monthly income standards are as follows:

	Area 1	Area 2
(a) Single person	\$570.90	\$550.45
(b) A legally married couple who are both eligible	\$836.90	\$817.00
(c) Supplied shelter	\$367.05	\$367.05

(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

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[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 1396r-5, 02-10-116, § 388-478-0080, filed 4/30/02, effective 5/31/02. 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 388-480 WAC STRIKERS

### WAC

388-480-0001 How being on strike effects food assistance benefits.

**WAC 388-480-0001 How being on strike effects food assistance benefits.** (1) A strike is a work stoppage, slow-down or other interruption of work caused by employees. You are not considered to be on strike if you are:

- (a) Locked out by your employer;
- (b) Unable to work because work is not available as a result of striking employees;
- (c) Not a member of the bargaining unit on strike and you fear someone may physically hurt you if you cross a picket line; or
- (d) Exempt from work registration the day before the strike for any reason other than being employed over thirty hours per week.

(2) If you apply for food assistance, you will not be eligible if you are on strike unless:

- (a) Your household met all income and resource eligibility standards the day before the strike; and
- (b) You are otherwise eligible at the time you apply.

(3) You will not receive an increase in your food assistance benefits solely due to receiving less income as a direct result of being on strike.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510, 00-05-007, § 388-480-0001, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-480-0001, filed 7/31/98, effective 9/1/98.]

## Chapter 388-482 WAC STUDENT STATUS

### WAC

388-482-0005 Student status for food assistance.

**WAC 388-482-0005 Student status for food assistance.** (1) A food assistance client is considered a student when the client is:

- (a) Aged eighteen through forty-nine years;
- (b) Physically and mentally able to work; and
- (c) Enrolled in an institution of higher education at least half-time as defined by the institution.

(2) An institution of higher education is:

- (a) Any educational institution requiring a high school diploma or general education development certificate (GED);
- (b) Business, trade or vocational schools requiring a high school diploma or GED; or

(c) A two-year or four-year college or university offering a degree but not requiring a high school diploma or GED.

(3) To be eligible for food assistance, a student as defined in subsection (1) of this section must meet at least one of the following requirements:

- (a) Be employed for a minimum of twenty hours per week.

(b) Work and receive money from a federal or state work study program;

(c) Be responsible for the care of a dependent household member age five or younger;

(d) Be responsible for the care of a dependent household member six through eleven years of age and the department has determined that there is not adequate child care available during the school year to allow the student to:

(i) Attend class and satisfy the twenty hour work requirement; or

(ii) Take part in a work study program.

(e) Be a single parent responsible for the care of a dependent household member eleven years old or younger even if child care is available;

(f) Be an adult who has parental control of a child eleven years of age or younger and neither the adult's spouse nor the child's parents reside in the home;

(g) Participate in the WorkFirst program as required under WAC 388-310-400;

(h) Receive benefits from TANF or SFA;

(i) Attend an institution of higher education through:

(i) The job training partnership act (JTPA);

(ii) Food assistance employment and training program (FS E&T);

(iii) An approved state or local employment and training program; or

(iv) Section 236 of the Trade Act of 1974.

(4) Student status:

(a) Begins the first day of the school term; and

(b) Continues through vacations. Vacations include the summer when the student plans to return to school for the next term.

(5) If the only reason a student is eligible for food assistance is the participation in work study, the student becomes ineligible during the summer months if the student is not working and receiving money from work study. Consider other student eligibility criteria during the summer months.

(6) Student status ends when a student:

(a) Graduates;

(b) Is suspended or expelled;

(c) Drops out; or

(d) Does not intend to register for the next school term other than summer.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-482-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-482-0005, filed 7/31/98, effective 9/1/98.]

## Chapter 388-484 WAC

### TANF/SFA FIVE YEAR TIME LIMIT

#### WAC

388-484-0005	There is a five year (sixty-month) time limit for TANF, SFA and GA-S cash assistance.
388-484-0006	TANF/SFA time limit extensions.
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?

(2003 Ed.)

**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, unless you are eligible for an extended period of cash assistance called a TANF/SFA time limit extension under WAC 388-484-0006.

**(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.

[Title 388 WAC—p. 769]

(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 may be required to repay up to sixty days of cash assistance if the department's decision is found to be correct as described in WAC 388-410-0001 (3)(b).

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-484-0005, filed 5/31/02, effective 6/1/02. 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 388-484-0006 TANF/SFA time limit extensions. (1) What happens after I receive sixty or more months of TANF/SFA cash assistance?**

After you receive sixty or more months of TANF/SFA cash assistance, you may qualify for additional months of cash assistance. We call these additional months of TANF/SFA cash assistance a TANF/SFA time limit extension.

**(2) Who is eligible for a TANF/SFA time limit extension?**

You are eligible for a TANF/SFA time limit extension if you are on TANF or otherwise eligible for TANF and:

(a) You qualify for one of the exemptions listed in WAC 388-310-0350; or

(b) You:

(i) Are participating satisfactorily in the WorkFirst program (see chapter 388-310 WAC for a description of Work-First participation requirements); or

(ii) Meet the family violence option criteria in WAC 388-61-001 and are participating satisfactorily in specialized activities listed in your individual responsibility plan.

(c) If you are refusing to participate as required and you do not have a good reason under WAC 388-310-1600(4), you do not qualify for a regular TANF/SFA time limit extension but your family may qualify for a Child SafetyNet Payment extension, described in WAC 388-310-1650.

**(3) Who reviews and approves an extension?**

(a) Your case manager or social worker will review your case and we will use the case staffing process to determine which extension type will be approved. Case staffing is a process to bring together a team of multidisciplinary experts including relevant professionals and you to identify issues, review case history and information, and recommend solutions.

(b) This review will not happen until after you have received at least fifty-two months of assistance but before you reach your time limit.

(c) During the case staffing, we will tell you about the different extensions. If you are in sanction (see WAC 388-310-1600), we will explain the consequences of continued nonparticipation and tell you the steps you must take to end the sanction. We will explain that continued failure to participate will result in your getting a Child SafetyNet Payment with additional restrictions after the sixtieth month.

(d) After the case staffing and before you reach your time limit, the department will send you a notice that tells you whether your extension was approved, how to request a fair hearing if you disagree with the decision, and any changes to your IRP that were made as a result of the case staffing.

**(4) Do my WorkFirst participation requirements change if I receive a TANF/SFA time limit extension?**

Your participation requirements do not change. You must still meet all of the WorkFirst participation requirements listed in chapter 388-310 WAC while you receive a TANF/SFA time limit extension.

**(5) Do my benefits change if I receive a TANF/SFA time limit extension?**

(a) You are still a TANF/SFA recipient. If you are:

(i) Receiving a regular TANF/SFA time limit extension, your cash assistance, services, or supports will not change as long as you continue to meet all other TANF/SFA eligibility requirements.

(ii) Receiving a Child SafetyNet Payment, your benefits will be different and are described in WAC 388-310-1650.

(b) During the TANF/SFA time limit extension, you must continue to meet all other TANF/SFA eligibility requirements. If you no longer meet TANF/SFA eligibility criteria during your extension, your benefits will end.

**(6) What happens if I stop participating in WorkFirst activities as required during a TANF/SFA time limit extension?**

If you do not participate in the WorkFirst activities required in your individual responsibility plan, and you do not have a good reason under WAC 388-310-1600(4), the department will follow the sanction rules in WAC 388-310-1600, and will move you into Child SafetyNet Payment which will reduce your benefits (see WAC 388-310-1650).

**(7) How long will a TANF/SFA time limit extension last?**

(a) We will review your TANF/SFA time limit extension and your case periodically for changes in family circumstances:

(i) If you are extended under WAC 388-484-0006 (2)(a) then we will review your extension at least every twelve months;

(ii) If you are extended under WAC 388-484-0006 (2)(b) then we will review your extension at least every six months;

(iii) If you are extended under WAC 388-484-0006 (2)(c) then we will review your extension at least every twelve months.

(b) Your TANF/SFA time limit extension may be renewed for as long as you continue to meet the criteria to qualify.

(c) If during the extension period we get proof that your circumstances have changed, we may review your case and change the type of TANF/SFA time limit extension.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-484-0006, filed 5/31/02, effective 6/1/02.]

**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.

(2003 Ed.)

[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 388-486 WAC

### TEEN PARENTS

#### WAC

388-486-0005	Unmarried pregnant or parenting minors—Required living arrangement.
388-486-0010	Unmarried pregnant or parenting minors—Required school attendance.

**WAC 388-486-0005 Unmarried pregnant or parenting minors—Required living arrangement.** (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) The following definitions apply to terms used in this section:

(a) "Unmarried" means a person who have never been married or whose marriage has been annulled. It does not include a person who has been divorced or widowed.

(b) "Minor" means a person younger than eighteen years of age.

(c) "Legal guardian" means a court-appointed legal guardian or court-appointed permanent custodian.

(d) "Relative" is a person who related to the pregnant or parenting minor as defined under RCW 74.15.020(4).

(3) An unmarried pregnant or parenting minor is not eligible for TANF, SFA or GA-S unless the person:

(a) Has been emancipated by a court; or

(b) Lives in a home approved by the department and has a protective payee.

(4) The home of a minor's parent, legal guardian, or adult relative may be approved unless:

(a) The minor has no living parent, legal guardian, or adult relative that can be located or those persons do not want the minor to live with them;

(b) The minor or the minor's child is being or has been seriously harmed either physically, emotionally or sexually in the home of the parent, legal guardian, or adult relative;

(c) Substantial evidence exists of an act or failure to act by the parent, legal guardian, or adult relative that presents imminent or serious harm to the minor or the minor's child if they lived there; or

(d) The department determines that it is in the best interest of the minor or the minor's child to waive the requirement of living in the home of a parent, legal guardian, or adult relative.

(5) If the home of a minor's parent, legal guardian, or adult relative is not available or suitable, one of the following alternatives may be approved:

(a) A facility or home licensed under chapter 74.15 RCW that provides a supportive and supervised living arrangement requiring residents to learn parenting skills;

(b) A maternity home;

(c) Other adult-supervised living arrangement; or

(d) The minor's current or proposed living arrangement, if the department determines it is appropriate.

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(6) A home that includes the other natural parent of the minor's child or unborn child is never approved if:

(a) The minor is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for rape of a child as set forth in RCW 9A.44.073, 9A.44.076, and 9A.44.079.

(7) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0005, filed 7/31/98, effective 9/1/98.]

**WAC 388-486-0010 Unmarried pregnant or parenting minors—Required school attendance.** (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) To be eligible for TANF or SFA, an unmarried pregnant or parenting minor who has not completed high school or a general education development (GED) certificate program must participate in educational activities leading to the attainment of a high school diploma or GED.

(3) The minor must meet the standard for satisfactory attendance set by the school or program in which the minor is enrolled.

(4) An unmarried minor is exempt from this rule if the minor has:

(a) Been emancipated by a court; or

(b) A child who is less than twelve weeks old.

(5) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0010, filed 7/31/98, effective 9/1/98.]

## Chapter 388-488 WAC

### TRANSFER OF PROPERTY

#### WAC

388-488-0005 Transfer of property to qualify for cash assistance.  
388-488-0010 Transfer of property to qualify for food assistance.

**WAC 388-488-0005 Transfer of property to qualify for cash assistance.** This rule applies to cash assistance programs only and does not affect Medicaid eligibility for a person who is not institutionalized. For transfer of property for institutional medical see WAC 388-513-1365.

(1) An assistance unit is disqualified from receiving benefits when it transferred or transfers real or personal property for less than its market value in an attempt to qualify for benefits:

(a) Two years prior to the date of application;

(b) During the application process; or

(c) Anytime while receiving benefits.

(2) When an assistance unit transferred property for less than its fair market value in an attempt to qualify for benefits, the disqualification period:

(a) For applicants, begins the first day of the month the property was transferred.

(b) For recipients, begins the first day of the month after the month the property was transferred.

(3) To determine the number of months an assistance unit will be disqualified, divide the uncompensated resource value of the transferred property by the state gross median income. The uncompensated resource value is the equity value minus the amount the client received when transferring a resource.

(4) An assistance unit can provide evidence to clarify the reasons for transferring the property when the department presumes that the assistance unit transferred the property in an attempt to qualify for benefits.

(5) The benefits received by an assistance unit are not affected by the transfer of separate property of a spouse who is not a member of the assistance unit.

(6) An assistance unit's disqualification period is reduced when the client:

(a) Verifies undue hardship will exist if the benefits are denied such as an eviction;

(b) Secures a return of some or all of the transferred property or the equivalent value of the transferred property;

(c) Verifies an unforeseen change in circumstances such as extensive hospitalization; or

(d) Is responsible for and can verify medical expenses.

(7) When a disqualification period has been adjusted and the client is otherwise eligible, benefits will be authorized. Any benefits authorized because of the reason(s) in subsection (6) of this section, are not considered an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-518-1820.]

**WAC 388-488-0010 Transfer of property to qualify for food assistance.** (1) An assistance unit is disqualified from the program when it transfers a resource to qualify or attempt to qualify for benefits:

(a) Three months prior to the month of application; or

(b) Beginning the month the household is approved for benefits.

(2) The length of disqualification depends on the dollar amount the household is over the resource limit. The countable resources transferred are added to the assistance unit's other countable resources. This total is compared to the resource limit. The amount in excess of the resource limit is located on the chart below to determine the length of the disqualification period.

Amount Over the Resource Limit	Disqualification Period
\$ 0 - \$ 249.99	1 month
250 - 999.99	3 months
1,000 - 2,999.99	6 months
3,000 - 4,999.99	9 months
5,000 and over	12 months

(3) The disqualification period begins:

(a) For applicants, the month of application; or

(b) For recipients, the first of the month after the advance notice period expires.

(4) An assistance unit will not be disqualified for transferring the following:

- (a) Excluded resources that do not affect eligibility;
- (b) Resources sold or traded at or near fair market value (FMV);
- (c) Resources transferred between assistance unit members of the same household including ineligible household members; and
- (d) Resources transferred for reasons other than to qualify for benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-488-0010, filed 7/31/98, effective 9/1/98.]

### Chapter 388-490 WAC VERIFICATION

#### WAC

388-490-0005 The department requires proof before authorizing benefits for cash, medical, and food assistance.

**WAC 388-490-0005 The department requires proof before authorizing benefits for cash, medical, and food assistance.** This rule applies to cash, medical, and food assistance.

(1) When you first apply for benefits, the department may require you to provide proof of things that help us decide your eligibility. This is also called "verification." The types of things that need to be proven are different for each program.

(2) After that, we will ask you to give us proof when:

- (a) You report a change;
  - (b) We find out that your circumstances have changed;
- or
- (c) The information we have is questionable or confusing.

(3) Whenever we ask for proof, we will give you a notice as described in WAC 388-458-0001.

(4) You must give us the proof within the time limits described in:

- (a) WAC 388-406-0030 and 388-406-0035 if you are applying for benefits; and
- (b) WAC 388-458-0001 if you currently receive benefits.

(5) We will accept any proof that you can easily get when it reasonably supports your statement or circumstances. The proof you give to us must:

- (a) Clearly relate to what you are trying to prove;
  - (b) Be from a reliable source; and
  - (c) Be accurate, complete, and consistent.
- (6) We cannot make you give us a specific type or form of proof.

(7) If the only type of proof that you can get costs money, we will pay for it.

(8) If the proof that you give to us is questionable or confusing, we may:

- (a) Ask you to give us more proof or provide a collateral contact (a "collateral contact" is a statement from someone outside of your residence that knows your situation);

(2003 Ed.)

(b) Schedule a visit to come to your home and verify your circumstances; or

(c) Send an investigator from the division of fraud investigations (DFI) to make an unannounced visit to your home to verify your circumstances.

(9) By signing the application, eligibility review, or change of circumstances form, you give us permission to contact other people, agencies, or institutions.

(10) If you do not give us all of the proof that we have asked for, we will determine if you are eligible based on the information that we already have. If we cannot determine that you are eligible based on this information, we will deny or stop your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 00-08-091, § 388-490-0005, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-490-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0460.]

### Chapter 388-492 WAC

#### WASHINGTON COMBINED APPLICATION PROJECT

#### WAC

388-492-0010	Washington state combined application program (WASHCAP) definitions.
388-492-0020	What is WASHCAP?
388-492-0030	Who can get WASHCAP?
388-492-0040	Can I choose whether I get WASHCAP or regular food assistance?
388-492-0050	How do I apply for Washington state combined application program (WASHCAP) benefits?
388-492-0060	How do I get my Washington state combined application program (WASHCAP) benefits?
388-492-0070	How are my Washington state combined application program (WASHCAP) benefits calculated?
388-492-0080	Where do I report changes?
388-492-0090	How often does my Washington state combined application program (WASHCAP) case need to be reviewed?
388-492-0100	How is my eligibility for Washington state combined application program (WASHCAP) reviewed?
388-492-0110	What happens if my Washington state combined application program (WASHCAP) benefits end?
388-492-0120	What happens to my Washington state combined application program (WASHCAP) benefits if I am disqualified?
388-492-0130	What can I do if I disagree with a decision the department made about my Washington state combined application program (WASHCAP) benefits?

**WAC 388-492-0010 Washington state combined application program (WASHCAP) definitions. "Assistance unit" (AU)** — For this chapter, a person who:

- (1) Is eligible to receive federal SSI,
- (2) Is eighteen years old or older,
- (3) Is not in an institution,
- (4) Meets the definition of living arrangement "A" (Social Security considers you as a separate household),
- (5) Has no earned income, and
- (6) 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 a home and community service office (HCS). The centralized unit or HCS office processes new applications for WASHCAP benefits and handles current WASHCAP cases.

**"SSA"** — Social Security Administration. A federal agency that issues all SSA and SSI cash benefits.

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**"SSA benefits"** — A federal program that gives money to aged, blind or disabled clients based on their past wages.

**"SDX"** — State data exchange. The computer system for exchanging information between SSA and DSHS regarding SSI applicants, beneficiaries and terminated SSI beneficiaries.

**"SSI benefits"** — Supplemental Security Income. The SSA federal cash grant program for needy aged, blind or disabled clients who did not have enough wages in the past to qualify for SSA benefits.

**"WASHCAP"** — Washington state combined application program. A simplified food assistance program that automatically opens food assistance benefits for certain SSI clients.

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0010, filed 7/22/02, effective 9/1/02; 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 program. WASHCAP is a simplified food assistance program for clients that are eligible for 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) While you get WASHCAP benefits, you must report all changes to SSA. SSA automatically shares your information we need for your WASHCAP benefits. You can report changes to your WASHCAP worker, but you do not have to do so. See WAC 388-492-0080 regarding changes to shelter costs.

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0020, filed 7/22/02, effective 9/1/02; 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) Are eligible to receive 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.

(2) You are not eligible for WASHCAP if:

- (a) You live in an institution; or
- (b) You are under age twenty-two and you live in the same home as your parents.

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0030, filed 7/22/02, effective 9/1/02; 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

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have regular food assistance benefits instead of WASHCAP benefits when:

(1) Your shelter costs are more than four hundred ninety-nine dollars a month. We count the following items as a shelter cost:

- (a) Rent or mortgage;
- (b) Property taxes;
- (c) Homeowner's insurance (for the building only); or
- (d) Mandatory homeowner's association or condo fees.

(2) Your out-of-pocket medical expenses are more than thirty-five dollars a month;

(3) You would get more benefits from being in the regular food assistance program; or

(4) You are waiting to receive WASHCAP benefits.

[Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 03-01-045, § 388-492-0040, filed 12/10/02, effective 1/10/03; 02-15-148, § 388-492-0040, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0040, filed 10/16/01, effective 12/1/01.]

**WAC 388-492-0050 How do I apply for Washington state combined application program (WASHCAP) benefits?** (1) You apply for WASHCAP at Social Security Administration (SSA) when you apply for Supplemental Security Income (SSI). If you want food assistance, your SSA worker will ask you questions for WASHCAP eligibility 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:

- (a) Your local community services office (CSO);
- (b) Your local home and community services office (HCS) if you get long-term care services; or
- (c) The SSA district office if you give them an application for expedited services when you apply for SSI. SSA forwards the food assistance application to the local CSO to process.

(4) If you want food assistance before you get SSI, you must apply for regular food assistance at:

- (a) SSA if you give them an application for food assistance when you apply for SSI;
- (b) Your local CSO; or
- (c) Your local HCS office if you get long-term care services.

(5) If you get regular food assistance these benefits will continue:

- (a) Through the end of your certification period; or
- (b) Through the month before your WASHCAP benefits start.

(6) If your regular food assistance ends before you are eligible for WASHCAP, you must reapply for these benefits to continue.

(7) If you get regular food assistance and you become eligible for WASHCAP, we will automatically change your benefits to WASHCAP.

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0050, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0050, filed 10/16/01, effective 12/1/01.]

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0050, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0050, filed 10/16/01, effective 12/1/01.]

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0050, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0050, filed 10/16/01, effective 12/1/01.]

**WAC 388-492-0060 How do I get my Washington state combined application program (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 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0060, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0060, filed 10/16/01, effective 12/1/01.]

**WAC 388-492-0070 How are my Washington state combined application program (WASHCAP) benefits calculated?** We calculate your WASHCAP benefits as follows:

(1) We begin with your gross income. (Social Security Administration (SSA) tells us how much income you have.)

(2) We subtract one hundred thirty-four dollars from your gross income to get your countable income.

(3) We figure your shelter cost as follows:

(a) If SSA tells us you pay three hundred two dollars or more a month for shelter, we use three hundred twelve dollars as your shelter cost; or

(b) If SSA tells us you pay three hundred one dollars a month or less for shelter, we use one hundred fifty 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 income by subtracting your shelter deduction from your countable income.

(6) We figure your WASHCAP benefits (allotment) by:

(a) Multiplying your net 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. 03-01-045, § 388-492-0070, filed 12/10/02, effective 1/10/03; 02-15-148, § 388-492-0070, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0070, filed 10/16/01, effective 12/1/01.]

**WAC 388-492-0080 Where do I report changes?** (1) You report all changes to Social Security Administration (SSA) according to their reporting requirements. Social Security reports these changes to your department of social and health services (DSHS) worker. SSA will not accept or report shelter costs changes until SSA does its redetermination.

(2) You do not have to report any changes to DSHS.

(3) You can choose to report the following changes to your Washington combined application project (WASHCAP) worker to see if you will get more food assistance benefits.

(a) A change in your address;

(b) An increase in your shelter costs; or

(c) An increase in your out-of-pocket medical expenses.

(4) If changes are reported to DSHS, proof will be required.

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0080, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0080, filed 10/16/01, effective 12/1/01.]

**WAC 388-492-0090 How often does my Washington state combined application program (WASHCAP) case need to be reviewed?** (1) Your eligibility for WASHCAP benefits must be reviewed at least every twenty-four months.

(2) Your certification period is the amount of time your assistance unit is eligible for WASHCAP benefits.

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0090, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0090, filed 10/16/01, effective 12/1/01.]

**WAC 388-492-0100 How is my eligibility for Washington state combined application program (WASHCAP) reviewed?** (1) If Social Security Administration (SSA) reviews your Supplemental Security Income (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 home and community services office (HCS).

(3) We do WASHCAP reviews by mail. If you bring your WASHCAP application to the local office, we will process the application as follows:

(a) If you get long-term care services, your local HCS office will process your application; or

(b) If you do not get long-term care services, the local office will forward your application to the WASHCAP central unit.

(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 your application is not complete, we will return it to you to complete.

(6) 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.

(7) If we get your completed one-page application form more than thirty days after your benefits end, your WASHCAP benefits open the first of the next month after you turn in your application and SSA shows you are eligible for WASHCAP in their system.

(8) If you want regular food assistance while you are waiting for WASHCAP benefits, you must apply for these benefits at the local CSO or HCS office.

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0100, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0100, filed 10/16/01, effective 12/1/01.]

**WAC 388-492-0110 What happens if my Washington state combined application program (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 at your local community services office (CSO) or home and community services (HCS) 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. If you are a HCS client, your medical case will remain at HCS.

(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 and tell you where to take your application to find out if you are eligible for benefits. If you are an HCS client, your case will remain at your HCS office.

(b) You will still receive the same medical benefits until we decide what medical programs you are eligible for under WAC 388-418-0025.

(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 unless you are a HCS client;

(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 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0110, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0110, filed 10/16/01, effective 12/1/01.]

**WAC 388-492-0120 What happens to my Washington state combined application program (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. This includes clients who:

(a) Are ineligible for food assistance under WAC 388-400-0040(9); or

(b) Did not cooperate with quality assurance as required under WAC 388-465-001.

[Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0120, filed 7/22/02, effective 9/1/02; 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 Washington state combined application program (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 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0130, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0130, filed 10/16/01, effective 12/1/01.]

## Chapter 388-500 WAC MEDICAL DEFINITIONS

### WAC

388-500-0005 Medical definitions.

**WAC 388-500-0005 Medical definitions.** Unless defined in this chapter or in other chapters of the *Washington Administrative Code*, use definitions found in the *Webster's New World Dictionary*. This section contains definitions of words and phrases the department uses in rules for medical programs. Definitions of words used for both medical and financial programs are defined under WAC 388-22-030.

**"Assignment of rights"** means the client gives the state the right to payment and support for medical care from a third party.

**"Base period"** means the time period used in the limited casualty program which corresponds with the months considered for eligibility.

**"Beneficiary"** means an eligible person who receives:

\*A federal cash Title XVI benefit; and/or

\*State supplement under Title XVI; or

\*Benefits under Title XVIII of the Social Security Act.

**"Benefit period"** means the time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for Medicare payments.

**"Cabulance"** means a vehicle for hire designed and used to transport a physically restricted person.

**"Carrier"** means:

\*An organization contracting with the federal government to process claims under Part B of Medicare; or

\*A health insurance plan contracting with the department.

**"Categorical assistance unit (CAU)"** means one or more family members whose eligibility for medical care is determined separately or together based on categorical relatedness.

"**Categorically needy**" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-503-0310, chapter 388-517 WAC and WAC 388-523-2305.

"**Children's health program**" means a state-funded medical program for children under age eighteen:

\*Whose family income does not exceed one hundred percent of the federal poverty level; and

\*Who are not otherwise eligible under Title XIX of the Social Security Act.

"**Coinsurance-Medicare**" means the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges.

"**Community services office (CSO)**" means an office of the department which administers social and health services at the community level.

"**Couple**" means, for the purposes of an SSI-related client, an SSI-related client living with a person of the opposite sex and both presenting themselves to the community as husband and wife. The department shall consider the income and resources of such couple as if the couple were married except when determining institutional eligibility.

"**Deductible-Medicare**" means an initial specified amount that is the responsibility of the client.

"**Part A of Medicare-inpatient hospital deductible**" means an initial amount of the medical care cost in each benefit period which Medicare does not pay.

"**Part B of Medicare-physician deductible**" means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.

"**Delayed certification**" means department approval of a person's eligibility for medicaid made after the established application processing time limits.

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

"**Early and periodic screening, diagnosis and treatment (EPSDT)**" also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.

"**Electronic fund transfers (EFT)**" means automatic bank deposits to a client's or provider's account.

"**Emergency medical condition**" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

\*Placing the patient's health in serious jeopardy;

\*Serious impairment to bodily functions; or

\*Serious dysfunction of any bodily organ or part.

"**Emergency medical expense requirement**" means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

"**Essential spouse**" see "spouse."

"**Extended care patient**" means a recently hospitalized Medicare patient needing relatively short-term skilled nursing and rehabilitative care in a skilled nursing facility.

"**Garnishment**" means withholding an amount from earned or unearned income to satisfy a debt or legal obligation.

"**Grandfathered client**" means:

\*A noninstitutionalized person who meets all current requirements for Medicaid eligibility except the criteria for blindness or disability; and

\*Was eligible for Medicaid in December 1973 as blind or disabled whether or not the person was receiving cash assistance in December 1973; and

\*Continues to meet the criteria for blindness or disability and other conditions of eligibility used under the Medicaid plan in December 1973; and

\*An institutionalized person who was eligible for Medicaid in December 1973 or any part of that month, as an inpatient of a medical institution or resident of an intermediate care facility that was participating in the Medicaid program and for each consecutive month after December 1973 who:

\*Continues to meet the requirements for Medicaid eligibility that were in effect under the state's plan in December 1973 for institutionalized persons; and

\*Remains institutionalized.

"**Health maintenance organization (HMO)**" means an entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.

"**Healthy kids,**" see "EPSDT."

"**Home health agency**" means an agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"**Hospital**" means an institution licensed as a hospital by the department of health.

"**Income for an SSI-related client,**" means the receipt by an individual of any property or service which the client can apply either directly, by sale, or conversion to meet the client's basic needs for food, clothing, and shelter.

"**Earned income**" means gross wages for services rendered and/or net earnings from self-employment.

"**Unearned income**" means all other income.

"**Institution**" means an establishment which furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally retarded.

"**Institution-public**" means an institution, including a correctional institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

"**Institution for mental diseases**" means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.



**"Institution for the mentally retarded or a person with related conditions"** means an institution that:

\*Is primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or a person with related conditions; and

\*Provides, in a protected residential setting, on-going care, twenty-four hour supervision, evaluation, and planning to help each person function at the greatest ability.

**"Institution for tuberculosis"** means an institution for the diagnosis, treatment, and care of a person with tuberculosis.

**"Medical institution"** means an institution:

\*Organized to provide medical care, including nursing and convalescent care;

\*With the necessary professional personnel, equipment and facilities to manage the health needs of the patient on a continuing basis in accordance with acceptable standards;

\*Authorized under state law to provide medical care; and

\*Staffed by professional personnel. Services include adequate physician and nursing care.

**"Intermediary"** means an organization having an agreement with the federal government to process Medicare claims under Part A.

**"Legal dependent"** means a person for whom another person is required by law to provide support.

**"Limited casualty program (LCP)"** means a medical care program for medically needy, as defined under WAC 388-503-0320 and for medically indigent, as defined under WAC 388-503-0370.

**"Medicaid"** means the federal aid Title XIX program under which medical care is provided to persons eligible for:

\*Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or

\*Medically needy program as defined in WAC 388-503-0320.

**"Medical assistance."** See **"Medicaid."**

**"Medical assistance administration (MAA)"** means the unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs.

**"Medical assistance unit (MAU)"** means one or more family members whose eligibility for medical care is determined separately or together based on financial responsibility.

**"Medical care services"** means the limited scope of care financed by state funds and provided to general assistance (GAU) and ADATSA clients.

**"Medical consultant"** means a physician employed by the department.

**"Medical facility"** see **"Institution."**

**"Medically indigent (MI)"** means a state-funded medical program for a person who has an emergency medical condition requiring hospital-based services.

**"Medically necessary"** is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or mal-

function. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

**"Medically needy (MN)"** is the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

**"Medicare"** means the federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

\***"Part A"** covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

\***"Part B"** is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

**"Medicare assignment"** means the method by which the provider receives payment for services under Part B of Medicare.

**"Month of application"** means the calendar month a person files the application for medical care. When the application is for the medically needy program, at the person's request and if the application is filed in the last ten days of that month, the month of application may be the following month.

**"Nursing facility"** means any institution or facility the department [of health] licenses as a nursing facility, or a nursing facility unit of a licensed hospital, that the:

\*Department certifies; and

\*Facility and the department agree the facility may provide skilled nursing facility care.

**"Outpatient"** means a nonhospitalized patient receiving care in a hospital outpatient or hospital emergency department, or away from a hospital such as in a physician's office, the patient's own home, or a nursing facility.

**"Patient transportation"** means client transportation to and from covered medical services under the federal Medicaid and state medical care programs.

**"Physician"** means a doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

**"Professional activity study (PAS)"** means a compilation of inpatient hospital data, conducted by the commission of professional and hospital activities, to determine the average length of hospital stay for patients.

**"Professional review organization for Washington (PRO-W)"** means the state level organization responsible for determining whether health care activities:

\*Are medically necessary;

\*Meet professionally acceptable standards of health care; and

\*Are appropriately provided in an outpatient or institutional setting for beneficiaries of Medicare and clients of Medicaid and maternal and child health.

**"Prosthetic devices"** means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to:

\*Artificially replace a missing portion of the body;

\*Prevent or correct physical deformity or malfunction;  
or

\*Support a weak or deformed portion of the body.

**"Provider" or "provider of service"** means an institution, agency, or person:

\*Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and

\*Is eligible to receive payment from the department.

**"Resources for an SSI-related client,"** means cash or other liquid assets or any real or personal property that an individual or spouse, if any, owns and could convert to cash to be used for support or maintenance.

\*If an individual can reduce a liquid asset to cash, it is a resource.

\*If an individual cannot reduce an asset to cash, it is not considered an available resource.

\*Liquid means properties that are in cash or are financial instruments which are convertible to cash such as, but not limited to, cash, savings, checking accounts, stocks, mutual fund shares, mortgage, or a promissory note.

\*Nonliquid means all other property both real and personal evaluated at the price the item can reasonably be expected to sell for on the open market.

**"Retroactive period"** means the three calendar months before the month of application.

**"Spell of illness"** see **"benefit period."**

**"Spenddown"** means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department.

**"Spouse"** means:

\***"Community spouse"** means a person living in the community and married to an institutionalized person or to a person receiving services from a home and community-based waived program as described under chapter 388-515 WAC.

\***"Eligible spouse"** means an aged, blind or disabled husband or wife of an SSI-eligible person, with whom such a person lives.

\***"Essential spouse"** means, a husband or wife whose needs were taken into account in determining old age assistance (OAA), aid to the blind (AB), or disability assistance (DA) client for December 1973, who continues to live in the home and to be the spouse of such client.

\***"Ineligible spouse"** means the husband or wife of an SSI-eligible person, who lives with the SSI-eligible person and who has not applied or is not eligible to receive SSI.

\***"Institutionalized spouse"** means a married person in an institution or receiving services from a home or community-based waived program.

\***"Nonapplying spouse"** means an SSI-eligible person's husband or wife, who has not applied for assistance.

**"SSI-related"** means an aged, blind or disabled person not receiving an SSI cash grant.

**"Supplemental security income (SSI) program, Title XVI"** means the federal grant program for aged, blind, and disabled established by section 301 of the Social Security amendments of 1972, and subsequent amendments, and administered by the Social Security Administration (SSA).

**"Supplementary payment (SSP)"** means the state money payment to persons receiving benefits under Title XVI, or who would, but for the person's income, be eligible for such benefits, as assistance based on need in supplementation of SSI benefits. This payment includes:

\***"Mandatory state supplement"** means the state money payment to a person who, for December 1973, was a client receiving cash assistance under the department's former programs of old age assistance, aid to the blind and disability assistance; and

\***"Optional state supplement"** means the elective state money payment to a person eligible for SSI benefits or who, except for the level of the person's income, would be eligible for SSI benefits.

**"Third party"** means any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

**"Title XIX"** is the portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

**"Transfer"** means any act or omission to act when title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person; including delivery of personal property, bills of sale, deeds, mortgages, pledges, or any other instrument conveying or relinquishing an interest in property. Transfer of title to a resource occurs by:

\*An intentional act or transfer; or

\*Failure to act to preserve title to the resource.

**"Value-fair market for an SSI-related person"** means the current value of a resource at the price for which the resource can reasonably be expected to sell on the open market.

**"Value of compensation received"** means, for SSI-related medical eligibility, the gross amount paid or agreed to be paid by the purchaser of a resource.

**"Value-uncompensated"** means, for SSI-related medical eligibility, the fair market value of a resource, minus the amount of compensation received in exchange for the resource.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-500-0005, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-500-0005, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-500-0005, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-80-005, 388-82-006, 388-92-005 and 388-93-005.]

**Reviser's note:** RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

## Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—  
GENERAL

## WAC

388-501-0050	Medical and dental general coverage.
388-501-0100	Subrogation.
388-501-0125	Advance directives.
388-501-0135	Patient requiring regulation.
388-501-0160	Exception to rule—Request for a noncovered medical or dental service, or related equipment.
388-501-0165	Determination process for coverage of medical equipment and medical or dental services.
388-501-0175	Medical care provided in bordering cities.
388-501-0180	Out-of-state medical care.
388-501-0200	Third-party resources.
388-501-0213	Case management services.
388-501-0300	Limits on scope of medical program services.

DISPOSITION OF SECTIONS FORMERLY  
CODIFIED IN THIS CHAPTER

388-501-0105	Applicability. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0105, filed 5/3/94, effective 6/3/94. Formerly WAC 388-80-002.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-501-0110	Purpose of the medical care program. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0110, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-81-005, 388-81-025, 388-99-005 and 388-100-005.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
388-501-0130	Administrative controls. [Statutory Authority: RCW 74.08.090 and 74.09.290. 96-06-041 (Order 3949), § 388-501-0130, filed 3/1/96, effective 4/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-015.] Repealed by 00-23-014, filed 11/3/00, effective 12/4/00. Statutory Authority: RCW 74.08.090, 43.20B.675.
388-501-0140	Fraud. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0140, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-446-0001.
388-501-0150	Confidential records. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-035.] Repealed by 00-14-047, filed 6/30/00, effective 7/31/00.
388-501-0170	Third party resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0170, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-010 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0540.
388-501-0190	Maternity care distressed area. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0190, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-070.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

**WAC 388-501-0050 Medical 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 waived 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 388-501-0100 Subrogation.** (1) For the purpose of this section, "liable third party" means:

(a) The tort-feasor or insurer of the tort-feasor, or both; and

(b) Any person who is liable to provide coverage for the illness or injuries for which the medical assistance administration (MAA) is providing assistance or residential care. That liability must be based on any contract or insurance purchased by the client or any other person.

(2) As a condition of medical care eligibility, a client must assign to the state any right the client may have to receive payment from any other third party. An eligible client who receives health care items or services from the state under medical care programs under chapter 74.09 RCW and who has a right to payment from any other third party for those items or services, subrogates that right of payment to the state. This applies except as provided in subsection (3) of this section.

(3) To the extent authorized by a contract executed under RCW 74.09.522, a managed health care plan has the rights and remedies of the department as provided in RCW 43.20B.060 and 70.09.180.

(4) MAA is not responsible to pay for medical care for a client whose personal injuries are caused by the negligence or wrongdoing of another. However, MAA may provide the medical care required as a result of an injury to the client if both of the following apply:

(a) The client is otherwise eligible for medical care; and

(b) No other liable third party has been identified at the time the claim is filed.

(5) The department may pursue its right to recover the value of medical care provided to an eligible client from any liable third party as a subrogee, assignee, or by enforcement of its public assistance lien as provided under RCW 43.20B.-040 through 43.20B.070.

(6) Recovery pursuant to the subrogation rights, assignment, or enforcement of the lien granted to the department is not reduced, prorated, or applied to only a portion of a judgment, award, or settlement. The secretary of the department or the secretary's designee must consent in writing to any discharge or compromise of any settlement or judgment of a lien created under RCW 42.20B.060. The department considers the compromise or discharge of a medical care lien only as authorized by federal regulation at 42 CFR 433.139.

(7) The doctrine of equitable subrogation does not apply to defeat, reduce, or prorate any recovery made by the department that is based on its assignment, lien, or subrogation rights.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0100, filed 12/14/99, effective 1/14/00.]

**WAC 388-501-0125 Advance directives.** In this section "advance directive" means a written instruction, recognized under state law, relating to the provision of health care when an individual is incapacitated.

(1) All agencies, health maintenance organizations (HMOs), and facilities including hospitals, critical access hospitals, skilled nursing and nursing facilities, and providers of in-home care services that serve medical assistance clients

eighteen years of age or older must have written policies and procedures concerning advance directives.

(2) The agencies, HMOs, and facilities must give the following information to each adult client, in writing and orally, and in a language the client understands:

(a) A statement about the client's right to:

(i) Make decisions concerning the client's medical care;

(ii) Accept or refuse surgical or medical treatment;

(iii) Execute an advance directive;

(iv) Revoke an advance directive at any time;

(b) The written policies of the agency, HMO, or facility concerning advance directives, including any policy that would preclude it from honoring the client's advance directive; and

(c) The client's rights under state law.

(3) The agencies, HMOs, and facilities must provide the information described in subsection (2) of this section to adult clients as follows:

(a) Hospitals at the time the client is admitted as an inpatient;

(b) Nursing facilities at the time the client is admitted as a resident;

(c) Providers of in-home care services before the client comes under the care of the provider or at the time of the first home visit so long as it is provided prior to care being rendered;

(d) Hospice programs at the time the client initially receives hospice care from the program; and

(e) HMOs at the time the client enrolls with the organization.

(4) If the client is incapacitated at the time of admittance or enrollment and is unable to receive information or articulate whether or not the client has executed an advance directive, the agencies, HMOs, and facilities:

(a) May give information about advance directives to the person authorized by RCW 7.70.065 to make decisions regarding the client's health care;

(b) Must document in the client's file that the client was unable to communicate whether an advance directive exists if no one comes forward with a previously executed advance directive; and

(c) Must give the information described in subsection (2) to the client once the client is no longer incapacitated.

(5) The agencies, HMOs, and facilities must:

(a) Review each client's medical record prior to admittance or enrollment to determine if the client has an advance directive;

(b) Honor the directive or follow the process explained in subsection (6); and

(c) Not refuse, put conditions on care, or otherwise discriminate against a client based on whether or not the client has executed an advance directive.

(6) If an agency, HMO, or facility has a policy or practice that would keep it from honoring a client's advance directive, the facility or organization must:

(a) Tell the client prior to admission or enrollment or when the client executes the directive;

(b) Provide the client with a statement clarifying the differences between institution-wide conscience objections and those that may be raised by individual physicians and

explaining the range of medical conditions or procedures affected;

(c) Prepare and keep a written plan of intended actions according to the requirements in RCW 70.122.060 if the client still chooses to retain the facility or organization; and

(d) Make a good faith effort to transfer the client to another health care practitioner who will honor the directive if the client chooses not to retain the facility or organization.

(7) A health care practitioner may refuse to implement a directive, and may not be discriminated against by the facility or organization for refusing to withhold or withdraw life-sustaining treatment.

(8) The agencies, HMOs, and facilities must document, in a prominent place in each client's medical record, whether or not the client has executed an advance directive.

(9) The agencies, HMOs, and facilities must educate staff and the community on issues concerning advance directives.

(10) The agencies, HMOs, and facilities must comply with state and federal laws and regulations concerning advance directives, including but not limited to: 42 USC 1396a, subsection (w); 42 CFR 417.436; 42 CFR 489 Subpart I; and chapter 70.122 RCW.

[Statutory Authority: RCW 74.08.090, 74.09.035, 00-19-050, § 388-501-0125, filed 9/14/00, effective 10/15/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0125, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-017.]

**WAC 388-501-0135 Patient requiring regulation.** (1) Patient requiring regulation (PRR) is a health and safety program for clients needing help in the appropriate use of medical services. A client in PRR is restricted to one primary care provider (PCP) and one pharmacy. Enrollment in the PRR program is for twenty-four months.

(2) Any client of the department's medical programs is reviewed for assignment to PRR if:

(a) The client has:

(i) Made repeated and documented efforts to seek medically unnecessary health services; and

(ii) Been counseled at least once by a health care provider or managed care plan representative about the appropriate use of health care services; or

(b) Any three of the following conditions have been met or exceeded in a ninety-day period. The client:

(i) Received services from four different physicians; or

(ii) Had prescriptions filled by four different pharmacies;

or

(iii) Received ten prescriptions; or

(iv) Had prescriptions filled by four different prescribers; or

(v) Used two emergency room (ER) visits.

(3) If subsections (2)(a) or (b) of this section apply, then the client's use of medical services is reviewed by the department. The review considers the client's diagnoses, history of services provided, or other medical information supplied by the health care provider or managed care plan. The review is done by a nurse consultant, physician, or other qualified medical staff according to established medical review guidelines.

(4) If the medical review finds that the client uses inappropriate or medically unnecessary services the client receives written notice which:

(a) Asks the client to select a primary care provider and one pharmacy; and

(b) Notifies the client of their right to request a fair hearing within ninety days (see subsection (6) of this section); and

(c) Requires the client to respond within twenty days by:

(i) Selecting a primary care provider and pharmacy; or

(ii) Submitting additional medical information, which justifies the client's use of medical services; or

(iii) Writing or calling the PRR representative, who is identified in the PRR notice, requesting assistance; or

(iv) Requesting a fair hearing (see subsection (6) of this section).

(5) A client who does not respond to the notice within twenty days is assigned to the PRR program. The department assigns the client to a PCP and pharmacy. The client may change the assigned PCP and pharmacy once within the initial sixty days. The assigned providers will be:

(a) Located in the client's local geographic area; and

(b) Reasonably accessible to the client.

(6) A client has ninety days to request a fair hearing. A client who requests a fair hearing within twenty days from the date they receive notice under subsection (4) of this section will not be assigned to the PRR program until a fair hearing decision is made. A client who requests a fair hearing after twenty days may have been assigned a PCP and pharmacist. An assigned client will remain in PRR until a fair hearing decision is made.

(7) When a PRR client chooses or the department assigns a PCP and pharmacy, the PCP and pharmacy requirements are:

(a) A PCP supervises and coordinates medical care for the client. The PCP makes referrals for specialist care and provides continuity of care. A PCP must be:

(i) A physician who meets the criteria under WAC 388-502-0020 and 388-502-0030; or

(ii) An advanced registered nurse practitioner (ARNP) who meets criteria under WAC 388-502-0020 and 388-502-0030; or

(iii) A licensed physician assistant, practicing with a sponsoring supervising physician.

(b) A single pharmacy fills all prescriptions for the client. For fee for service clients the pharmacy must be contracted with MAA.

(c) For clients enrolled in a managed care plan, the pharmacy and PCP must be contracted with the client's managed care plan.

(8) The PRR client's medical assistance identification card (MAID) will be marked in the "restricted" column.

(9) A client in PRR cannot change their PCP or pharmacy for twelve months unless the:

(a) Client changes to a residence outside the provider's geographic area; or

(b) PCP or pharmacy moves out of the client's geographical area; or

(c) PCP or pharmacy refuses to continue as the client's provider; or

(d) Client was assigned providers. The client may change the assigned providers once within sixty days of the initial assignment.

(10) A PRR client enrolled in a managed care plan must select a PCP and pharmacy from those identified as available within their plan. In addition to the reasons given in subsection (9) of this section, the client may change a provider if the:

(a) Chosen or assigned PCP or pharmacy no longer participates with their plan. The client may:

(i) Select a new PCP from the list of available PCPs provided by the plan; or

(ii) Transfer enrollment of all family members to the new department-contracted plan which the established PCP has joined.

(b) Client chooses a new plan during the managed care program's open enrollment period, which occurs during the twenty-four-month PRR enrollment period as defined in subsection (1) of this section.

(11) After twenty-four months, a PRR client's use of services is reviewed. A client is removed from PRR if:

(a) The billing records show the care received was reasonable and appropriate; or

(b) The PCP reports the services requested and received were reasonable and appropriate.

(12) If the client is not removed from PRR under subsection (11) of this section, the client continues to be in PRR for an additional twelve months. After that twelve-period, the client is reviewed again according to subsection (11)(a) and (b) of this section.

(13) Under the PRR program, MAA or the client's managed care plan will pay for only:

(a) Those services authorized by the PCP, the PCP-referred specialist, or the pharmacist; or

(b) Emergencies services; or

(c) Family planning services; or

(d) Women's health care services. A client enrolled with a managed care plan must self-refer to providers within the plan's network.

The client may be responsible for payment of services not covered by the PRR program.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-501-0135, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-501-0135, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-03-038, § 388-501-0135, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0135, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-100.]

**WAC 388-501-0160 Exception to rule—Request for a noncovered medical or dental service, or related equipment.** A client and/or their provider may request prior authorization for MAA to pay for a noncovered medical or dental service, or related equipment. This is called an exception to rule.

(1) MAA cannot approve an exception to rule if the exception violates state or federal law or federal regulation.

(2) For MAA to consider the request, sufficient client-specific information and documentation must be submitted for the MAA medical director or designee to determine if:

(a) The client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s); and

(b) The requested service or equipment will result in lower overall costs of care for the client.

(3) The MAA medical director or designee evaluates and considers requests on a case-by-case basis according to the information and documentation submitted from the provider.

(4) Within fifteen working days of MAA's receipt of the request, MAA notifies the provider and the client, in writing, of MAA's decision to grant or deny the exception to rule.

(5) Clients do not have a right to a fair hearing on exception to rule decisions.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035. 00-03-035, § 388-501-0160, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-030.]

**WAC 388-501-0165 Determination process for coverage of medical equipment and medical or dental services.** This section applies to fee for service (FFS) requests for medical equipment and medical or dental services that require prior authorization.

(1) MAA evaluates requests on an individual basis, and bases the decision to approve or deny on submitted and obtainable evidence.

(2) MAA denies a request when MAA determines the service or equipment is not:

(a) Medically/dentally necessary;

(b) Covered; or

(c) Generally considered as acceptable treatment by the medical/dental profession based on the medical/dental standard of practice, or is investigative or experimental in nature. However, MAA may approve such a request if the provider submits sufficient objective clinical evidence demonstrating that a client's particular circumstances make the request medically/dentally necessary.

(3) Requests for covered services and equipment are approved when MAA determines that the service or equipment is medically necessary as defined in WAC 388-500-0005 or dentally necessary as defined in WAC 388-535-1050.

(4) The examining physician/dentist responsible for the client's diagnosis and/or treatment must submit specific evidence sufficient to determine if the covered service or equipment is medically/dentally necessary. Such evidence may include, but is not limited to:

(a) A client-specific physiological description of the disease, injury, impairment, or other ailment;

(b) Pertinent laboratory findings;

(c) X-ray and/or imaging reports;

(d) Individual patient records pertinent to the case or request;

(e) Photographs and/or videos when requested by MAA;

(f) Dental x-rays; and

(g) Objective medical/dental information, including but not limited to medically/dentally acceptable clinical findings and diagnoses resulting from physical or mental examinations.



(5) MAA gives substantial weight to objective medical/dental information and resulting conclusions from an examining physician/dentist responsible for the client's diagnosis and/or treatment.

(a) MAA accepts the examining physician's/dentist's uncontradicted and adequately substantiated conclusion with respect to medical/dental necessity, unless MAA presents specific detailed reasons for rejecting that conclusion. MAA's reasons will be consistent with sound medical/dental practice and supported by objective medical/dental information in the client's file.

(b) If two or more examining physicians/dentists provide conflicting medical/dental information or conclusions about medical/dental necessity for the request under review, MAA will use all information submitted to reach a decision. If MAA concludes the request is not medically/dentally necessary, MAA will enumerate specific reasons, supported by objective medical/dental information in the client's file, for that decision.

(6) Within fifteen calendar days of receiving a request:

(a) MAA approves or denies the request; or

(b) Requests additional justifying information from the prescribing physician, dentist, specialty therapist, and/or service vendor if the documentation submitted is insufficient to reasonably determine medical or dental necessity. Examples of information that MAA may request are shown in subsection (4) of this section. MAA sends a copy of the request to the client at the same time.

(i) If MAA does not receive the information within thirty days of the date requested, MAA denies the original request within the next five working days on the basis of insufficient justification of medical/dental necessity;

(ii) If MAA receives the information within thirty days, MAA makes a final determination on the request within five working days of the receipt of that additional information.

(7) When MAA denies all or part of a request for a covered service(s) or equipment, MAA sends the client and the provider written notice of the denial within five working days of the decision. The notice includes:

(a) The WAC reference(s) used as a basis for the decision;

(b) A summary statement of the specific facts MAA relied upon for the decision;

(c) An explanation of the reasons for the denial, including the reasons why the specific facts relied upon did not meet the requirements for approval;

(d) When required by subsection (5) of this section, a specific statement of the reasons and supporting facts for rejecting any medical/dental information or conclusions of an examining physician/dentist;

(e) Notice of the client's right to a fair hearing and filing deadlines;

(f) Instructions about how to request the hearing;

(g) A statement that the client may be represented at the hearing by legal counsel or other representative; and

(h) Upon the client's request, the name and address of the nearest legal services office.

(8) When MAA receives a request for a noncovered service(s) or equipment, MAA may:

(a) Approve the request as an exception to rule according to WAC 388-501-0160; or

(b) Deny the request as a noncovered service, and send the client and the provider written notice of the denial within five working days of the decision. The notice includes:

(i) The WAC reference(s) used as a basis for the decision;

(ii) The reason for the denial;

(iii) Notice of the client's right to a fair hearing and filing deadlines;

(iv) Instructions about how to request the hearing;

(v) A statement that the client may be represented at the hearing by legal counsel or other representative; and

(vi) Upon the client's request, the name and address of the nearest legal services office.

(9) If a fair hearing is requested, MAA or the client may request an independent medical/dental assessment. MAA will pay for the independent assessment if MAA agrees that it is necessary, or a fair hearing judge determines that the assessment is necessary.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035, 00-03-035, § 388-501-0165, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0165, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-038.]

**WAC 388-501-0175 Medical care provided in bordering cities.** (1) An eligible Washington state resident may receive medical care in a recognized out-of-state bordering city on the same basis as in-state care.

(2) The only recognized bordering cities are:

(a) Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho; and

(b) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

[Statutory Authority: RCW 74.04.050 and 74.08.090, 00-01-088, § 388-501-0175, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0175, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-130.]

**WAC 388-501-0180 Out-of-state medical care.** (1) The department of social and health services (DSHS) considers cities bordering Washington state and listed in WAC 388-501-0175 the same as in-state cities for:

(a) Medical care coverage under all medical programs administered by the medical assistance administration (MAA); and

(b) Reimbursement purposes.

(2) The department does not cover out-of-state medical care for clients under the following state-administered (Washington state medical care only) medical programs:

(a) General assistance-unemployable (GA-U);

(b) Alcohol and Drug Addiction Treatment and Support Act (ADATSA); or

(c) Medically indigent program (MIP).

(3) Subject to the exceptions and limitations in this section, the department covers out-of-state medical care provided to eligible clients when the services are:

(a) Within the scope of the client's medical care program as specified under chapter 388-529 WAC; and

(b) Medically necessary as defined in WAC 388-500-0005.

(4) If the client travels out-of-state expressly to obtain medical care, the medical services must have prior authorization through the department's determination process described in WAC 388-501-0165.

(5) See WAC 388-501-0165 for the department's determination process for requests for:

(a) Any service that is listed in any Washington Administrative Code section as noncovered;

(b) A service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550; and

(c) A covered service that is subject to the department's limitations or other restrictions and the request for the service exceeds those limitations or restrictions.

(6) The department determines out-of-state coverage for transportation services, including ambulance services, according to chapter 388-546 WAC.

(7) The department reimburses an out-of-state provider for medical care provided to an eligible client if the provider:

(a) Meets the licensing requirements of the state in which care is provided;

(b) Contracts with the department to be an enrolled provider; and

(c) Meets the same criteria for payment as in-state providers.

[Statutory Authority: RCW 74.08.090 and 74.09.035. 01-01-011, § 388-501-0180, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0180, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-135 and 388-92-015.]

**WAC 388-501-0200 Third-party resources.** (1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the EPSDT program.

(3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.

(5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:

(a) Third-party payment when the payment is less than MAA's maximum allowable rate; or

(b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.

(6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

[Statutory Authority: RCW 74.04.050, 74.08.090. 00-11-141, § 388-501-0200, filed 5/23/00, effective 6/23/00; 00-01-088, § 388-501-0200, filed 12/14/99, effective 1/14/00.]

**WAC 388-501-0213 Case management services.** (1) The department shall provide case management services to medical assistance recipients:

(a) By contract with providers of case management services.

(b) Limited to target groups of clients as determined by the contract.

(c) Limited to services as determined by the contract.

(2) Case management services are services which will assist clients in gaining access to needed medical, social, educational, and other services.

[00-23-067, recodified as § 388-501-0213, filed 11/15/00, effective 11/15/00. Statutory Authority: RCW 74.08.090. 87-22-094 (Order 2555), § 388-86-017, filed 11/4/87.]

**WAC 388-501-0300 Limits on scope of medical program services.** (1) The medical assistance administration (MAA) 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 waived 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

388-502-0010	Payment—Eligible providers defined.
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388-502-0260	Appeals and dispute resolution for providers with contracts other than core provider agreements.

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

388-502-0205	Civil rights. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0205, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-010 (part).] Repealed by 00-15-050, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530.
388-502-0250	Interest penalties—Providers. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.] Amended and decodified by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090. Later promulgation, see WAC 388-502-0130.

**WAC 388-502-0010 Payment—Eligible providers defined.** The department reimburses enrolled providers for covered medical services, equipment and supplies they provide to eligible clients.

(1) To be eligible for enrollment, a provider must:

(a) Be licensed, certified, accredited, or registered according to Washington state laws and rules; and

(b) Meet the conditions in this chapter and chapters regulating the specific type of provider, program, and/or service.

(2) To enroll, an eligible provider must sign a core provider agreement or a contract with the department and receive a unique provider number.

(3) Eligible providers listed in this subsection may request enrollment. Out-of-state providers listed in this subsection are subject to conditions in WAC 388-502-0120.

(a) Professionals:

(i) Advanced registered nurse practitioners;

(ii) Anesthesiologists;

(iii) Audiologists;

(iv) Chiropractors;

(v) Dentists;

(vi) Dental hygienists;

(vii) Denturists;

(viii) Dietitians or nutritionists;

(xiv) Maternity case managers;

(x) Midwives;

(xi) Occupational therapists;

(xii) Ophthalmologists;

(xiii) Opticians;

(xiv) Optometrists;

(xv) Orthodontists;

(xvi) 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 388-502-0030 Denying, suspending, and terminating a provider's enrollment.** (1) The department terminates enrollment or does not enroll or reenroll a provider if, in the department's judgement, it may be a danger to the health or safety of clients.

(2) Except as noted in subsection (3) of this section, the department does not enroll or reenroll a provider to whom any of the following apply:

- (a) Has a restricted professional license;
- (b) Has been terminated, excluded, or suspended from Medicare/Medicaid; or
- (c) Has been terminated by the department for quality of care issues or inappropriate billing practices.

(3) The department may choose to enroll or reenroll a provider who meets the conditions in subsection (2) of this section if all of the following apply:

- (a) The department determines the provider is not likely to repeat the violation that led to the restriction or sanction;
- (b) The provider has not been convicted of other offenses related to the delivery of professional or other medical services in addition to those considered in the previous sanction; and

(c) If the United States Department of Health and Human Services (DHHS) or Medicare suspended the provider from Medicare, DHHS or Medicare notifies the department that the provider may be reinstated.

(4) The department gives thirty days written notice before suspending or terminating a provider's enrollment. However, the department suspends or terminates enrollment immediately if any one of the following situations apply:

- (a) The provider is convicted of a criminal offense related to participation in the Medicare/Medicaid program;
- (b) The provider's license, certification, accreditation, or registration is suspended or revoked;
- (c) Federal funding is revoked;
- (d) By investigation, the department documents a violation of law or contract;
- (e) The MAA medical director or designee determines the quality of care provided endangers the health and safety of one or more clients; or
- (f) The department determines the provider has intentionally used inappropriate billing practices.

(5) The department may terminate a provider's number if:

(a) The provider does not disclose ownership or control information;

(b) The provider does not submit a claim to the department for twenty-four consecutive months;

(c) The provider's address on file with the department is incorrect;

(d) The provider requests a new provider number (e.g., change in tax identification number or ownership); or

(e) The provider voluntarily withdraws from participation in the medical assistance program.

(6) Nothing in this chapter obligates the department to enroll all eligible providers who request enrollment.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0030, filed 7/17/00, effective 8/17/00.]

**WAC 388-502-0100 General conditions of payment.**

(1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

- (a) The service is within the scope of care of the client's medical assistance program;
- (b) The service is medically or dentally necessary;
- (c) The service is properly authorized;
- (d) The provider bills within the timeframe set in WAC 388-502-0150;
- (e) The provider bills according to department rules and billing instructions; and
- (f) The provider follows third-party payment procedures.

(2) The department is the payer of last resort, unless the other payer is:

- (a) An Indian health service;
- (b) A crime victims program through the department of labor and industries; or
- (c) A school district for health services provided under the Individuals with Disabilities Education Act.

(3) The provider must accept Medicare assignment for claims involving clients eligible for both Medicare and medical assistance before MAA makes any payment.

(4) The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.

(5) The department may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:

- (a) The department considered the person eligible at the time of service;
- (b) The service was not otherwise paid for; and
- (c) The provider submits a request for payment to the department.

(6) The department does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.

(7) Information about medical care for jail inmates is found in RCW 70.48.130.

(8) The department pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0100, filed 7/17/00, effective 8/17/00.]

**WAC 388-502-0110 Conditions of payment—Medicare deductible and coinsurance.** (1) The department pays the deductible and coinsurance amounts for a client participating in Parts A and/or B of Medicare (Title XVIII of the Social Security Act) when the:

(a) Total reimbursement to the provider from Medicare and the department does not exceed the rate in the department's fee schedule; and

(b) Provider accepts assignment for Medicare payment.

(2) The department pays the deductible and coinsurance amounts for a client who has Part A of Medicare. If the client:

(a) Has not exhausted lifetime reserve days, the department considers the Medicare diagnostic related group (DRG) as payment in full; or

(b) Has exhausted lifetime reserve days during an inpatient hospital stay, the department considers the Medicare DRG as payment in full until the Medicaid outlier threshold is reached. After the Medicaid outlier threshold is reached, the department pays an amount based on the policy described in the Title XIX state plan.

(3) If Medicare and Medicaid cover the service, the department pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less. If only Medicare and not Medicaid covers the service, the department pays only the deductible and/or coinsurance up to Medicare's allowed amount.

(4) The department bases its outlier policy on the methodology described in the department's Title XIX state plan, methods, and standards used for establishing payment rates for hospital inpatient services.

(5) The department pays, according to department rules and billing instructions, for Medicaid covered services when the client exhausts Medicare benefits.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0110, filed 7/17/00, effective 8/17/00.]

**WAC 388-502-0120 Payment for medical care outside the state of Washington.** (1) The medical assistance administration (MAA) pays the provider of service in designated bordering cities as if the care were provided within the state of Washington (see WAC 388-501-0175). MAA requires providers to meet the licensing requirements of the state in which care is rendered.

(2) MAA does not authorize payment for out-of-state medical care furnished to clients in state-only funded medical programs.

(3) MAA applies the three-month retroactive coverage as defined under WAC 388-500-0005 to covered medical services that are furnished to eligible clients by out-of-state providers.

(4) MAA requires out-of-state providers to obtain a valid provider number in order to be reimbursed.

(a) MAA requires a completed core provider agreement, and furnishes the necessary billing forms, instructions, and a core provider agreement to providers.

(b) MAA issues a provider number after receiving the signed core provider agreement.

(c) The billing requirements of WAC 388-502-0100 and 388-502-0150 apply to out-of-state providers.

(2003 Ed.)

(5) For Medicare-eligible clients, providers must submit Medicare claims, on the appropriate Medicare billing form, to the intermediary or carrier in the provider's state. If the provider checks the Medicare billing form to show the state of Washington as being responsible for medical billing, the intermediary or carrier may either:

(a) Forward the claim to MAA on behalf of the provider; or

(b) Return the claim to the provider, who then submits it to MAA.

(6) For covered services for eligible clients, MAA reimburses approved out-of-state nursing facilities at the lower of:

(a) The billed amount; or

(b) The adjusted statewide average reimbursement rate for in-state nursing facility care.

(7) For covered services for eligible clients, MAA reimburses approved out-of-state hospitals at the lower of:

(a) The billed amount; or

(b) The adjusted statewide average reimbursement rate for in-state hospitals.

(8) For covered services for eligible clients, MAA reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX Medicaid program.

[Statutory Authority: RCW 74.08.090, 01-02-076, § 388-502-0120, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-502-0120, filed 12/14/99, effective 1/14/00.]

**WAC 388-502-0130 Interest penalties—Providers.**

(1) Providers who are enrolled as contractors with the department's medical care programs may be assessed interest on excess benefits or other inappropriate payments. Nursing home providers are governed by WAC 388-96-310 and are not subject to this section.

(2) The department assesses interest when:

(a) The excess benefits or other inappropriate payments were not the result of department error; and

(b) A provider is found liable for receipt of excess benefits or other payments under RCW 74.09.220; or

(c) A provider is notified by the department that repayment of excess benefits or other payments is due under RCW 74.09.220.

(3) The department assesses interest at the rate of one percent for each month the overpayment is not satisfied. Daily interest calculations and assessments are made for partial months.

(4) Interest is calculated beginning from the date the department receives payment from the provider. Interest ceases to be calculated and collected from the provider once the overpayment amount is received by the department.

(5) The department calculates interest and amounts, which are identified on all department collection notices and statements.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, recodified as § 388-502-0130, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.]

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**WAC 388-502-0150 Time limits for providers to bill MAA.** Providers may bill the **medical assistance administration (MAA)** for covered services provided to eligible clients.

(1) MAA requires providers to submit initial claims and adjust prior claims in a timely manner. MAA has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims, see subsections (7) and (8) of this section; and

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section.

(2) The provider must submit claims to MAA as described in MAA's billing instructions.

(3) Providers must submit their claim to MAA and have an internal control number (ICN) assigned by MAA within three hundred sixty-five days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders MAA to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) MAA may grant exceptions to the three hundred sixty-five-day time limit for initial claims when billing delays are caused by either of the following:

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

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

(5) MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to MAA's billing limits.

(6) When a client is covered by both Medicare and MAA, the provider must bill Medicare for the service before billing Medicaid. If Medicare:

(a) Pays the claim the provider must bill MAA within six months of the date Medicare processes the claim; or

(b) Denies payment of the claim, MAA requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) MAA allows providers to resubmit, modify, or adjust any claim, other than a prescription drug claim, with a timely ICN within thirty-six months of the date the service was provided to the client. This applies to any claim, other than a prescription drug claim, that met the time limits for an initial claim, whether paid or denied. MAA does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(8) The thirty-six-month period described in subsection (7) of this section does not apply to overpayments that a provider must refund to the department. After thirty-six months, MAA does not allow a provider to refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(9) MAA allows providers to resubmit, modify, or adjust any prescription drug claim with a timely ICN within fifteen months of the date the service was provided to the client. After fifteen months, MAA does not accept any prescription drug claim for resubmission, modification or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the department. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) MAA does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements of this section, resulting in the claim not being paid by MAA.

[Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.45. 00-14-067, § 388-502-0150, filed 7/5/00, effective 8/5/00.]

**WAC 388-502-0160 Billing a client.** (1) A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay 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 client'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;

(f) The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA; or

(g) The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a three-dollar copayment may be imposed on the client by the hospital, except when:

(i) Reasonable alternative access to care was not available;

(ii) The "indigent person" criteria in WAC 246-453-040(1) applies;

(iii) The client was eighteen years of age or younger;

(iv) The client was pregnant or within sixty days post-pregnancy;

(v) The client is an American Indian or Alaska Native;

(vi) The client was enrolled in a MAA managed care plan, including primary care case management (PCCM);

(vii) The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or

(viii) The client receives waived services such as community options program entry system (COPES) and community alternatives program (CAP).

(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.

(2003 Ed.)

(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 and under the circumstance described in subsection (3)(g) of this section.

(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, 74.09.055, 2001 c 7, Part II. 02-12-070, § 388-502-0160, filed 5/31/02, effective 7/1/02. 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.]

**WAC 388-502-0210 Statistical data-provider reports.** (1) At the request of the medical assistance administration (MAA), all providers enrolled with MAA programs must submit full reports, as specified by MAA, of goods and services furnished to eligible medical assistance clients. MAA furnishes the provider with a standardized format to report these data.

(2) MAA analyzes the data collected from the providers' reports to secure statistics on costs of goods and services furnished and makes a report of the analysis available to MAA's advisory committee, the state welfare medical care committee, representative organizations of provider groups enrolled with MAA, and any other interested organizations or individuals.

[Statutory Authority: RCW 74.08.090, 74.09.035, 00-15-049, § 388-502-0210, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-502-0210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-020.]

**WAC 388-502-0220 Administrative appeal contractor/provider rate reimbursement.** (1) Any enrolled contractor/provider of medical services has a right to an administrative appeal when the contractor/provider disagrees with the medical assistance administration's (MAA) reimbursement rate. The exception to this is nursing facilities governed by WAC 388-96-904.

(2) The first level of appeal. A contractor/provider who wants to contest a reimbursement rate must file a written appeal with MAA.

(a) The appeal must include all of the following:

(i) A statement of the specific issue being appealed;

(ii) Supporting documentation; and

(iii) A request for MAA to recalculate the rate.

(b) When a contractor/provider appeals a portion of a rate, MAA may review all components of the reimbursement rate.

(c) In order to complete a review of the appeal, MAA may do one or both of the following:

(i) Request additional information; and/or

(ii) Conduct an audit of the documentation provided.

(d) MAA issues a decision or requests additional information within sixty calendar days of receiving the rate appeal request.

(i) When MAA requests additional information, the contractor/provider has forty-five calendar days from the date of MAA's request to submit the additional information.

(ii) MAA issues a decision within thirty calendar days of receipt of the completed information.

(e) MAA may adjust rates retroactively to the effective date of a new rate or a rate change. In order for a rate increase to be retroactive, the contractor/provider must file the appeal within sixty calendar days of the date of the rate notification letter from MAA. MAA does not consider any appeal filed after the sixty day period to be eligible for retroactive adjustment.

(f) MAA may grant a time extension for the appeal period if the contractor/provider makes such a request within the sixty-day period referenced under (e) of this subsection.

(g) Any rate increase resulting from an appeal filed within the sixty-day period described in subsection (2)(e) of this section is effective retroactively to the rate effective date in the notification letter.

(h) Any rate increase resulting from an appeal filed after the sixty-day period described in subsection (2)(e) of this section is effective on the date the rate appeal is received by the department.

(i) Any rate decrease resulting from an appeal is effective on the date specified in the appeal decision letter.

(j) Any rate change that MAA grants that is the result of fraudulent practices on the part of the contractor/provider as described under RCW 74.09.210 is exempt from the appeal provisions in this chapter.

(3) The second level of appeal. When the contractor/provider disagrees with a rate review decision, it may file a request for a dispute conference with MAA. For this section "dispute conference" means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with a department action as described under subsection (1) of this section, and not agreed upon at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) If a contractor/provider files a request for a dispute conference, it must submit the request to MAA within thirty calendar days after the contractor/provider receives the rate review decision. MAA does not consider dispute conference requests submitted after the thirty-day period for the first level decision.

(b) MAA conducts the dispute conference within ninety calendar days of receiving the request.

(c) A department-appointed conference chairperson issues the final decision within thirty calendar days of the conference. Extensions of time for extenuating circumstances may be granted if all parties agree.

(d) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(e) The dispute conference is the final level of administrative appeal within the department and precede judicial action.

(4) MAA considers that a contractor/provider who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-502-0220, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-043.]

#### **WAC 388-502-0230 Provider review and appeal. (1)**

As authorized by chapter 74.09 RCW, the medical assistance administration (MAA) monitors and reviews all providers who furnish medical, dental, or other services to eligible medical assistance clients. MAA determines whether the providers are complying with the rules and regulations of the program(s) and providing appropriate quality of care, and recovers any identified overpayments. Examples of provider reviews are:

(a) A review of all billing/medical/dental/service records for medical assistance clients;

(b) A statistical sampling of billing/medical/dental/service records for medical assistance clients, extrapolated per WAC 388-502-0240 (9), (10), and (11); and

(c) A review focused on selected billing/medical/dental/service records for medical assistance clients.

(2) The Washington State Health Professions Quality Assurance Commissions serve in an advisory capacity to MAA in conducting provider reviews and monitoring.

(3) MAA may determine that a provider's billing does not comply with program regulations or the provider is not meeting quality of care practices. MAA may do, but is not limited to, any of the following:

(a) Conduct pre-pay reviews of all claims the provider submits to MAA;

(b) Refer the provider to MAA's auditors (see WAC 388-502-0240);

(c) Refer the provider to Medicaid's Fraud Control Unit;

(d) Refer the provider to the appropriate state health professions quality assurance commission;

(e) Impose provisional stipulations for the provider to continue participation in medical assistance programs;

(f) Terminate the provider's participation in medical assistance programs;

(g) Assess a civil penalty against the provider, per RCW 74.09.210; and

(h) Recover any monies that the provider received as a result of inappropriate payments.

(4) When any part of the time period that is reviewed or monitored falls on or before June 30, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request an administrative review hearing to dispute the action(s).

(a) The request for an administrative review hearing must be in writing and:

(i) Be sent within twenty-eight days of the date of the notice of action(s);

(ii) State the reason(s) why the provider thinks the action(s) are incorrect;

(iii) Be sent by certified mail (return receipt) or other means that provides proof of delivery to:

The Medical Assistance Administration  
Attn: Deputy Assistant Secretary  
P.O. Box 45500  
Olympia WA 98504-5500

(b) The administrative review hearing consists of a review by MAA's deputy assistant secretary of all documents submitted by the provider and MAA. At the deputy assistant secretary's discretion, the administrative review hearing may be conducted in person, as a telephone conference, in written submissions, or a combination thereof.

(c) When a final decision is issued, the office of financial recovery collects any amount the provider is ordered to repay.

(d) The administrative review hearing referenced in this subsection is the final level of administrative review.

(5) When the entire time period that is reviewed or monitored falls on or after July 1, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request a hearing to dispute the action(s).

(a) The request for hearing must be in writing and;

(i) Be sent within twenty-eight days of the date of the notice of action(s), by certified mail (return receipt) or other means that provides proof of delivery to:

The Office of Financial Recovery  
P.O. Box 9501  
Olympia, WA 98507-5501; and

(ii) State the reason(s) why the provider thinks the action(s) are incorrect.

(b) The office of administrative hearings schedules and conducts the hearing under the Administrative Procedure Act, chapter 34.05 RCW. MAA offers a pre-hearing/alternative dispute conference prior to the hearing.

(c) The office of financial recovery collects any amount the provider is ordered to repay.

(6) A provider who disagrees with a department action regarding termination may appeal the action per WAC 388-502-0260. The provider may request a dispute conference; the request must be:

(a) In writing;

(b) Sent within thirty days of the date the provider received the termination notice;

(c) Include a statement of the action(s) appealed and supporting justification; and

(d) Sent to:

DSHS Central Contract Services  
P.O. Box 45811  
Olympia, WA 98504-5811

(7) See WAC 388-502-0220 for rate reimbursement appeals. See WAC 388-502-0240 for appeals of audit findings. See WAC 388-502-0260 for appeals related to contracts other than MAA's core provider agreements.

[Statutory Authority: RCW 74.08.090, 74.09.520, 34.05.020, 34.05.220, 00-22-017, § 388-502-0230, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-502-0230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-042.]

(2003 Ed.)

**WAC 388-502-0240 Audits and the audit appeal process for contractors/providers.** (1) This section applies to all contractor/providers except the following:

(a) Nursing homes as described in chapters 388-96, 388-97, and 388-98 WAC; and

(b) Managed care contractors as described in chapter 388-538 WAC.

(2) Subject to the limitations in subsection (1) of this section, the following definitions apply to this section:

(a) "**Contractor/provider**" means any person or organization that has a signed core provider agreement with the medical assistance administration (MAA) to provide services to eligible clients.

(b) "**Extrapolation**" means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(c) "**Probability sample**" means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(3) MAA may audit an MAA contractor/provider who furnishes medical or other covered services to eligible clients. See WAC 388-502-0220 for rate appeals. See WAC 388-502-0230 for dispute appeals involving provider review, termination and appeal. See WAC 388-502-0260 for contract appeals, other than those contained in core provider.

(4) MAA conducts audits as necessary to identify benefits or payments to which contractor/providers are not entitled.

(5) The Washington state health professions quality assurance commissions serve in an advisory capacity to MAA in conducting audits.

(6) An MAA audit includes the following:

(a) An examination of provider records, by either an on-site or desk audit. See subsections (7) and (8) of this section;

(b) A draft audit report, which contains preliminary findings and recommendations. See subsection (13) of this section;

(c) A dispute conference, if the contractor/provider requests it. See subsection (14) of this section;

(d) A final audit report. See subsection (15) of this section; and

(e) The right to an administrative appeal, if the contractor/provider requests it. See subsections (15) and (16) of this section.

(7) MAA audits providers who furnish medical and other services as authorized by chapter 74.09 RCW. An audit:

(a) Determines whether providers are:

(i) Complying with the rules and regulations of the program;

(ii) Meeting the community standard of practice; and

(iii) Billing allowable costs; or

(b) Investigates any of the following:

(i) Complaints/allegations;

(ii) Actions taken regarding Medicare or medical assistance; or

(iii) Actions taken by the health profession's quality assurance commissions.

(8) As part of the audit:

(a) MAA examines provider records.

(i) MAA examines those records, or portion thereof, that were reimbursed by MAA.

(ii) MAA examines records as necessary to verify usual and customary charges and payable and receivable accounts to verify third party liability.

(iii) MAA may remove copies of, but not original, records from the provider's premises.

(b) MAA gives a provider twenty days advance notice that it is going to audit paid claims or patient medical records for compliance with program rules, standards, or the community standard of practice. See subsection (16) of this section to request an extension of this notification period. This notice does not:

(i) Apply to providers who are suspected of fraudulent or abusive practices;

(ii) Apply to providers whose practices MAA considers may present a risk of imminent danger to medical assistance clients;

(iii) Include names of patient files that MAA will review; and

(iv) Apply to medical assistance provider business and financial records and patient financial records when they are reviewed as part of a third-party liability compliance audit.

(c) Whenever possible, MAA works with the provider to minimize inconvenience and disruption of health care delivery during the audit.

(d) MAA destroys all copies of identified client medical records made during an audit, after all appeal rights are exhausted.

(9) MAA may audit on a claim-by-claim basis, or using a probability sample.

(10) When MAA conducts a probability sample audit, all of the following apply:

(a) The sample claims are selected on the basis of recognized and generally accepted sampling methods;

(b) The sample claims are examined for compliance with relevant federal and state laws and regulations, department billing instructions, and numbered memoranda; and

(c) When projecting the overpayment, MAA uses a sample that is sufficient to ensure a minimum ninety-five percent confidence level.

(11) MAA uses probability sampling as described in subsection (10) of this section.

(a) If the audit findings demonstrate that MAA has made an overpayment to a Washington state Title XIX or other medical program provider(s), MAA recovers those statistically calculated overpayments.

(b) When calculating the amount to be recovered, MAA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(c) MAA does not consider nonbilled services or supplies when calculating underpayments or overpayments.

(12) When MAA uses the results of a probability sample to extrapolate the amount to be recovered as described in subsection (11) of this section, the provider may request a description of all of the following:

(a) The universe from which MAA drew the sample;

(b) The sample size and method that MAA used to select the sample; and

(c) The formulas and calculation procedures MAA used to determine the amount to be recovered.

(13) Upon completion of the audit, MAA identifies for the contractor/provider those files or records that are necessary for the audit, but were not located at the time of the audit.

(a) MAA allows the contractor/provider thirty calendar days from the date of completion of the on-site audit to locate and provide the missing files or records. Undocumented services will be considered as program overpayments; and

(b) At the end of this thirty day period, MAA issues the draft audit report. At this time:

(i) The contractor/provider may review, comment, and provide any additional information related to the draft audit report, that the contractor/provider wants considered. This information must be submitted within forty-five days of the date the contractor/provider received the draft audit report. See subsection (16) of this section to request an extension of this time period;

(ii) MAA works with the contractor/provider to resolve areas of disagreement; and

(iii) If necessary, MAA issues a revised draft audit report.

(14) A contractor/provider who wants to dispute draft audit findings must request a dispute conference.

(a) The contractor/provider must submit a written request for a dispute conference within forty-five calendar days of the date the draft audit report was received by the contractor/provider. MAA may grant an additional thirty day extension of the forty-five day limit as long as the contractor/provider requests the time extension in writing within the forty-five day limit and states the reason for the request.

(b) The dispute request must:

(i) Specify which finding(s) the contractor/provider is disputing; and

(ii) Supply documentation to support the contractor/provider's position.

(c) MAA acknowledges each request for a dispute conference.

(d) MAA responds to each disputed item in writing.

(e) If MAA and the contractor/provider reach an agreement during the dispute conference process, MAA issues the final audit report and the recommendations are binding.

(f) If MAA and the contractor/provider cannot reach an agreement during the dispute conference process, and the contractor/provider has had the opportunity to raise all concerns related to the audit findings, MAA may close the dispute conference process and issue a final audit report. After MAA issues the final audit report, the contractor/provider may request an audit appeal hearing per subsection (15) of this section.

(15) After MAA issues the final audit report, the contractor/provider may appeal findings in the report and request an audit appeal hearing. When the contractor/provider requests an audit appeal hearing, and when any part of the audited time period falls on or before June 30, 1998, the following process applies. This hearing is not governed by the Administrative Procedure Act (chapter 34.05 RCW).

(a) The request for an audit appeal hearing must meet all of the following:

- (i) Be in writing;
- (ii) Be submitted within twenty-eight calendar days of the date of delivery of the final audit report, by certified mail. (Contact the office of financial recovery to request an extension of this time period.) Send the request to:  
Office of Financial Recovery/DSHS  
POB 45862  
Olympia, WA 98504-5862
- (iii) Include a copy of the final audit report cover letter;
- (iv) State the contractor/provider's name, address, and contract number (DSHS contract number or core provider agreement number);
- (v) State the audit time period's beginning and ending dates; and
- (vi) Provide additional documentation, limited to the issues identified in the audit, that the contractor/provider requests to be considered within the hearing.

(b) The audit appeal hearing consists of an administrative review of all documents submitted for consideration by the contractor/provider and MAA. DSHS appoints a hearing officer to conduct such a review. At the hearing officer's discretion, the review may be conducted as a telephone conference, as an in-person meeting in Olympia, Washington, or as a combination thereof.

(c) The decision made by the hearing officer serves as the final agency action and is binding.

(d) The office of financial recovery collects any amount the provider is ordered to repay.

(16) A contractor/provider may request an extension of the time periods in this section by sending a request to MAA that contains all of the following. The request must:

- (a) Be in writing;
- (b) Be received by MAA before the applicable time period has elapsed;
- (c) Include the reason(s) for the request; and
- (d) Include the date the contractor/provider expects to submit or respond to requested information.

(17) When a contractor/provider requests an audit appeal hearing, and the entire audit period falls on or after July 1, 1998, the audit hearing is governed by the process in RCW 43.20B.675.

(18) MAA considers that a contractor/provider has abandoned the dispute, if the provider fails to identify and attempt to resolve disputed audit findings as provided in this section, has abandoned the dispute. MAA proceeds with issuing and/or implementing the final audit report.

(19) Based on the findings of an audit, MAA may order the provider to repay excess benefits or payments received, as follows:

- (a) MAA may assess civil penalties as provided for in chapter 74.09 RCW;
- (b) The amount of civil penalties may not exceed three times the amount of excess benefits or payments the provider received; and
- (c) The repayment includes interest on the amount of excess benefits or payments, per RCW 43.20B.695.

(20) When MAA imposes a civil penalty or suspends or terminates a provider from the program, written notice of the

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action taken is given to the appropriate licensing agency, disciplinary commission, and/or other entity requiring a report.

(21) When an audit shows that a provider has demonstrated a significant noncompliance with the provisions of the medical care program, MAA may refer that provider to the appropriate disciplinary commission.

(22) Where MAA finds evidence of or has reason to suspect fraud, those contractors/providers are referred to the appropriate prosecuting authority for possible criminal action.

[Statutory Authority: RCW 74.08.090, 43.20B.675. 00-23-014, § 388-502-0240, filed 11/3/00, effective 12/4/00.]

**WAC 388-502-0260 Appeals and dispute resolution for providers with contracts other than core provider agreements.** (1) Providers of medical services who have a contract, other than a core provider agreement, with a dispute resolution provision must follow the dispute resolution process described in the contract.

(2) See WAC 388-502-0220 for disputes involving rates. See WAC 388-502-0240 for disputes involving audits. See WAC 388-502-0230 for disputes involving provider reviews and termination.

[Statutory Authority: RCW 74.08.090, 74.09.290. 00-22-016, § 388-502-0260, filed 10/20/00, effective 11/20/00.]

**Chapter 388-503 WAC**

**PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE**

**WAC**

- 388-503-0505 General eligibility requirements for medical programs.
- 388-503-0510 How a client is determined "related to" a categorical program.
- 388-503-0515 Medical coverage resulting from a cash grant.

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

- 388-503-0305 Program priorities. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-503-0305, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
- 388-503-0310 Categorically needy eligible persons. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-503-0310, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-036, § 388-503-0310, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090 and SPA 95-11. 96-12-001 (Order 3981), § 388-503-0310, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-17-036 (Order 3769), § 388-503-0310, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-503-0310, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-010 and 388-82-115.] Repealed by 99-19-091, filed 9/17/99, effective 10/18/99. Statutory Authority: RCW 74.08.090.
- 388-503-0320 Medically needy eligible persons. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-503-0320, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-503-0320, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-005 and 388-99-010.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority:



- RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0100.
- 388-503-0350 Medical care services—GAU/ADATSA. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-503-0350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-126 and 388-83-006.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110 and 388-529-0100.
- 388-503-0370 Medically indigent eligible persons. [Statutory Authority: RCW 74.08.090, 95-22-039 (Order 3913, #100246), § 388-503-0370, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-503-0370, filed 5/3/94, effective 6/3/94. Formerly WAC 388-100-005 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110, 388-519-0300 and 388-438-0100.

**WAC 388-503-0505 General eligibility requirements for medical programs.** (1) Persons applying for benefits under the medical coverage programs established under chapter 74.09 RCW must meet the eligibility criteria established by the department in chapters 388-400 through 388-555 WAC.

(2) Persons applying for medical coverage are considered first for federally funded or federally matched programs. State-funded programs are considered after federally funded programs are not available to the client except for brief periods when the state-funded programs offer a broad scope of care which meet a specific client need.

(3) Unless otherwise specified in program specific WAC, the eligibility criteria for each medical program is as follows:

- (a) Verification of age and identity (chapters 388-404, 388-406, and 388-490 WAC); and
- (b) Residence in Washington state (chapter 388-468 WAC); and
- (c) Citizenship or immigration status in the United States (chapter 388-424 WAC); and
- (d) Possession of a valid Social Security Account Number (chapter 388-476 WAC); and
- (e) Assignment of medical support rights to the state of Washington (WAC 388-505-0540); and
- (f) Cooperation in securing medical support (chapter 388-422 WAC); and
- (g) Countable resources within program limits (chapters 388-470 and 388-478 WAC); and
- (h) Countable income within program limits (chapters 388-450 and 388-478 WAC).

(4) In addition to the general eligibility requirements in subsection (3) of this section, each program has specific eligibility requirements as described in applicable WAC.

(5) Persons living in a public institution, including a correctional facility, are not eligible for the department's medical coverage programs. A person living in a city or county jail may be considered only for the medically indigent (MI) program. For a person under age twenty or over age sixty-five who is a patient in an institution for mental disease see WAC 388-513-1315(13) for exception.

(6) Persons terminated from SSI or TANF cash grants and those who lose eligibility for categorically needy (CN) medical coverage have their CN coverage continued while

their eligibility for other medical programs is redetermined. This continuation of medical coverage is described in chapter 388-434 WAC.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-503-0505, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-503-0505, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0110, 388-503-0305 and 388-505-0501.]

**WAC 388-503-0510 How a client is determined "related to" a categorical program.** (1) A person is related to the Supplemental Security Income (SSI) program if they are:

- (a) Aged, blind, or disabled as defined in WAC 388-511-1105(1) or chapter 388-475 WAC; or
  - (b) Considered as eligible for SSI under WAC 388-511-1105(5) or chapter 388-475 WAC; or
  - (c) Children meeting the requirements of WAC 388-505-0210(6).
- (2) A person or family is considered to be related to the temporary assistance for needy families (TANF) program if they meet:
- (a) The program requirements for the TANF cash assistance programs or the requirements of WAC 388-505-0210 or 388-505-0220; or
  - (b) Would meet such requirements except that the assistance unit's countable income or resources exceed the TANF.

(3) Persons related to SSI or to TANF are eligible for categorically needy (CN) or medically needy (MN) medical coverage if they meet the other eligibility criteria for these medical programs. See chapters 388-475, 388-505 and 388-519 WAC for these eligibility criteria.

(4) Persons related to SSI or to TANF and who receive the related CN medical coverage have redetermination rights as described in WAC 388-503-0505(6).

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-503-0510, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-503-0510, filed 7/31/98, effective 9/1/98.]

**WAC 388-503-0515 Medical coverage resulting from a cash grant.** (1) Families or individuals eligible for SSI, SSI state supplement or TANF cash grants are automatically eligible for categorically needy (CN) medical coverage. These clients receive medical coverage benefits without making a separate application. Certification for CN medical coverage parallels that for the cash benefits.

(2) Upon termination of cash benefits as described in subsection (1) of this section, medical coverage continues until the client's eligibility for other medical coverage can be completed. Continuing medical coverage is terminated if the client does not cooperate with the eligibility redetermination process.

(3) Individuals eligible for state financial assistance (SFA) cash grants may receive medical coverage for:

- (a) An emergent medical condition as described in WAC 388-438-0110; or
- (b) Pregnancy as described in WAC 388-462-0015.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-503-0515, filed 8/12/02, effective 9/12/02.]

Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0515, filed 7/31/98, effective 9/1/98.]

## Chapter 388-505 WAC FAMILY MEDICAL

### WAC

- 388-505-0110 Medical assistance coverage for adults not covered under family medical programs.  
388-505-0210 Children's medical eligibility.  
388-505-0220 Family medical eligibility.  
388-505-0540 Assignment of rights and cooperation.

### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-505-0501 Eligibility—General. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0501, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
- 388-505-0505 Age. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
- 388-505-0510 Residence. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2), 97-15-025, § 388-505-0510, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-025.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-468-0010.
- 388-505-0520 Citizenship. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997, 98-15-066, § 388-505-0520, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090, 96-13-002 (Order 3983), § 388-505-0520, filed 6/6/96, effective 7/7/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp. s. c. 18, 95-24-016 (Order 3923), § 388-505-0520, filed 11/22/95, effective 12/23/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0520, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-424-0005 and 388-424-0010.
- 388-505-0530 Social Security number. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-017.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-476-0005.
- 388-505-0560 Cooperation in securing medical support. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0560, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-013.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-472-0005, 388-505-0540, 388-422-0005, 388-422-0010 and 388-422-0020.
- 388-505-0570 Good cause for noncooperation—Medical care support. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0570, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-014.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-422-0020(4)(c).

388-505-0580 Resources. [Statutory Authority: RCW 74.08.090, 96-01-005 (Order 3932, # 100268), § 388-505-0580, filed 12/6/95, effective 1/6/96; 95-02-026 (Order 3817), § 388-505-0580, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-505-0580, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-026.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0015, 388-470-0020, 388-470-0040, 388-488-0005 and 388-450-0210.

388-505-0590 Income. [Statutory Authority: RCW 74.08.090, 95-17-031 (Order 3878), § 388-505-0590, filed 8/9/95, effective 9/9/95; 95-04-047 (Order 3827), § 388-505-0590, filed 1/25/95, effective 2/25/95; 94-10-065 (Order 3732), § 388-505-0590, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-041.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0005, 388-450-0015, 388-450-0210 and 388-450-0215.

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 388-505-0110 Medical assistance coverage for adults not covered under family medical programs.** (1) An adult who does not meet the institutional status requirements as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for categorically needy (CN) coverage under this chapter. Persons excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for CN coverage when the person:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has CN countable income and resources that do not exceed the income and resource standards in WAC 388-478-0080; and

(c) Is sixty-five years of age or older, or meets the blind and/or disability criteria of the federal SSI program.

(2) An adult not meeting the conditions of subsection (1)(b) is eligible for CN medical coverage if the person:

(a) Is a current beneficiary of Title II of the Social Security Act (SSA) benefits who:

(i) Was a concurrent beneficiary of Title II and Supplemental Security Income (SSI) benefits;

(ii) Is ineligible for SSI benefits and/or state supplementary payments (SSP); and

(iii) Would be eligible for SSI benefits if certain cost-of-living (COLA) increases are deducted from the client's current Title II benefit amount:

(A) All Title II COLA increases under P.L. 94-566, section 503 received by the client since their termination from SSI/SSP; and

(B) All Title II COLA increases received during the time period in subsection (1)(d)(iii)(A) of this section by the client's spouse or other financially responsible family member living in the same household.

(b) Is an SSI beneficiary, no longer receiving a cash benefit due to employment, who meets the provisions of section 1619(b) of Title XVI of the SSA;

(c) Is a currently disabled client receiving widow's or widower's benefits under section 202 (e) or (f) of the SSA if the disabled client:

(i) Was entitled to a monthly insurance benefit under Title II of the SSA for December 1983; and

(ii) Was entitled to and received a widow's or widower's benefit based on a disability under section 202 (e) or (f) of the SSA for January 1984;

(iii) Became ineligible for SSI/SSP in the first month in which the increase provided under section 134 of P.L. 98-21 was paid to the client;

(iv) Has been continuously entitled to a widow's or widower's benefit under section 202 (e) or (f) of the SSA;

(v) Would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent COLA increases provided under section 215(i) of the SSA, were disregarded;

(vi) Is fifty through fifty-nine years of age; and

(vii) Filed an application for Medicaid coverage before July 1, 1988.

(d) Was receiving, as of January 1, 1991, Title II disabled widow or widower benefits under section 202 (e) or (f) of the SSA if the person:

(i) Is not eligible for the hospital insurance benefits under Medicare Part A;

(ii) Received SSI/SSP payments in the month before receiving such Title II benefits;

(iii) Became ineligible for SSI/SSP due to receipt of or increase in such Title II benefits; and

(iv) Would be eligible for SSI/SSP if the amount of such Title II benefits or increase in such Title II benefits under section 202 (e) or (f) of the SSA, and any subsequent COLA increases provided under section 215(i) of the act were disregarded.

(e) Is a disabled or blind client receiving Title II Disabled Adult Childhood (DAC) benefits under section 202(d) of the SSA if the client:

(i) Is at least eighteen years old;

(ii) Lost SSI/SSP benefits on or after July 1, 1988, due to receipt of or increase in DAC benefits; and

(iii) Would be eligible for SSI/SSP if the amount of the DAC benefits or increase under section 202(d) of the DAC and any subsequent COL increases provided under section 215(i) of the SSA were disregarded.

(f) Is a client who:

(i) In August 1972, received:

(A) Old age assistance (OAA);

(B) Aid to blind (AB);

(C) Aid to families with dependent children (AFDC); or

(D) Aid to the permanently and totally disabled (APTD);

and

(ii) Was entitled to or received retirement, survivors, and disability insurance (RSDI) benefits; or

(iii) Is eligible or OAA, AB, AFDC, SSI, or APRD solely because of the twenty percent increase in Social Security benefits under P.L. 92-336.

(3) An adult who does not meet the institutional status requirement as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for medically needy (MN) coverage under this chapter. Persons excluded from this section have

rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for MN coverage when the person:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has MN countable income that does not exceed the income standards in WAC 388-478-0070, or meets the excess income spenddown requirements in WAC 388-519-0110; and

(c) Meets the countable resource standards in WAC 388-478-0070; and

(d) Is sixty-five years of age or older or meets the blind and/or disability criteria of the federal SSI program.

(4) MN coverage is available for an aged, blind, or disabled ineligible spouse of an SSI recipient. See WAC 388-519-0100 for additional information.

(5) An adult may be eligible for the alien emergency medical program as described in WAC 388-438-0110.

(6) An adult is eligible for the state-funded general assistance - expedited Medicaid disability (GA-X) program when they:

(a) Meet the requirements of the cash program in WAC 388-400-0025 and 388-478-0030; or

(b) Meet the SSI-related disability standards but cannot get the SSI cash grant due to immigration status or sponsor deeming issues.

Clients may be eligible for GA cash benefits and CN medical coverage due to different sponsor deeming requirements.

(7) An adult is eligible for the state-funded medical care services (MCS) program when the person is eligible for GAU or ADATSA program coverage as described in WAC 388-478-0030.

(8) An adult is eligible for the state-funded medical indigent (MI) program when the person meets the requirements listed in WAC 388-438-0100.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-505-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0350 and 388-503-0370.]

#### **WAC 388-505-0210 Children's medical eligibility.**

(1) A child under the age of one is eligible for categorically needy (CN) medical assistance when:

(a) The child's mother was eligible for and receiving coverage under a medical program at the time of the child's birth; and

(b) The child remains with the mother and resides in the state.

(2) Children under the age of nineteen are eligible for CN medical assistance when they meet the requirements for:

(a) Citizenship or U.S. national status as described in WAC 388-424-0005(1) or immigrant status as described in WAC 388-424-0010 (1) or (2);

(b) State residence as described in chapter 388-468 WAC;

(c) A social security number as described in chapter 388-476 WAC; and

(d) Family income levels as described in WAC 388-478-0075 (1)(c).

(3) Children under the age of nineteen are eligible for the state children's health insurance program (SCHIP), 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 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.

(5) 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.

(6) 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).

(7) 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 (5)(b); and

(b) Has countable income above the level described in WAC 388-478-0070(1).

(8) There are no resource limits for children under.

(9) 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.

(10) Except for a client described in subsection (4)(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, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-505-0210, filed 8/12/02, effective 9/12/02. Statutory

(2003 Ed.)

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, except SFA relatable families, 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) 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.

(4) Except for a client described in WAC 388-505-0210 (4)(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, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-505-0220, filed 8/12/02, effective 9/12/02. 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 388-505-0540 Assignment of rights and cooperation.** (1) When a person becomes eligible for any of the department's medical programs, they make assignment of certain rights to the state of Washington. This assignment includes all rights to any type of coverage or payment for medical care which results from:

- (a) A court order;
- (b) An administrative agency order; or
- (c) Any third-party benefits or payment obligations for medical care which are the result of **subrogation** or contract (see WAC 388-501-0100).

(2) **Subrogation** is a legal term which describes the method by which the state acquires the rights of a client for whom or to whom the state has paid benefits. The subrogation rights of the state are limited to the recovery of its own costs.

(3) The person who signs the application makes the assignment of rights to the state. Assignment is made on their own behalf and on behalf of any eligible person for whom they can legally make such assignment.

(4) A person must cooperate with the department in the identification, use or collection of third-party benefits. Failure to cooperate results in a termination of eligibility for the responsible person. Other obligations for cooperation are located in chapters 388-14A and 388-422 WAC. The following clients are exempt from termination of eligibility for medical coverage as a result of noncooperation:

- (a) A pregnant woman, and
- (b) Minor children, and
- (c) A person who has been determined to have "good cause" for noncooperation (see WAC 388-422-0015).

(5) A person will not lose eligibility for medical assistance programs due solely to the noncooperation of any third party.

(6) A person will be responsible for the costs of other-wise covered medical services if:

- (a) The person received and kept the third-party payment for those services; or
- (b) The person refused to provide to the provider of care their legal signature on insurance forms.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-505-0540, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0540, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-04-005, § 388-505-0540, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0540, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-012, 388-501-0170 and 388-505-0560.]

## Chapter 388-506 WAC

### MEDICAL FINANCIAL RESPONSIBILITY

#### WAC

388-506-0620 SSI-related medical clients.

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

388-506-0610 AFDC-related medical programs. [Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. 95-19-007 (Order

3895), § 388-506-0610, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. 95-10-025 (Order 3847), § 388-506-0610, filed 4/26/95, effective 5/27/95; 94-17-034 (Order 3767), § 388-506-0610, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-506-0610, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-046 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055, 388-450-0005 and 388-470-0070.

388-506-0630 SSI-related income deeming. [Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-506-0630, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0630, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-027 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055 and 388-450-0150.

#### WAC 388-506-0620 SSI-related medical clients. (1)

The department shall consider income and resources for an institutionalized:

- (a) Child as described under WAC 388-513-1315(6); or
- (b) Spouse as described under WAC 388-513-1330 and 388-513-1350.

(2) The department shall consider the income and resources of spouses as available to each other through the month in which the spouses stopped living together. See WAC 388-513-1330 and 388-513-1350 when a spouse is institutionalized.

(3) The department shall follow WAC 388-515-1505, 388-515-1510, or 388-515-1530 when one or both spouses are receiving community options program entry system (COPES), community alternatives program (CAP), outward bound residential alternatives (OBRA), or coordinated community aids service alternatives (CASA) waived service program.

(4) The department shall allow a community spouse applying for medically needy a spousal deduction equal to the one-person medically needy income level (MNIL) less the spouse's income when:

- (a) The community spouse is living in the same household as the spouse; and
- (b) The spouse is receiving home-based and community-based services.

(5) The department shall consider income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a congregate care facility (CCF), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disability-group home (DDD-GH) facility when:

- (a) Only one spouse enters the facility;
- (b) Both spouses enter the same facility but have separate rooms; or
- (c) Both spouses enter separate facilities.

(6) The department shall consider income and resources jointly when spouses are placed in a CCF, AFH, ARRC/ARTF, or DDD-GH facility and share a room.

(7) See Wac 388-408-0055 for rules on medical assistance units that include SSI-related persons.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-506-0620, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0620, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-025.]

### Chapter 388-510 WAC

#### ALIEN MEDICAL ELIGIBILITY

##### WAC

388-510-1005 Definitions—Aliens.

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

- 388-510-1020 Alien—Eligibility. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and RCW 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-510-1020, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-510-1020, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. Later promulgation, see WAC 388-424-0005.
- 388-510-1030 Alien—Deeming. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-510-1030, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. Later promulgation, see WAC 388-470-0060(6).

**WAC 388-510-1005 Definitions—Aliens. "Legal immigrant"** means an alien residing in the United States who is lawfully present with intent to remain. A legal immigrant includes, but is not limited to, an alien meeting PRUCOL criteria.

**"Nonimmigrant"** means an alien legally residing in the country but without an intent to remain permanently or who is not lawfully present.

**"PRUCOL"** means a person permanently residing under color of law.

**"Qualified alien"** means an alien:

- (1) Who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 12, Sec. 101 (a)(20));
- (2) Who is a refugee admitted to the United States under section 207 of such act;
- (3) Who is granted asylum under section 208 of act;
- (4) Whose deportation is being withheld under section 243(h) of such act;
- (5) Who is paroled into the United States under section 212 (d)(5) of such act for a period of at least one year;
- (6) Who is granted conditional entry under section 203 (a)(7) of such act as in effect prior to April 1, 1980;
- (7) Who is a victim of domestic violence or an immigrant child that has been battered or subjected to extreme cruelty when:
  - (a) The immigrant petitions for legal status under section 204(a) of the INA or a petition for suspension of deportation under section 244(a) of the INA; and
  - (b) The person responsible for the battery no longer resides with the immigrant.

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(8) Who is a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or

(9) Who is an Amerasian immigrant as defined in the Balanced Budget Agreement of 1997.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-510-1005, filed 7/13/98, effective 7/30/98.]

### Chapter 388-511 WAC

#### SSI-RELATED MEDICAL ELIGIBILITY

##### WAC

- 388-511-1105 SSI-related eligibility requirements.
- 388-511-1130 SSI-related income availability.

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

- 388-511-1110 SSI-related resource standards. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1110, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-050.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0050 and 388-478-0080.
- 388-511-1115 SSI-related income standards. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1115, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0070 and 388-478-0055.
- 388-511-1140 SSI-related income exemptions. [Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-511-1140, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and State Plan Amendment Sup. 8a to Article 2.6-A page 6. 96-05-010 (Order 3943, #100295), § 388-511-1140, filed 2/9/96, effective 3/1/96. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605. 95-08-070 (Order 3845), § 388-511-1140, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1140, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-034 and 388-92-036.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020 and 388-450-0040.
- 388-511-1150 SSI-related resource availability. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-040.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see chapter 388-470 WAC.
- 388-511-1160 SSI-related resource exemptions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 42 CFR 435.601 and Section 4735 of the Federal Balanced Budget Act of 1997 (Public Law 105-33 (H.R. 2015)). 98-04-031, § 388-511-1160, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-034, § 388-511-1160, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605. 95-08-070 (Order 3845), § 388-511-1160, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-045.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0040.

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388-511-1170 SSI—State data exchange. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1170, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

**WAC 388-511-1105 SSI-related eligibility requirements.** (1) For the purposes of SSI-related medical assistance, the client shall be:

(a) Sixty-five years of age or over; or

(b) Blind with:

(i) Central visual acuity of 20/200 or less in the better eye with the use of a correcting lens; or

(ii) A limitation in the fields of vision so the widest diameter of the visual field subtends an angle no greater than twenty degrees; or

(c) Disabled.

(i) Decisions on SSI-related disability are the responsibility of the medical assistance administration (MAA) and shall be subject to the authority of:

(A) Federal statutes and regulations codified at 42 U.S.C. Sec 1382c and 20 C.F.R. Parts 404 and 416, as amended; or

(B) Controlling federal court decisions which define the OASDI and SSI disability standard and determination process.

(ii) For MAA's purposes, "disabled" means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which:

(A) Can be expected to result in death; or

(B) Has lasted or can be expected to last for a continuous period of not less than twelve months.

(iii) In the case of a child seventeen years of age or younger, if the child suffers from any medically determinable physical or mental impairment of comparable severity.

(2) When a person has applied for Title II or Title XVI benefits and the SSA has denied the person's application solely because of a failure to meet Title II and Title XVI blindness or disability criteria, the SSA denial shall be binding on the department, unless the applicant's:

(a) SSA denial is under appeals in the reconsideration stage, the SSA's administrative hearing process, or the SSA's appeals council; or

(b) Medical condition has changed since the SSA denial was issued.

(3) The ineligible spouse, of an SSI beneficiary receiving a state supplement payment for the ineligible spouse, shall not be eligible for Medicaid as noninstitutional categorically needy. Such ineligible spouse may be eligible for noninstitutional medically needy.

(4) The client shall be resource eligible under WAC 388-478-0080 on the first day of the month to be eligible for any day or days of that month. The department shall make a resource determination of the first moment of the first day of the month. The department shall determine changes in the amount of a client's countable resources during a month do not affect eligibility or ineligibility for that month. Refer to WAC 388-513-1395 for an institutionalized client.

(5) The department shall consider a client under 1619(b) of the Social Security Act as eligible for SSI.

(6) The department shall provide a resident of Washington requiring medical assistance outside the United States care according to WAC 388-501-0180.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-18-079, § 388-511-1105, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.04.050, 97-03-036, § 388-511-1105, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605, 95-08-070 (Order 3845), § 388-511-1105, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1105, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-85-115 and 388-92-015.]

#### **WAC 388-511-1130 SSI-related income availability.**

The department:

(1) Considers client checks received in advance of the month of normal receipt as income in the month of normal receipt;

(2) Considers electronically transferred client funds available as income in the month of normal receipt, regardless of the date the banking institution posted the funds to the client's bank account;

(3) Includes as countable income to the client any earned or unearned income amounts withheld due to garnishment under a court, administrative or agency order. See WAC 388-513-1380 (7)(a) for garnishment that affects an institutionalized client; and

(4) Requires a client, as a condition of eligibility, to take all necessary steps to obtain any of the following benefits to which the client is entitled unless the client can show good cause for not doing so:

(a) Annuity;

(b) Pension;

(c) Retirement;

(d) Disability; and

(e) Other benefits, including but not limited to:

(i) Unemployment compensation;

(ii) Veteran's compensation; or

(iii) Old age survivor's disability insurance (OASDI).

[Statutory Authority: RCW 74.04.050, 74.08.090, 00-22-029, § 388-511-1130, filed 10/23/00, effective 12/1/00. Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160, 97-10-022, § 388-511-1130, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-034 (part).]

### **Chapter 388-512 WAC**

#### **SSI-RELATED GRANDFATHERED RECIPIENTS**

##### **WAC**

388-512-1210 Program description.

#### **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.
- 388-512-1280 Application following termination. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1280, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-080.] Repealed by 98-04-004, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510.

**WAC 388-512-1210 Program description.** The department shall provide medical assistance within limitations set forth in these rules and regulations to a person who is a grandfathered client.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-010.]

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## Chapter 388-513 WAC

### CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

#### WAC

- 388-513-1301 Definitions related to long-term care (LTC) services.
- 388-513-1305 Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF).
- 388-513-1315 Eligibility for long-term care (institutional, waived, and hospice) services.
- 388-513-1320 Determining institutional status for long-term care (LTC) services.
- 388-513-1325 Determining available income for a single client for long-term care (LTC) services.
- 388-513-1330 Determining available income for legally married couples for long-term care (LTC) services.
- 388-513-1340 Determining excluded income for long-term care (LTC) services.
- 388-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program.
- 388-513-1350 Defining the maximum amount of resources allowed and determining resources availability for long-term care (LTC) services.
- 388-513-1360 Determining excluded resources for long-term care (LTC) services.
- 388-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 for long-term care (LTC) services.
- 388-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services.
- 388-513-1380 Determining a client's participation in the cost of care for long-term care (LTC) services.
- 388-513-1395 Determining eligibility for institutional or hospice services and for facility care only under the medically needy (MN) program.
- 388-513-1396 Clients living in a fraternal, religious, or benevolent nursing facility.

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

- 388-513-1300 Applicability of alternate living and institutional rules. [Statutory Authority: RCW 74.08.090. 95-06-025 (Order 3834), § 388-513-1300, filed 2/22/95, effective 3/25/95.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act.
- 388-513-1310 Resource standard—Institutional. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1310, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-390.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act.

**WAC 388-513-1301 Definitions related to long-term care (LTC) services.** This section defines the meaning of certain terms used in chapters 388-513 and 388-515 WAC. Within these chapters, institutional, waived, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used. Definitions of terms used in certain rules that regulate LTC programs are as follows:

**"Add-on hours"** means additional hours the department purchases from providers to perform medically-oriented

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tasks for clients who require extra help because of a handicapping condition.

"**Alternate living facility (ALF)**" means one of the following community residential facilities that are contracted with the department to provide certain services:

(1) Adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care.

(2) Adult residential care facility (ARC) (formerly known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision.

(3) Adult residential rehabilitation center (ARRC) or Adult residential treatment facility (ARTF), a licensed facility that provides its residents with twenty-four hour residential care for impairments related to mental illness.

(4) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living.

(5) Division of developmental disabilities (DDD) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision.

(6) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs.

"**Clothing and personal incidentals (CPI)**" means the same as personal needs allowance (PNA) later in this section.

"**Community alternatives program (CAP)**" means a Medicaid-waivered program that provides home and community-based services as an alternative to an institution for the mentally retarded (ICF-MR) to persons determined eligible for services from DDD.

"**Community options program entry system (COPES)**" means a Medicaid-waivered program that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility.

"**Community spouse (CS)**" means a person who does not live in a medical institution or nursing facility, and who is legally married to an institutionalized client or to a person receiving services from home and community-based waiver programs.

"**Comprehensive assessment (CA)**" means the evaluation process used by a department designated social services worker to determine the client's need for long-term care services.

"**Coordinated community AIDS service alternative (CASA)**" means a Medicaid-waivered program that provides a person with Acquired Immune Deficiency Syndrome (AIDS) or Disabled Class IV Human Immunodeficiency Virus (HIV) and at risk of hospitalization with the option to remain at home or in an alternate living facility.

"**Fair market value (FMV)**" means the price an asset may reasonably be expected to sell for on the local market at the time of transfer or assignment. A transfer of assets for love and affection is not considered a transfer for FMV.

"**Federal benefit rate (FBR)**" means the basic benefit amount the Social Security Administration (SSA) pays to clients who are eligible for the Supplemental Security Income (SSI) program.

"**Institutional services**" means services paid for by Medicaid or state payment and provided in a nursing facility or equivalent care provided in a medical facility.

"**Institutional status**" means what is described in WAC 388-513-1320.

"**Institutionalized client**" means a client who has attained institutional status as described in WAC 388-513-1320.

"**Institutionalized spouse**" means a client who has attained institutional status as described in WAC 388-513-1320 and is legally married to a person who is not an institutionalized client.

"**Legally married**" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"**Likely to reside**" means there is a reasonable expectation the client will remain in a medical facility for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"**Look-back period**" means the number of months prior to the month of application for LTC services that the department will consider for transfer of assets.

"**Maintenance needs amount**" means a monthly income amount a client keeps or that is allocated to a spouse or dependent family member who lives in the client's home.

"**Medically intensive children (MIC)**" program means a Medicaid-waivered program that enables medically fragile children under age eighteen to live in the community. The program allows them to obtain medical and support services necessary for them to remain at home or in a home setting instead of in a hospital. Eligibility is included in the OBRA program described in WAC 388-515-1510.

"**Noninstitutional medical assistance**" means medical benefits provided by Medicaid or state-funded programs that do not include LTC services.

"**Nursing facility turnaround document (TAD)**" means the billing document nursing facilities use to request payment for institutionalized clients.

"**Outward bound residential alternative (OBRA)**" means a Medicaid-waivered program that provides a person approved for services from DDD with the option to remain at home or in an alternate living facility.

"**Participation**" means the amount a client is responsible to pay each month toward the total cost of care they receive each month. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income.

"**Penalty period**" means a period of time for which a client is not eligible to receive LTC services.

"**Personal needs allowance (PNA)**" means a standard allowance for clothing and other personal needs for clients

who live in a medical or alternate living facility. This allowance is sometimes referred to as "CPL."

"**Prouty benefits**" means special "age seventy-two" Social Security benefits available to persons born before 1896 who are not otherwise eligible for Social Security.

"**Short stay**" means a person who has entered a medical facility but is not likely to remain institutionalized for thirty consecutive days.

"**Special income level (SIL)**" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI Federal Benefit Rate (FBR).

"**Swing bed**" means a bed in a medical facility that is contracted as both a hospital and a nursing facility bed.

"**Transfer of a resource or asset**" means any act or failure to act, by a person or a nonapplying joint tenant, whereby title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person.

"**Uncompensated value**" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"**Undue hardship**" means the person is not able to meet shelter, food, clothing, or health needs.

"**Value of compensation received**" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"**Veterans benefits**" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

(1) Aid and attendance for an individual needing regular help from another person with activities of daily living;

(2) "Housebound" for an individual who, when without assistance from another person, is confined to the home;

(3) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount; or

(4) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both.

"**Waivered programs/services**" means programs for which the federal government authorizes exceptions to Medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under Medicaid. In Washington state, waived programs are CAP, CASA, COPEs, MIC, and OBRA.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 02-09-052, § 388-513-1301, filed 4/12/02, effective 5/13/02. 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;

(2003 Ed.)

and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1301, filed 12/8/99, effective 1/8/00.]

**WAC 388-513-1305 Determining eligibility for non-institutional medical assistance in an alternate living facility (ALF).** This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC 388-478-0045 for the personal needs allowance (PNA) amount that applies in this rule.

(1) Alternate living facilities include the following:

(a) An adult family home (AFH);

(b) An adult residential care facility (ARC);

(c) An adult residential rehabilitation center (ARRC);

(d) An adult residential treatment facility (ARTF);

(e) An assisted living facility (AL);

(f) A division of developmental disabilities (DDD) group home (GH); and

(g) An enhanced adult residential care facility (EARC).

(2) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program that cannot exceed the special income level (SIL) equals the following amounts. For a client who lives in:

(a) An ARC, an ARRC, an ARTF, an AL, a DDD GH, or an EARC, the department-contracted rate based on a thirty-one day month plus the PNA; or

(b) An AFH, the department-contracted rate based on a thirty-one day month plus the PNA plus the cost of any add-on hours authorized by the department.

(3) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility rate based on a thirty-one-day month plus the PNA.

(4) The monthly income standard for noninstitutional medical assistance under the general assistance (GA) program equals the GA grant standard described in WAC 388-478-0030.

(5) The department determines a client's nonexcluded resources as described in chapter 388-470 WAC and WAC 388-505-0595.

(6) The department determines a client's nonexcluded income as described in chapter 388-450 WAC, WAC 388-505-0595, 388-506-0620, and 388-511-1130.

(7) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who receives Supplemental Security Income (SSI) or who is SSI-related as described in WAC 388-503-0510(1), if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client's nonexcluded income described in subsection (6) does not exceed the CN standard described in subsection (2).

(8) The department approves MN noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client satisfies any spenddown liability as described in chapter 388-519 WAC.

(9) The department approves GA noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for a client determined eligible for the program as described in WAC 388-400-0025.

(10) The client described in subsections (7) and (9) keeps the PNA amount and pays remaining income to the facility for board and room.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1305, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1305, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1305, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-036 and 388-99-036.]

**WAC 388-513-1315 Eligibility for long-term care (institutional, waived, and hospice) services.** This section describes how the department determines a client's eligibility for institutional, waived, or hospice services under the categorically needy (CN) program and institutional or hospice services under the medically needy (MN) program. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (11) and emergency medical programs described in subsections (10) and (12).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a) through (f);

(b) Attain institutional status as described in WAC 388-513-1320; and

(c) Not be subject to a penalty period of ineligibility as described in WAC 388-513-1365 and 388-513-1366.

(2) To be eligible for institutional, waived, or hospice services under the CN program, a client must either:

(a) Be related to the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1) or be approved for the general assistance expedited Medicaid disability (GA-X) program; and

(b) Meet the following financial requirements, by having:

(i) Gross nonexcluded income described in subsection (7)(a) that does not exceed the special income level (SIL); and

(ii) Nonexcluded resources described in subsection (6) that do not exceed the resource standard described in WAC 388-513-1350(1), unless subsection (3) applies; or

(c) Be eligible for the CN children's medical program as described in WAC 388-505-0210; or

(d) Be eligible for the temporary assistance for needy families (TANF) program or state family assistance (SFA) program as described in WAC 388-505-0220.

(3) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eli-

gibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the SIL.

(4) To be eligible for waived or hospice services, a client must also meet the program requirements described in:

(a) WAC 388-515-1505 for COPES services;

(b) WAC 388-515-1510 for CAP and OBRA services;

(c) WAC 388-515-1530 for CASA services; or

(d) Chapter 388-551 WAC for hospice services.

(5) To be eligible for institutional or hospice services under the MN program, a client must be:

(a) Eligible for the MN children's medical program as described in WAC 388-505-0210; or

(b) Related to the SSI program as described in WAC 388-503-0510(1) and meet all requirements described in WAC 388-513-1395.

(6) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers resources available as described in WAC 388-513-1350;

(b) Excludes resources described in WAC 388-513-1360, 388-513-1365, and 388-513-1366; and

(c) Compares the nonexcluded resources to the standard described in WAC 388-513-1350(1).

(7) To determine income eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;

(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;

(c) Disregards income for the MN program as described in WAC 388-513-1345; and

(d) Follows program rules for the MN program as described in WAC 388-513-1395.

(8) A client who meets the requirements of the CN program is approved for a period of up to twelve months for:

(a) Institutional services in a medical facility;

(b) Waivered services at home or in an alternate living facility; or

(c) Hospice services at home or in a medical facility.

(9) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395 (5)(a)(ii) for:

(a) Institutional services in a medical facility; or

(b) Hospice services at home or in a medical facility.

(10) The department determines eligibility for LTC services under the alien emergency medical (AEM) program described in WAC 388-438-0110 for a client who meets all other requirements for such services but does not meet citizenship requirements.

(11) The department determines eligibility for institutional services under the GA program described in WAC 388-448-0001 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (10).

(12) The department determines eligibility for institutional services under the medically indigent program described in WAC 388-438-0100 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (11).

(13) A client is eligible for Medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 388-513-1320; and

(b) Is less than twenty-one years old or is at least sixty-five years old.

(14) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

(15) The department considers the parents' income and resources available as described in WAC 388-405-0055 (1)(c) for a minor who is less than eighteen years old and is receiving or is expected to receive inpatient chemical dependency and/or inpatient mental health treatment.

(16) The department considers the parents' income and resources available only as contributed for a client who is less than twenty-one years old and has attained institutional status as described in WAC 388-513-1320

(17) The department determines a client's participation in the cost of care for LTC services as described in WAC 388-513-1380.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1315, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1315, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.08.090 and 42 CFR 435.1005. 98-04-003, § 388-513-1315, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 96-11-072 (Order 3980), § 388-513-1315, filed 5/10/96, effective 6/10/96. Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. 95-19-007 (Order 3895), § 388-513-1315, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1315, filed 5/3/94, effective 6/3/94.]

**WAC 388-513-1320 Determining institutional status for long-term care (LTC) services.** Institutional status is an eligibility requirement for LTC services.

(1) To attain institutional status, a client must:

(a) Be approved for and receiving waived or hospice services; or

(b) Reside or be likely to reside in a medical facility for a continuous period of:

(i) Ninety days for a child seventeen years of age or younger receiving inpatient chemical dependency and/or inpatient mental health treatment; or

(ii) Thirty days for:

(A) An SSI-related client;

(B) A child not described in subsection (1)(b)(i); or

(C) A client related to medical eligibility as described in WAC 388-513-1315 (10), (11), or (12).

(2) A client's institutional status is not affected by a:

(a) Transfer between medical facilities; or

(b) Change from one kind of long-term care services to another.

(3) A client loses institutional status when the client:

(a) Is absent from the medical facility for at least thirty consecutive days; or

(b) Does not receive waived or hospice services for at least thirty consecutive days.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20

C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1320, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1320, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2). 97-15-025, § 388-513-1320, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090. 96-11-072 (Order 3980), § 388-513-1320, filed 5/10/96, effective 6/10/96; 94-10-065 (Order 3732), § 388-513-1320, filed 5/3/94, effective 6/3/94.]

**WAC 388-513-1325 Determining available income for a single client for long-term care (LTC) services.** This section describes income the department considers available when determining a single client's eligibility for LTC services.

(1) Refer to WAC 388-513-1330 for rules related to available income for legally married couples.

(2) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 388-450-0005 (3) and (4), Income—Ownership and availability;

(b) WAC 388-450-0085, Self-employment income—Allowable expenses;

(c) WAC 388-450-0210 (4)(b), (e), and (h), Countable income for medical programs;

(d) WAC 388-506-0620, SSI-related medical clients;

(e) WAC 388-511-1130, SSI-related income availability; and

(f) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waived, and hospice) services.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1325, filed 12/8/99, effective 1/8/00.]

**WAC 388-513-1330 Determining available income for legally married couples for long-term care (LTC) services.** This section describes income the department considers available when determining a legally married client's eligibility for LTC services.

(1) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 388-450-0005 (3) and (4), Income—Ownership and availability;

(b) WAC 388-450-0085, Self-employment income—Allowable expenses;

(c) WAC 388-450-0210 (4)(b), (e), and (h), Countable income for medical programs;

(d) WAC 388-506-0620, SSI-related medical clients;

(e) WAC 388-511-1130, SSI-related income availability; and

(f) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waived, and hospice) services.

(2) For an institutionalized client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available, unless subsection (4) applies:

(a) Income received in the client's name;

(b) Income paid to a representative on the client's behalf;



(c) One-half of the income received in the names of both spouses; and

(d) Income from a trust as provided by the trust.

(3) The department considers the following income unavailable to an institutionalized client:

(a) Separate or community income received in the name of the community spouse; and

(b) Income established as unavailable through a fair hearing.

(4) For the determination of eligibility only, if available income described in subsections (2)(a) through (d) minus income exclusions described in WAC 388-513-1340 exceeds the special income level (SIL), then:

(a) The department follows community property law when determining ownership of income;

(b) Presumes all income received after marriage by either or both spouses to be community income; and

(c) Considers one-half of all community income available to the institutionalized client.

(5) If both spouses are either applying or approved for LTC services, then:

(a) The department allocates one-half of all community income described in subsection (4) to each spouse; and

(b) Adds the separate income of each spouse respectively to determine available income for each of them.

(6) The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.

(7) The department considers income not generated by a transferred resource available to the client, even when the client transfers or assigns the rights to the income to:

(a) The spouse; or

(b) A trust for the benefit of the spouse.

(8) The department evaluates the transfer of a resource described in subsection (6) according to WAC 388-513-1365 and 388-513-1366 to determine whether a penalty period of ineligibility is required.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1330, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1330, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-513-1330, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1330, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1330, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-335 and 388-95-340.]

**WAC 388-513-1340 Determining excluded income for long-term care (LTC) services.** This section describes income the department excludes when determining a client's eligibility and participation in the cost of care for LTC services with the exceptions described in subsections (30) and (33).

(1) Crime victim's compensation;

(2) Earned income tax credit (EITC);

(3) Native American benefits excluded by federal statute (refer to WAC 388-450-0040);

(4) Tax rebates or special payments excluded by other statutes;

(5) Any public agency's refund of taxes paid on real property and/or on food;

(6) Supplemental Security Income (SSI) and certain state public assistance based on financial need;

(7) The amount a representative payee charges to provide services when the services are a requirement for the client to receive the income;

(8) The amount of expenses necessary for a client to receive compensation, e.g., legal fees necessary to obtain settlement funds;

(9) Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution;

(10) Child support payments received from an absent parent for a minor child who is not institutionalized;

(11) The amount of expenses related to impairments of a permanently and totally disabled client that allow the client to work;

(12) The amount of expenses related to blindness that allow the client to work;

(13) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);

(14) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(15) Assistance (other than wages or salary) received under the Older Americans Act;

(16) Assistance (other than wages or salary) received under the foster grandparent program;

(17) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(18) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(19) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(20) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(21) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(22) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(23) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(24) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(25) Payments made from *Susan Walker v. Bayer Corporation, et al.*, 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(26) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(27) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(28) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(29) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(30) Interest earned from payments described in subsections (24) through (29) is considered available and counted as nonexcluded income;

(31) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(32) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent;

(b) Unusual medical expenses, aid and attendance allowance, and housebound allowance, with the exception described in subsection (33);

(33) Benefits described in subsection (32)(b) for a client who resides in a state veterans' home and has no dependents are excluded when determining eligibility, but are considered available when determining participation in the cost of care.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-513-1340, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1340, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1340, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

**WAC 388-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program.** This section describes income the department disregards when determining a client's eligibility for institutional or hospice services under the MN program. The department considers disregarded income available when determining a client's participation in the cost of care.

(1) The department disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a client is:

(i) Based on need; and

(ii) Totally or partially funded by the federal government or a private agency.

(2) For a client who is related to the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1), the first sixty-five dollars per month of earned income not excluded under WAC 388-513-1340, plus one-half of the remainder.

(3) For a TANF/SFA-related client, fifty percent of gross earned income.

(4) Department of Veterans Affairs benefits if:

(a) Those benefits are designated for:

(i) Unusual medical expenses;

(ii) Aid and attendance allowance; or

(iii) Housebound allowance; and

(b) The client:

(i) Resides in a state veterans' home; and

(ii) Has no dependents.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-513-1345, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1345, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1345, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

**WAC 388-513-1350 Defining the 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 388-513-1360 Determining excluded resources for long-term care (LTC) services.** This section describes resources the department excludes when determining a client's eligibility for LTC services.

(1) Effective July 1, 1996, if an aged, blind, or disabled client purchases a long-term care insurance policy approved by the Washington insurance commissioner under the Washington long-term care partnership program, the department reduces the client's available resources by the amount paid by the policy for LTC services. The amount the department excludes in this process is not subject to the rules described in WAC 388-513-1365 and 388-513-1366 for a transfer of assets.

(2) The amount of resources described in subsection (1) remains subject to estate recovery rules, if the client retained ownership of them.

(3) If a client has a community spouse, the value of one automobile is excluded regardless of its use or value. This is in addition to the vehicle described in WAC 388-470-0040(7), if the client's current period of institutional status began on or after October 1, 1989.

(4) For SSI-related clients, the department excludes resources described in WAC 388-470-0020 and 388-470-0040.

(5) For clients who are not SSI-related, the department excludes resources according to the rules of the program used to relate them to medical eligibility.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1360, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1360, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and 48.85.020. 96-12-002 (Order 3982), § 388-513-1360, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1360, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-380.]

**WAC 388-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 for long-term care (LTC) services.** This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1366 for rules used to evaluate the transfer of an asset made before March 1, 1997.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC 388-513-1360 with the exception of the client's home,

unless the transfer meets the conditions described in subsection (1)(d);

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4), and the asset is transferred:

(i) To the client's spouse or to another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To the client's child who meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) is less than the value of the transferred asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (1)(f) as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC 388-505-0595.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in subsection (6)(a)(ii).

(7) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1360 does not affect the client's eligibility;

(b) That remains after an acquisition described in subsection (7)(a) becomes an available resource as of the first day of the following month.

(8) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(9) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in (9)(a) is divided by the statewide average monthly private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole months found by following subsections (9)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 01-02-076, § 388-513-1365, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1365, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500, 99-06-045, § 388-513-1365, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.585 and § 17 of the Social Security Act. 97-05-040, § 388-513-1365, filed 2/14/97, effective 3/17/97. Statutory Authority: RCW 74.08.090, 95-02-027 (Order 3818), § 388-513-1365, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-513-1365, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-395.]

**WAC 388-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services.** This section describes how the department evaluates the transfer of an asset made before March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1365 for rules used to evaluate the transfer of an asset on or after March 1, 1997.

(1) When evaluating the transfer of an asset made before March 1, 1997, the department must apply rules described in WAC 388-513-1365 (1) through (4) and (7) through (11) in addition to the rules described in this section.

(2) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received before October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty months, if the asset was transferred before August 11, 1993; or

(b) Thirty-six months, if the asset was transferred on or after August 11, 1993.

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(3) If a client or the client's spouse transferred an asset without receiving adequate compensation before August 11, 1993, the department must establish a penalty period that:

(a) Runs concurrently for transfers made in more than one month in the look-back period; and

(b) Begins on the first day of the month in which the asset is transferred and ends on the last day of the month which is the lesser of:

(i) Thirty months after the month of transfer; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(4) If a client or the client's spouse transferred an asset without receiving adequate compensation on or after August 11, 1993 and before March 1, 1997, the department must establish a penalty period as follows:

(a) If the transfer is made during the look-back period, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

(b) If the transfer is made while the client is receiving LTC services or during a period of ineligibility, then the penalty period:

(i) Begins on the latter of the first day of the month:

(A) In which the transfer is made; or

(B) After a previous penalty period has ended; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1366, filed 12/8/99, effective 1/8/00.]

**WAC 388-513-1380 Determining a client's participation in the cost of care for long-term care (LTC) services.** This 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 waived 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;

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(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 garnished 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.

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(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)(1)(m). 97-16-008, § 388-513-1380, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1380, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 95-11-045 (Order 3848), § 388-513-1380, filed 5/10/95, effective 6/10/95. Statutory Authority: RCW 74.08.090

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and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

**WAC 388-513-1395 Determining eligibility for institutional or hospice services and for facility care only under the medically needy (MN) program.** This section describes how the department determines a client's eligibility for institutional or hospice services and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance under the MN program.

(1) To be eligible for institutional or hospice services under the MN program, a client must meet the financial requirements described in subsection (5)(a). In addition, a client must meet program requirements described in WAC 388-513-1315; and

(a) Be an SSI-related client with nonexcluded income as described in subsection (4)(a) that is more than the special income level (SIL); or

(b) Be a child not described in subsection (1)(a) with nonexcluded income as described in subsection (4)(b) that exceeds the categorically needy (CN) standard for the children's medical program.

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total is less than the:

(a) Private facility rate plus the amount of recurring medical expenses, for institutional services; or

(b) Private hospice rate plus the amount of recurring medical expenses, for hospice services received at home.

(3) The department determines a client's nonexcluded resources for institutional and hospice services under the MN program in the following way:

(a) For an SSI-related client, the department reduces available resources described in WAC 388-513-1350 by excluding resources described in WAC 388-513-1360;

(b) For a child not described in subsection (3)(a), no determination of resource eligibility is required.

(4) The department determines a client's nonexcluded income for institutional and hospice services under the MN program in the following way:

(a) For an SSI-related client, the department reduces available income as described in WAC 388-513-1325 and 388-513-1330 by:

(i) Excluding income described in WAC 388-513-1340;

(ii) Disregarding income described in WAC 388-513-1345; and

(iii) Subtracting previously incurred medical expenses that:

(A) Are not subject to third-party payment;

(B) Have not been used to satisfy a previous spenddown liability; and

(C) Are amounts for which the client remains liable.

(b) For a child not described in subsection (4)(a), the department:

(i) Follows the income rules described in WAC 388-505-0210 for the children's medical program; and

(ii) Subtracts the medical expenses described in subsection (4)(a)(iii).

(5) If the combined total of a client's nonexcluded income, which when added to nonexcluded resources in excess of the standard described in WAC 388-513-1350(1), is:

(a) Less than the department-contracted rate plus the amount of recurring medical expenses, the client:

(i) Is eligible for institutional and hospice services and noninstitutional medical assistance;

(ii) Is approved for a choice of three or six months as described in chapter 388-416 WAC; and

(iii) Participates in the cost of care as described in WAC 388-513-1380;

(b) Less than the private facility rate plus the amount of recurring medical expenses, but more than the department-contracted rate, the client:

(i) Is eligible for facility care only that is approved for a choice of three or six months as described in chapter 388-416 WAC;

(ii) Participates in the cost of care as described in WAC 388-513-1380; and

(iii) Is approved for noninstitutional medical assistance for a choice of three or six months as described in chapters 388-416 and 388-519 WAC, if income and resources remaining after allocations described in WAC 388-513-1380 are used to satisfy any spenddown liability.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1395, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1395, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-513-1395, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-513-1395, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1395, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-400.]

**WAC 388-513-1396 Clients living in a fraternal, religious, or benevolent nursing facility.** This section describes how the department determines eligibility for institutional services and noninstitutional medical assistance for a client living in a fraternal, religious, or benevolent nursing facility.

(1) For a client living in a licensed nursing facility operated by a fraternal, religious, or benevolent organization who meets all other eligibility requirements, the department approves institutional services and noninstitutional medical assistance, if:

(a) Any contract between the client and the facility excludes such benefits on a free or prepaid basis for life; or

(b) The facility is unable to fulfill the terms of the contract and has:

(i) Voided the contract; and

(ii) Refunded any of the client's existing assets to the client.

(2) For a client described in subsection (1), the department denies institutional services and noninstitutional medical assistance, if the client:

(a) Signs a contract with the organization that includes such benefits on a free or prepaid basis for life; and

(b) Surrenders income and/or resources to the organization in exchange for such benefits.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(e), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1396, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1396, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-310.]

**Chapter 388-515 WAC**

**ALTERNATE LIVING—INSTITUTIONAL MEDICAL**

**WAC**

388-515-1505	Community options program entry system (COPES).
388-515-1510	Community alternatives program (CAP) and outward bound residential alternatives (OBRA).
388-515-1530	Coordinated community AIDS services alternatives (CASA) program.

**WAC 388-515-1505 Community options program entry system (COPES).** This section describes the financial eligibility requirements for waiver services under the community options program entry system (COPES) and the rules used to determine a client's participation in the total cost of care.

(1) To be eligible for COPES a client must:

(a) Be eighteen years of age or older;

(b) Meet the disability criteria of the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1);

(c) Require the level of care provided in a nursing facility as described in WAC 388-71-0700;

(d) Be residing in a medical facility as defined in WAC 388-513-1301, or likely be placed in one within the next thirty days in the absence of waived services described in WAC 388-71-0410 and 388-71-0415;

(e) Have attained institutional status as described in WAC 388-513-1320;

(f) Be determined in need of waived services and be approved for a plan of care as described in WAC 388-71-0435;

(g) Be able to live at home with community support services and chooses to remain at home, or live in a department-contracted:

(i) Enhanced adult residential care (EARC) facility;

(ii) Licensed adult family home (AFH); or

(iii) Assisted living (AL) facility.

(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1365 and 388-513-1366; and

(i) Meet the resource and income requirements described in subsections (2), (3) and (4).

(2) Refer to WAC 388-513-1315 for rules used to determine nonexcluded resources and income.

(3) Nonexcluded resources above the standard described in WAC 388-513-1350(1):

(2003 Ed.)

(a) Are allowed during the month of an application or eligibility review if, when excess resources are added to non-excluded income, the combined total is not over the special income level (SIL).

(b) Are reduced by 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:

(i) Health insurance and Medicare premiums, deductions, and co-insurance charges; and

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan.

(c) Not allocated to participation must be at or below the resource standard.

[(a)] (4) Nonexcluded income:

(a) Must be at or below the SIL;

(b) Is allocated in the following order:

(i) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(ii) Maintenance and personal needs allowances as described in subsection (6), (7), and (8) of this section;

(iii) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-079 WAC;

(iv) Income garnisheed for child support or withheld pursuant to a child support order:

(A) For the time period covered by the maintenance amount; and

(B) Not deducted under another provision in the post-eligibility process.

(v) Monthly maintenance needs allowance for the community spouse not to exceed that in WAC 388-513-1380 (6)(b) unless a greater amount is allocated as described in subsection (5) of this section. This amount:

(A) Is allowed only to the extent that the client's income is made available to the community spouse; and

(B) Consists of a combined total of both:

(I) An amount added to the community spouse's gross income to provide a total equal to the amount allocated in WAC 388-513-1380 (6)(b); and

(II) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for the community spouse's principal residence of:

• Rent;

• Mortgage;

• Taxes and insurance;

• Any maintenance care for a condominium or cooperative; and

• The food assistance standard utility allowance (for LTC services this is set at the standard utility allowance (SUA) for a four-person household), provided the utilities are not included in the maintenance charges for a condominium or cooperative;

• LESS the standard shelter allocation listed in WAC 388-513-1380 (7)(a).

(III) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community or institutionalized spouse based on the living arrangement of the dependent. If the dependent:

- Resides with the community spouse, the amount is equal to one-third of the community spouse income allocation as described in WAC 388-513-1380 (6)(b)(I)(A) that exceeds the dependent family member's income;

- Does not reside with the community spouse, the amount is equal to the MNIL for the number of dependent family members in the home less the income of the dependent family members. Child support received from an absent parent is the child's income;

- Incurred medical expenses described in subsection (3)(b) not used to reduce excess resources.

(5) The amount allocated to the community spouse may be greater than the amount in subsection (4)(b)(iv) 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.

(6) A client who receives SSI does not use income to participate in the cost of personal care, but does use SSI income to participate in paying costs of board and room. Other income an SSI client receives is used to participate in the cost of personal care. Such a client who lives:

(a) At home, retains a maintenance needs amount equal to the following:

(i) Up to one hundred percent of the one-person Federal Poverty Level (FPL), if the client is:

(A) Single; or

(B) Married, and is:

(I) Not living with the community spouse; or

(II) Whose spouse is receiving long-term care (LTC) services outside of the home.

(ii) Up to one hundred percent of the one-person FPL for each client, if both are receiving COPES services;

(iii) Up to the one-person MNIL if the client is living with a community spouse who is not receiving LTC services.

(b) In an EARC, AFH, or AL:

(i) Retains a personal needs allowance (PNA) of fifty-eight dollars and eighty-four cents; and

(ii) Pays remaining SSI income to the facility for the cost of board and room.

(7) An SSI-related client living:

(a) At home, retains a maintenance needs amount equal to the following:

(i) Up to one hundred percent of the one-person Federal Poverty Level (FPL), if the client is:

(A) Single; or

(B) Married, and is:

(I) Not living with the community spouse; or

(II) Whose spouse is receiving long-term care (LTC) services outside of the home.

(ii) Up to one hundred percent of the one-person FPL for each client, if both are receiving COPES services;

(iii) Up to the one-person medically needy income level (MNIL) for a married client who is living with a community spouse who is not receiving COPES.

(b) In an ARC, EARC, AFH, or AL retains a maintenance needs amount equal to the one-person MNIL and:

(i) Retains a PNA taken from the MNIL of fifty-eight dollars and eighty-four cents; and

(ii) Pays the remainder of the MNIL to the facility for the cost of board and room.

(8) A client who is eligible for the general assistance expedited Medicaid disability (GAX) program does not participate in the cost of personal care. Such a client who lives:

(a) At home, retains the cash grant amount authorized under the general assistance program; or

(b) In an AFH, EARC, or AL, retains a PNA of thirty-eight dollars and eighty-four cents, and pays remaining income and GAX grant to the facility for the cost of board and room.

(9) The client's remaining income after the allocations described in subsections (4) through (8) is the client's participation in the total cost of care.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 02-05-003, § 388-515-1505, filed 2/7/02, effective 3/10/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1505, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-515-1505, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-14-058 (Order 100346), § 388-515-1505, filed 6/27/96, effective 7/28/96; 95-20-030 (Order 3899), § 388-515-1505, filed 9/27/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-515-1505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-200.]

**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 388-515-1510 Community alternatives program (CAP) and outward bound residential alternatives (OBRA).** This section describes the eligibility requirements for waived services under the CAP and OBRA programs and the rules used to determine a client's participation in the cost of care.

(1) The department establishes eligibility for CAP and OBRA services for a client who:

(a) Is both Medicaid eligible under the categorically needy (CN) program and meets the requirements for services provided by the division of developmental disabilities (DDD);

(b) Has attained institutional status as described in WAC 388-513-1320;

(c) Has been assessed as requiring the level of care provided in an intermediate care facility for the mentally retarded (IMR);

(d) Has a department-approved plan of care that includes support services to be provided in the community;

(e) Is able to reside in the community according to the plan of care and chooses to do so;

(f) Meets the income and resource requirements described in subsection (2); and

(g) For the OBRA program only, the client must be a medical facility resident at the time of application.

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonex-

cluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

(a) Nonexcluded income must be at or below the SIL; and

(b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(3) A client who is eligible for supplemental security income (SSI) does not participate in the cost of care for CAP or OBRA services.

(4) An SSI-related client retains a maintenance needs amount of up to the SIL, who is:

(a) Living at home; or

(b) Living in an alternate living facility described in WAC 388-513-1305(1).

(5) A client described in subsection (4)(b) retains the greater of:

(a) The SSI grant standard; or

(b) An amount equal to a total of the following:

(i) A personal needs allowance (PNA) of thirty-eight dollars and eighty-four cents; plus

(ii) The facility's monthly rate for board and room, which the client pays to the facility; plus

(iii) The first twenty dollars of monthly earned or unearned income; and

(iv) The first sixty-five dollars plus one-half of the remaining earned income not previously excluded.

(6) If a client has a spouse in the home who is not receiving CAP or OBRA services, the department allocates the client's income in excess of the amounts described in subsections (4) and (5) as an additional maintenance needs amount in the following order:

(a) One for the spouse, as described in WAC 388-513-1380 (7)(b); and

(b) One for any other dependent family member in the home, as described in WAC 388-513-1380 (7)(c).

(7) A client's participation in the cost of care for CAP or OBRA services is the client's income:

(a) That exceeds the amounts described in subsections (4), (5), and (6); and

(b) Remains after deductions for medical expenses not subject to third-party payment for which the client remains liable, included in the following:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical care recognized under state law but not covered by Medicaid.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1510, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-515-1510, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1510, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-515-1510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-210.]

(2003 Ed.)

**WAC 388-515-1530 Coordinated community AIDS services alternatives (CASA) program.** This section describes the eligibility requirements for waived services under the CASA program and the rules used to determine a client's participation in the cost of care.

(1) The department establishes eligibility for CASA services for a client who:

(a) Meets the disability criteria of the supplemental security income (SSI) program as described in WAC 388-503-0510(1);

(b) Has attained institutional status as described in WAC 388-513-1320;

(c) Has been diagnosed with:

(i) Acquired Immune Deficiency Syndrome (AIDS) or disabling Class IV human immunodeficiency virus disease; or

(ii) P2 HIV/AIDS, if fourteen years old or younger;

(d) Has been certified by the client's physician or nurse practitioner to be in the terminal state of life;

(e) Has been assessed as being medically at risk for needing inpatient care;

(f) Has a plan of care approved by the department and the department of health (DOH);

(g) Does not have private insurance, including a COBRA extension, that covers inpatient hospital care;

(h) Is able to live at home or in an alternate living facility (ALF) described in WAC 388-513-1305(1) and chooses to do so; and

(i) Meets the income and resource requirements described in subsection (2).

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or an eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

(a) Nonexcluded income must be at or below the SIL; and

(b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(3) A client who is eligible for SSI does not participate in the cost of care for CASA services.

(4) An SSI-related client retains a maintenance needs amount, if:

(a) Living at home, of up to the SIL; or

(b) Living in an ALF described in WAC 388-513-1305(1), of thirty-eight dollars and eighty-four cents.

(5) The income of a client described in subsections (4)(a) or (b) that exceeds the maintenance needs amount is allocated as described in WAC 388-513-1380 (7)(a) through (d), (8) and (9).

(6) The income of a client described in subsection (4)(b) that exceeds the maintenance needs amount and the amount described in subsection (5) is paid to the facility for the cost of board and room up to an amount that is equal to the difference between the:

(a) Amount of the SIL; and

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(b) The combined total of amounts described in subsections (4)(b) and (5).

(7) A client's participation in the cost of care for CASA services is the amount of income that remains after allocations described in subsections (4), (5), and (6).

(8) The client must meet any participation obligation, in order to remain eligible.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1530, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-515-1530, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1530, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 95-18-001 (Order 3882), § 388-515-1530, filed 8/23/95, effective 9/23/95; 94-10-065 (Order 3732), § 388-515-1530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-220.]

## Chapter 388-517 WAC

### MEDICARE-RELATED MEDICAL ELIGIBILITY

#### WAC

388-517-0300 Medicare savings programs.  
388-517-0400 Medicare coinsurance payment—Extended care patient.

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

388-517-1710 Medicare cost-sharing programs. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1710, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1710, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-060.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300.

388-517-1715 Qualified Medicare beneficiary (QMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1715, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1715, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1715, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(1) and 388-517-0500(6).

388-517-1720 Qualified Medicare beneficiaries—Income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m). 97-16-008, § 388-517-1720, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1720, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1720, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1730 Special low-income Medicare beneficiaries (SLMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1730, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1730, filed 6/28/95, effective 7/29/95;

94-10-065 (Order 3732), § 388-517-1730, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(2) and 388-517-0300(4).

388-517-1740 Special low-income Medicare beneficiaries (SLMB)—Income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m). 97-16-008, § 388-517-1740, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1740, filed 7/10/96, effective 7/10/96; 95-23-030 (Order 3917, #100251), § 388-517-1740, filed 11/8/95, effective 12/9/95; 95-11-056 (Order 3848A), § 388-517-1740, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1740, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1750 Qualified disabled working individuals (QDWI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1750, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1750, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1750, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(6) and 388-478-0085.

388-517-1760 Qualified disabled working individuals (QDWI) income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m). 97-16-008, § 388-517-1760, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1760, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1760, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1760, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1770 Qualified individuals (QI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1770, filed 5/19/98, effective 6/19/98.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(7) and 388-478-0085(5).

**WAC 388-517-0300 Medicare savings programs.** The Medicare savings programs help a client pay some of the costs that Medicare does not cover. When determining eligibility for these programs, the department follows the income and resource methodology of the Supplemental Security Income (SSI) program described in chapter 388-474 WAC. For a client receiving long-term care (LTC) services, refer to subsection (4) of this section.

(1) The department determines a person's eligibility in the following order:

- (a) The qualified medicare beneficiary (QMB) program;
- (b) The specified low-income medicare beneficiary (SLMB) program;
- (c) The qualified individual (QI-1) program, formerly known as the expanded special low income Medicare beneficiary (ESLMB) program;

(d) The qualified disabled working individual (QDWI) program;

(e) The qualified individual (QI-2) program, formerly known as the qualified individual (QI) program;

(f) The state-funded buy-in program, formerly known as the Medicare buy-in program.

(2) In order to be eligible for any of these programs, a person must:

(a) Be eligible or receiving Medicare Part A; and

(b) For the QDWI program only, be under the age of sixty-five; and

(c) Have nonexcluded resources at or below the resource standard, see WAC 388-478-0085(6).

(3) A person must also meet the income standards as follows:

(a) For the QMB program, see WAC 388-478-0085(1);

(b) For the SLMB program, see WAC 388-478-0085(2);

(c) For the QI-1 program, see WAC 388-478-0085(3);

(d) For the QDWI program, see WAC 388-478-0085(4);

(e) For the QI-2 program, see WAC 388-478-0085(5);

and

(f) For the state-paid buy-in program, there is no maximum income limit as long as the person receives services under either categorically needy (CN) or medically needy (MN) programs.

(4) When determining an LTC client's eligibility for Medicare savings programs, the department considers countable income and resources left after the following are deducted:

(a) Allocations to a spouse and/or dependent family members; and

(b) The client's participation in the cost of care.

Refer to chapter 388-513 WAC for the LTC rules.

(5) The department adjusts income standards for Medicare savings programs on April 1st of each year, see WAC 388-478-0085. The department also applies the annual Social Security cost-of-living adjustment (COLA) for these programs on April 1st of each year. Therefore, the annual COLA does not effect the eligibility of either applicants or clients of Medicare savings programs until April 1st of each year.

(6) The department pays the following benefits for Medicare savings program clients:

(a) Under the QMB program: Medicare Part A if any, Part B premiums, coinsurance, deductibles as described in subsection (7) of this section, and medical expenses the client's Medicare managed care plan charges;

(b) Under the SLMB or QI-1 programs: Only Medicare Part B premiums (see the exception under subsection (11) of this section);

(c) Under the QDWI program: Only Medicare Part A premiums;

(d) Under the QI-2 program: Only a part of the client's Medicare Part B premiums. The Centers for Medicare and Medicaid (CMS) determine the amount which is paid. The department pays the client on an annual basis (see the exception under subsection (11) of this section); and

(e) Under the state-funded buy-in program: Medicare Part B premiums, coinsurance, deductibles as described in

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subsection (7) of this section, and medical expenses a client's Medicare managed care plan charges.

(7) The department has certain maximum payments for services provided to Medicare savings programs clients:

(a) Medicare co-insurance charges are paid only if the Medicaid payment rate is higher than the amount paid by Medicare, and within that limit, only the cost-sharing liability;

(b) Dual eligible clients are those who are eligible for QMB and SLMB programs and another Medicaid program. For dual eligibles, the department's maximum payment is:

(i) for covered services, the Medicaid or the Medicare payment rate whichever is lower; and

(ii) for services only covered by Medicare, the Medicare deductibles and co-insurance is the maximum Medicaid payment.

(8) The department does authorize QMB, SLMB or state-funded buy-in programs for the client receiving categorically needy (CN) or medically needy (MN) programs. The state-funded buy-in program is only for a client receiving CN or MN medical coverage who is not eligible for the QMB or SLMB programs.

(9) The department does not authorize QI-1, QI-2, or QDWI programs for a client receiving CN or MN medical program benefits.

(10) The department does not authorize the QI-2 program for a client who is eligible for one of the other Medicare savings programs.

(11) When the department's annual allotment of federal funds for the QI-1 and QI-2 programs is exhausted, the department does not authorize benefits under the respective program for the remainder of that calendar year.

(12) For certification periods for the Medicare savings programs, refer to WAC 388-416-0035.

[Statutory Authority: RCW 74.08.090, 74.09.530, 02-11-074, § 388-517-0300, filed 5/13/02, effective 6/13/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-517-0300, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1710, 388-517-1730, 388-517-1750 and 388-517-1770.]

**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 388-519 WAC

### SPENDEDOWN

#### WAC

388-519-0100

388-519-0110

388-519-0120

Eligibility for the medically needy program.

Spendedown of excess income for the medically needy program.

Spendedown—Medically indigent program.



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

- 388-519-1905 Base period. [Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-519-1905, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-519-1905, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-519-1905, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-416-0025 and 388-519-0120.
- 388-519-1910 Allowable income deductions and exemptions. [Statutory Authority: RCW 74.08.090. 96-14-057 (Order 3986), § 388-519-1910, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1910, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-020 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020, 388-450-0110, 388-450-0150, 388-450-0210 and 388-519-0110.
- 388-519-1930 Computing spenddown; allowable spenddown expenses. [Statutory Authority: RCW 74.08.090. 96-14-057 (Order 3986), § 388-519-1930, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1930, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-020 and 388-99-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-519-0100 and 388-476-0070.
- 388-519-1950 Institutional spenddown. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-519-1950, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

**WAC 388-519-0100 Eligibility for the medically needy program.** (1) A person who meets the following conditions is considered for medically needy (MN) coverage under the special rules in chapter 388-513 WAC.

(a) A person who meets the institutional status requirements of WAC 388-513-1320; or

(b) A person who receives waiver services under chapter 388-515 WAC.

(2) MN coverage is considered under this chapter when a person:

(a) Is not excluded under subsection (1) of this section; and

(b) Is not eligible for categorically needy (CN) medical coverage because they have CN countable income which is above the CN income standard.

(3) MN coverage is available for children, for persons who are pregnant or for persons who are SSI-related. MN coverage is available to an aged, blind, or disabled ineligible spouse of an SSI recipient even though that spouse's countable income is below the CN income standard. Adults with no children must be SSI related in order to be qualified for MN coverage.

(4) A person not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to those used to arrive at CN countable income. The following deductions are used to calculate their countable income for MN. Those deductions to income are applied to each month of the base period and determine MN countable income:

(a) All health insurance premiums expected to be paid by the client during the base period are deducted from their income; and

(b) For persons who are SSI-related and who are married, see the income provisions for the nonapplying spouse in WAC 388-450-0210; and

(c) For persons who are not SSI-related and who are married, an income deduction is allowed for a nonapplying spouse:

(i) If the nonapplying spouse is living in the same home as the applying person; and

(ii) The nonapplying spouse is receiving community and home based services under chapter 388-515 WAC; then

(iii) The income deduction is equal to the one person MNIL less the nonapplying spouse's actual income.

(5) A person who meets the above conditions is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070. They are certified as eligible for up to twelve months of MN medical coverage. Certain SSI or SSI-related clients have a special MNIL. That MNIL exception is described in WAC 388-513-1305.

(6) A person whose MN countable income exceeds the MNIL may become eligible for MN medical coverage when they have or expect to have medical expenses. Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.

(7) That portion of a person's MN countable income which is over the department's MNIL standard is called "excess income."

(8) When a person has or will have "excess income" they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown."

(9) A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter a person is ineligible for MN coverage if their resources exceed the program standard in WAC 388-478-0070. A person who is considered for MN coverage under chapter 388-513 WAC is allowed to spenddown excess resources.

(10) No extensions of coverage or automatic redetermination process applies to MN coverage. A client must submit an application for each eligibility period under the MN program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0320, 388-518-1840, 388-519-1930 and 388-522-2230.]

**WAC 388-519-0110 Spenddown of excess income for the medically needy program.** (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.

(2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.

(3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three

calendar months immediately prior to the month of application.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) A client is not or will not be resource eligible for the required base period; or

(c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.

(6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).

(7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:

(a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;

(b) Second, medical expenses which would not be covered by the MN program;

(c) Third, hospital expenses paid by the person during the base period;

(d) Fourth, hospital expenses, regardless of age, owed by the applying person;

(e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and

(f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.

(8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

(9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.

(10) To be counted toward spenddown, medical expenses must:

(a) Not have been used to meet a previous spenddown; and

(b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:

(i) Forty-five days of the date of the service; or

(ii) Thirty days after the base period ends; and

(c) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period and be for services for:

(A) The applying person; or

(B) A family member legally or blood-related and living in the same household as the applying person.

(ii) Be for services received and paid for during the base period; or

(iii) Be for services received and paid for during a previous base period if that client payment was made necessary due to delays in the certification for that base period.

(11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do not qualify if they were paid by the program before the first day of the base period.

(12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:

(a) Charges for services which would have been covered by the department's medical programs as described in chapter 388-529 WAC, less any confirmed third party payments which apply to the charges; and

(b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable items or services must have been provided or prescribed by a licensed health care provider; and

(c) Medical insurance and Medicare copayments or coinsurance (premiums are income deductions under WAC 388-519-0100(4)); and

(d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days.

(13) Medical expenses may be used more than once if:

(a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and

(b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.

(14) To be considered toward spenddown, written proof of medical expenses must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.

(15) Once a person meets their spenddown and they are issued a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a clients failure to identify or list medical expenses.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0110, filed 7/31/98, effective 9/1/98. Formerly WAC

388-518-1830, 388-518-1840, 388-519-1905, 388-519-1910, 388-519-1930 and 388-522-2230.]

**WAC 388-519-0120 Spenddown—Medically indigent program.** (1) Persons ineligible for CN or MN coverage are considered for the medically indigent (MI) program under chapter 388-438 WAC. Medically indigent spenddown differs from medically needy spenddown in the following ways:

(a) In addition to spending down income in excess of the MNIL, the amount of countable resources which is in excess of the standard in WAC 388-478-0070 is spent down.

(b) The base period for MI begins on the first day of the month in which the following occurred:

- (i) Emergency ambulance transportation; or
- (ii) Hospital emergency room services were received; or
- (iii) The person was hospitalized for the emergency condition.

(c) The base period for MI is three months and it can join retroactive and prospective months into the same base period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0120, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1905.]

## Chapter 388-523 WAC

### MEDICAL EXTENSIONS

#### WAC

388-523-0100	Medical extensions—Eligibility.
388-523-0110	Medical extensions—Reporting requirements.
388-523-0120	Medical extensions—Premiums.
388-523-0130	Medical extension—Redetermination.

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

388-523-2305	Medical extensions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-523-2305, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-523-2305, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-029.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.
388-523-2320	Medicaid quarterly reporting. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-523-2320, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

#### WAC 388-523-0100 Medical extensions—Eligibility.

(1) A family who received temporary assistance for needy families (TANF), or family medical program in any three of the last six months in the state of Washington is eligible for extended medical benefits when they become ineligible for their current medical program because the family receives:

(a) Child or spousal support, which exceeds the payment standard described in WAC 388-478-0065, and they are not eligible for any other categorically needy (CN) medical program; or

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(b) Increased earned income, resulting in income exceeding the CN income standard described in WAC 388-478-0065.

(2) A family is eligible to receive extended medical benefits beginning the month after termination from TANF cash or family medical program for:

(a) Four months for a family described in subsection (1)(a) of this section; or

(b) Up to twelve months, in two six-month segments, for a family described in subsection (1)(b) of this section. For the purposes of this chapter, months one through six are the initial six-month extension period. Months seven through twelve are the second six-month extension period.

(3) A family member is eligible to receive six months of medical extension benefits as described in subsection (2)(b) of this section unless:

(a) The individual family member:

(i) Moves out of state;

(ii) Dies;

(iii) Becomes an inmate of a public institution;

(iv) Leaves the household; or

(v) Does not cooperate, without good cause, with the division of child support or with third party liability requirements.

(b) The family:

(i) Moves out of state;

(ii) Loses contact with the department or the department does not know the whereabouts of the family; or

(iii) No longer includes a child as defined in WAC 388-404-0005(1).

(4) A family member is eligible to receive the second six months of medical extension benefits as described in subsection (2)(b) of this section unless:

(a) The family is no longer eligible for the reasons described in subsection (3)(a) or (b); or

(b) The individual family member is the caretaker adult who:

(i) Stops working or whose earned income stops;

(ii) Does not, without good cause, complete and return the completed medical extension report or otherwise provide the required income and child care information; or

(iii) Does not, without good cause, pay the billed premium amount for one month.

(5) A family described in subsection (3) will not receive medical extension benefits for any family member who has been found ineligible for TANF/SFA cash because of fraud in any of the six months prior to the medical extension period.

(6) For the purposes of this chapter, only individual family members that are eligible for Medicaid are certified to receive medical benefits under this program.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-523-0100, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 02-10-018, § 388-523-0100, filed 4/22/02, effective 5/23/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-523-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2210, 388-523-2305 and 388-523-2320.]

**WAC 388-523-0110 Medical extensions—Reporting requirements.** (1) The family must report family income and

employment-related child care costs the family pays by the twenty-first day of:

(a) Month four of the extension period, for months one, two, and three; and

(b) Month seven of the extension period, for months four, five, and six.

(2) Circumstances may prevent a family from meeting the reporting requirements in subsection (1) of this section. The family remains eligible for the medical extension when good cause exists. Reasons for good cause include, but are not limited to:

(a) Illness, mental impairment, injury, trauma, or stress;

(b) Lack of understanding the reporting requirement due to a language barrier;

(c) Transportation problems;

(d) Payment for work in each month of the reporting period was paid in a different month than it was earned;

(e) The client expected to be able to meet the family medical needs, but could not; or

(f) The client was given incorrect information about the reporting requirements. Refer to WAC 388-422-0020 (4) and (5).

[Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209.02-10-018, § 388-523-0110, filed 4/22/02, effective 5/23/02.]

#### WAC 388-523-0120 Medical extensions—Premiums.

(1) "**Countable income**" means, for the purposes of determining the premium amount described in this chapter, all earned and unearned income of the adult family members except SSI cash assistance, minus the amount of employment-related child care paid for by the family. The earned and unearned income of an adult, living in the household, who is financially responsible for other members of the assistance unit is included, whether or not the person is an eligible member of the assistance unit.

(2) For a family whose first month of medical extension benefits occurs on or after February 2002, the department requires the family pay premiums for medical coverage provided during the second six-month medical extension period. The premium amount is one percent of the family's countable income per person/per month. This amount is rounded down to the nearest whole dollar.

(3) The premiums for:

(a) Months seven, eight, and nine are based solely on the average countable income received in months one, two and three of the medical extension period; and

(b) Months ten, eleven, and twelve are based solely on the average countable income received in months four, five, and six of the medical extension period.

(4) A subsequent change in income does not effect the premium amount described in subsection (2) and (3) of this section.

(5) When a family's premium is one month in arrears, the family is ineligible for the balance of the medical extension period unless good cause exists. Reasons for good cause include, but are not limited to:

(a) Illness, mental impairment, injury, trauma, or stress;

(b) Lack of understanding the premium payment requirement due to a language barrier;

(c) Transportation problems;

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(d) The client did not pay the premium because they expected to be able to meet the family medical needs, but could not; or

(e) The client was given incorrect information or did not receive advance and adequate notice about the premium payment requirements. Refer to WAC 388-422-0020 (4) and (5).

(6) The department exempts individual family members from the premium requirements, as follows:

(a) Children;

(b) Pregnant women;

(c) American Indians and Alaska Natives; and

(d) Caretaker adults in a family whose countable income is equal to or less than one hundred percent of the Federal Poverty Level based on family size as described in WAC 388-478-0075(2).

(7) When determining the exemption described in (6)(d), the department shall include in the household size an unborn child and a person who is financially responsible for other members of the assistance unit, whether or not the person is an eligible member of the assistance unit. A person receiving SSI cash assistance is not included when determining the household size.

(8) The department determines a family's exemption from the premium requirement as described in subsection (6)(d) for:

(a) Months seven, eight and nine based solely on information available to the department at the time the premium for these months is calculated; and

(b) Months ten, eleven, and twelve based solely on information available to the department at the time the premium for these months is calculated.

(9) Any income change resulting in an individual meeting the exemption criteria in subsection (6)(d) after the establishment of the premium amount for months seven, eight and nine is used to calculate the premium amount for months ten, eleven, and twelve.

[Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209.02-10-018, § 388-523-0120, filed 4/22/02, effective 5/23/02.]

#### WAC 388-523-0130 Medical extension—Redetermination.

(1) When the department determines the family or an individual family member is ineligible during the medical extension period, the department must determine if they are eligible for another medical program.

(2) When a family reports a reduction of income, the family may be eligible for a family medical program instead of medical extension benefits.

(3) Postpartum and family planning extensions are described in WAC 388-462-0015.

[Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209.02-10-018, § 388-523-0130, filed 4/22/02, effective 5/23/02.]

### Chapter 388-526 WAC

#### MEDICAL FAIR HEARINGS

##### WAC

388-526-2610

Prehearing reviews for clients who request a fair hearing.

**WAC 388-526-2610 Prehearing reviews for clients who request a fair hearing.** (1) A client who does not agree with a department decision regarding medical or dental services has a right to a fair hearing under chapter 388-02 WAC.

(a) See chapter 388-538 WAC for hearing requests regarding managed care plans;

(b) See chapter 388-542 WAC for hearing requests regarding the children's health insurance program (CHIP);

(c) See WAC 388-502-0165 for requests for noncovered services.

(2) When a fair hearing is requested, either the client or MAA has the right to request and the client receive a medical assessment appropriate to the nature of the decision from one or more professionally qualified persons who are not a party to the action being appealed. WAC 388-538-120 applies to clients who are managed care enrollees.

(3) After receiving a request for a fair hearing, MAA may request additional information from the client, the provider, or the department. After MAA reviews the available information, the result may be:

(a) A reversal of the initial department decision;

(b) Resolution of the client's issue(s); or

(c) A fair hearing conducted per chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 34.05.060, 00-21-062, § 388-526-2610, filed 10/16/00, effective 11/16/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-526-2610, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-040.]

### Chapter 388-527 WAC ESTATE RECOVERY

#### WAC

388-527-2700	Purpose.
388-527-2730	Estate recovery definitions.
388-527-2733	No liability for medical care.
388-527-2737	Deferring recovery.
388-527-2740	Age when recovery applies.
388-527-2742	Services subject to recovery.
388-527-2750	Waiver of recovery if undue hardship.
388-527-2754	Assets not subject to recovery and other limits on recovery.
388-527-2790	Filing a lien against real property.
388-527-2795	Serving notices on office of financial recovery (OFR).

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

388-527-2710	Recovery from estates. [Statutory Authority: RCW 74.08.090 and OBRA 1993, HB 2492, 94-17-035 (Order 3768), § 388-527-2710, filed 8/10/94, effective 9/10/94. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-527-2710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-047.] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.
388-527-2720	Restitution. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-527-2720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-050] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.
388-527-2735	Liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18, 95-19-001 (Order 3893), § 388-527-2735, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.
388-527-2752	Deferring recovery. [Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090, 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2752, filed 9/6/95

and 11/29/95, effective 10/7/95 and 12/30/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. No liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18, 95-19-001 (Order 3893), § 388-527-2753, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.

388-527-2753

**WAC 388-527-2700 Purpose.** The department will recover from the estate of a deceased client, the cost of medical care correctly paid on the client's behalf by the department as described by this chapter.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010, 99-11-076, § 388-527-2700, filed 5/18/99, effective 6/18/99.]

**WAC 388-527-2730 Estate recovery definitions.** For estate recovery purposes:

"Estate" means all real and personal property and any other assets that pass upon the client's death under the client's will or by intestate succession pursuant to chapter 11.04 RCW or under chapter 11.62 RCW. An estate also includes:

(1) For a client who died after June 30, 1995 and before July 27, 1997, nonprobate assets as defined by RCW 11.02.005, except property passing through a community property agreement; or

(2) For a client who died after July 26, 1997, nonprobate assets as defined by RCW 11.02.005.

The value of the estate shall be reduced by any valid liability against the deceased client's property at the time of death.

"Long-term care services" means the services administered directly or through contract by the aging and adult services administration of the department, including but not limited to nursing facility care and home and community services.

"State-funded long-term care" means the long-term care services that are paid only with state funds.

"Medical assistance" means the federal aid medical care program provided under Title XIX of the Federal Social Security Act.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010, 99-11-076, § 388-527-2730, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090, 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2730, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

**WAC 388-527-2733 No liability for medical care.** (1) The client's estate is not liable for services provided before July 26, 1987.

(2) The client's estate is not liable when the client died before July 1, 1994 and on the date of death there was:

(a) A surviving spouse; or

(b) A surviving child who was either:

(i) Under twenty-one years of age; or

(ii) Blind or disabled as defined under chapter 388-511 WAC.

(3) The estate of a frail elder or vulnerable adult under RCW 74.34.010 is not liable for the cost of adult protective services (APS) paid for only by state funds.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2733, filed 5/18/99, effective 6/18/99.]

**WAC 388-527-2737 Deferring recovery.** When a client died after June 30, 1994 and received services after June 30, 1994, recovery from the estate is deferred until:

- (1) The death of the surviving spouse, if any; and
- (2) There is no surviving child who is:
  - (a) Under twenty-one years of age, or
  - (b) Blind or disabled as defined under chapter 388-511 WAC.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2737, filed 5/18/99, effective 6/18/99.]

**WAC 388-527-2740 Age when recovery applies.** The client's age and the date when services were received determines whether the client's estate is liable for the cost of medical care provided. Subsection (1) of this section covers liability for medical assistance and subsection (2) covers liability for state-funded long-term care services. An estate may be liable under both subsections.

(1) For a client who on July 1, 1994 was:

(a) Age sixty-five or older, the client's estate is liable for medical assistance that was subject to recovery and which was provided on and after the date the client became age sixty-five or after July 26, 1987, whichever is later;

(b) Age fifty-five through sixty-four years of age, the client's estate is liable for medical assistance that was subject to recovery and which was provided on and after July 1, 1994; or

(c) Under age fifty-five, the client's estate is liable for medical assistance subject to recovery provided on and after the date the client became age fifty-five.

(2) The client's estate is liable for state-funded long-term care services provided on and after July 1, 1995 regardless of the client's age when the services were provided.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2740, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2740, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

**WAC 388-527-2742 Services subject to recovery.** The medical services the client received and the dates when services were provided determines whether the client's estate is liable for the medical care provided. Subsection (1) of this section covers liability for medical assistance and subsection (2) covers liability for state-funded long-term care services. An estate can be liable under both subsections.

(1) The client's estate is liable for:

(a) All medical assistance services provided from July 26, 1987 through June 30, 1994;

(b) The following medical assistance services provided after June 30, 1994 and before July 1, 1995:

- (i) Nursing facility services;
- (ii) Home and community-based services; and
- (iii) Hospital and prescription drug services provided to a client while receiving nursing facility services or home and community-based services.

(c) The following medical assistance services provided after June 30, 1995:

- (i) Nursing facility services;
- (ii) Home and community-based services;
- (iii) Adult day health;
- (iv) Medicaid personal care;
- (v) Private duty nursing administered by the aging and adult services administration of the department; and
- (vi) Hospital and prescription drug services provided to a client while receiving services described under (c)(i), (ii), (iii), (iv), or (v) of this subsection.

(2) The client's estate is liable for all state-funded long-term care services and related hospital and prescription drug services provided after June 30, 1995.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2742, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2742, filed 9/6/95, effective 10/7/95.]

**WAC 388-527-2750 Waiver of recovery if undue hardship.** Recovery is waived under this section when recovery would cause an undue hardship, except as provided in subsection (3) of this section. This waiver is limited to the period during which undue hardship exists.

(1) Undue hardship exists when:

(a) The estate subject to adjustment or recovery is the sole income-producing asset of one or more of the heirs and income is limited; or

(b) Recovery would result in the impoverishment of one or more of the heirs; or

(c) Recovery would deprive an heir of shelter and the heir lacks the financial means to obtain and maintain alternative shelter.

(2) Undue hardship does not exist when:

(a) The adjustment or recovery of the client's cost of assistance would merely cause the client's family members inconvenience or restrict the family's lifestyle.

(b) The heir divests assets to qualify under the undue hardship provision.

(3) When a deceased client's assets were disregarded in connection with a long-term care insurance policy or contract under chapter 48.85 RCW, recovery is not waived.

(4) When a waiver is not granted, the department will provide notice to the person who requested the waiver. The denial of a waiver must state:

(a) The requirements of an application for an adjudicative proceeding to contest the department's decision to deny the waiver; and

(b) Where assistance may be obtained to make such application.

(5) A person may contest the department's decision in an adjudicative proceeding when that person requested the department waive recovery, and suffered a loss because that request was not granted.

(6) An application for an adjudicative proceeding under this section must:

(a) Be in writing;

(b) State the basis for contesting the department's denial of the request to waive recovery;

(c) Include a copy of the department's denial of the request to waive recovery;



(d) Be signed by the applicant and include the applicant's address and telephone number;

(e) Be served within twenty-eight days of the date the applicant received the department's decision denying the request for a waiver. If the applicant shows good cause, the application may be filed up to thirty days late; and

(f) Be served on the office of financial recovery (OFR) as described in WAC 388-527-2795.

(7) An adjudicative proceeding held under this section shall be governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

[Statutory Authority: RCW 74.08.090, 01-02-076, § 388-527-2750, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010, 99-11-076, § 388-527-2750, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090, 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2750, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

**WAC 388-527-2754 Assets not subject to recovery and other limits on recovery.** (1) Recovery does not apply to the first fifty thousand dollars of the estate value at the time of death and is limited to thirty-five percent of the remaining value of the estate for services the client:

(a) Received before July 25, 1993; and

(b) When the client died with:

(i) No surviving spouse;

(ii) No surviving child who is:

(A) Under twenty-one years of age;

(B) Blind; or

(C) Disabled.

(iii) A surviving child who is twenty-one years of age or older.

(2) For services received after July 24, 1993, all services recoverable under WAC 388-527-2742 will be recovered, even from the first fifty thousand dollars of estate value that is exempt above, except as set forth in subsection (3) of this section.

(3) For a client who received services after July 24, 1993 and before July 1, 1994, the following property, up to a fair market value of two thousand dollars, is not recovered from the estate of the client:

(a) Family heirlooms,

(b) Collectibles,

(c) Antiques,

(d) Papers,

(e) Jewelry,

(f) Photos, and

(g) Other personal effects of the deceased client and to which a surviving child is entitled.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010, 99-11-076, § 388-527-2754, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090, 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2754, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

**WAC 388-527-2790 Filing a lien against real property.** (1) Liens are filed, adjustment sought, and other recoveries effected by the department for medical assistance or state-funded long-term care, or both, correctly paid on behalf

of a client consistent with 42 U.S.C. 1396p and chapters 43.20B RCW and 388-527 WAC.

(2) When the department seeks to recover from a client's estate the cost of medical assistance or state-funded long-term care, or both, provided to the client, prior to filing a lien against the deceased client's real property, notice shall be given to:

(a) The probate estate's personal representative, if any; or

(b) Any other person known to have title to the affected property.

(3) Prior to filing a lien against any of the deceased client's real property, a person known to have title to the property shall be notified and have an opportunity for an adjudicative proceeding as follows:

(a) Any person known to have title to the property shall be served with a notice of intent to file lien, which shall state:

(i) The deceased client's name, social security number, if known, date of birth, and date of death;

(ii) The amount of medical assistance, or state-funded long-term care, or both, correctly paid on behalf of the deceased client the department seeks to recover;

(iii) The department's intent to file a lien against the deceased client's real property to recover the medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client;

(iv) The county in which the real property is located; and

(v) The right of the person known to have title to the property to contest the department's decision to file a lien by applying for an adjudicative proceeding with the office of financial recovery (OFR).

(b) An adjudicative proceeding can determine whether:

(i) The amount of medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client alleged by the department's notice of intent to file a lien is correct; and

(ii) The deceased client had legal title to the real property at the time of the client's death.

(4) An application for an adjudicative proceeding must:

(a) Be in writing;

(b) State the basis for contesting the department's notice of intent to file the lien;

(c) Be signed by the applicant and state the applicant's address and telephone number;

(d) Be served on (OFR) within twenty-eight days of the date the applicant received the department's notice of intent to file the lien. An application filed up to thirty days late may be treated as timely filed if the applicant shows good cause for filing late; and

(e) Be served on OFR as described in WAC 388-527-2795.

(5) Persons known to have title to the property shall be notified of the time and place of the adjudicative proceeding by the department when it receives an application for the same.

(6) An adjudicative proceeding under this section shall be governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

(7) If no known title holder requests an adjudicative proceeding, a lien shall be filed by the department twenty-eight days after the date that the notice of intent to file the lien letter was mailed. The lien will be filed against the deceased client's real property in the amount of the correctly paid medical assistance or state-funded long-term care, or both.

(8) If an adjudicative proceeding is conducted in accordance with this regulation, when the final agency decision is issued, the department will file a lien against the deceased client's real property for the amount of the correctly paid medical assistance or state-funded long-term care, or both, as established by that final agency decision.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-527-2790, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2790, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2790, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

**WAC 388-527-2795 Serving notices on office of financial recovery (OFR).** (1) Legal service must be by personal service or certified mail, return receipt requested, to OFR at the address described in this section.

(2) The mailing address of the office of financial recovery is:

Office of Financial Recovery  
P.O. Box 9501  
Olympia, WA 98507-9501.

(3) The physical location of the office of financial recovery is:

Blake Office Park  
4450 10th Avenue Southeast  
Lacey, Washington.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2795, filed 5/18/99, effective 6/18/99.]

## Chapter 388-529 WAC

### SCOPE OF MEDICAL SERVICES

#### WAC

388-529-0100 Scope of covered medical services by program.  
388-529-0200 Medical services available to eligible clients.

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

388-529-2910 Scope of care—Categorically needy. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2910, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.

388-529-2920 Scope of care—Medically needy. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2920, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-060.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.

388-529-2930 Scope of care—GAU/ADATSA—Medical care services. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2930, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.

(2003 Ed.)

388-529-2940 Scope of care—Children's health. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2940, filed 5/3/94, effective 6/3/94.] Repealed by 00-05-039, filed 2/10/00, effective 3/12/00. Statutory Authority: RCW 74.08.090, 74.09.520.

388-529-2950 Scope of care—Medically indigent. [Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-529-2950, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-529-2950, filed 5/3/94, effective 6/3/94. Formerly WAC 388-100-035.] Repealed by 00-05-039, filed 2/10/00, effective 3/12/00. Statutory Authority: RCW 74.08.090, 74.09.520.

388-529-2960 Scope of care—Qualified Medicare beneficiary (QMB), special low-income Medicare beneficiary and qualified disabled working individual (QDWI). [Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510. 98-04-004, § 388-529-2960, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2960, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0100.

**WAC 388-529-0100 Scope of covered medical services by program.** (1) The scope of medical care which clients can receive is based on the medical program for which they are eligible. Clients eligible for the following medical programs have coverage for the medically necessary services indicated in the specific columns in the chart provided in WAC 388-529-0200:

(a) Categorically needy (CN) medical coverage is provided as described in the "CN" column. Coverage is modified by the provisions in this section and those found in other medical-assistance-related WAC;

(b) Medically needy (MN) medical coverage is provided as described in the "MN" column and as modified in this section and in other medical-assistance-related WAC;

(c) General assistance - unemployable (GAU) or alcohol and drug abuse treatment and support act (ADATSA) medical coverage is provided as described in the "MCS" column. Coverage is modified by the provisions in WAC 388-556-0500;

(d) The state-funded children's health program has medical coverage as described in the "CN" column and in subsection (1)(a) of this section;

(e) State-funded medically indigent (MI) program has medical coverage as described in the "MI" column to the extent that services are related to the qualifying emergency condition. Coverage begins after the client has met the annual emergency medical expense requirement (EMER) as described in WAC 388-438-0100.

(f) Pregnant undocumented aliens have medical coverage as described in the "CN" column and in subsection (1)(a) of this section.

(2) "Medically necessary" is a standard for coverage of services under the CN and MN programs. The term is defined in WAC 388-500-0005.

(3) Entries in WAC 388-529-0200 have the following meanings and conditions:

(a) "Yes":

(i) The service must be medically necessary as defined by the program; and

(ii) The service may have conditions placed on coverage in order to ensure that medical necessity exists. Examples are:

[Title 388 WAC—p. 827]

- (A) The prior authorization requirement,  
 (B) The primary care provider referral requirement,  
 (C) The limit on eyeglasses to be covered for adults only once in a twenty-four-month period without documentation of special circumstances, etc.

(b) "HK" - the services are provided to children under the healthy kids program as described in WAC 388-534-0100. This is consistent with the broader scope of coverage under the healthy kids program.

(c) "No" - This entry is used to describe coverage limitations of state-funded programs and indicates that the services are not covered. However, medically necessary services may be available under an "exception to rule" as described in chapter 388-440 WAC.

(d) "L" - the services are provided under limited circumstances described further under WAC 388-529-0200.

(e) "R" - the services are provided only as they are directly connected to emergency medical conditions. These program restrictions are described in WAC 388-438-0100.

(4) Coverage described in this chapter may be further limited by the notations defined in WAC 388-529-0200 and other medical-assistance-related WAC. Services may require prior authorization to ensure that medical necessity exists.

(5) Medical service categories not listed in WAC 388-529-0200 may not be covered under typical circumstances. Seeking specific coverage decisions in advance of service delivery is advised. Medical service providers may request authorization for any service which they see as medically necessary under WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 01-02-076, § 388-529-0100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-529-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0350, 388-529-2910, 388-529-2920 and 388-529-2930.]

**WAC 388-529-0200 Medical services available to eligible clients.** The following chart lists the medically necessary services available to clients eligible for a variety of assistance programs. Eligibility groups for CN, MCS, MN, and MI coverage are described in WAC 388-529-0100.

MEDICAL SERVICES	CN <sup>1/</sup>	MCS	MN	MI
Adult day health	Yes	Yes	Yes	No
Advanced RN practitioner services	Yes	Yes	Yes	No
Ambulance/ground and air	Yes	Yes	Yes	R <sup>2/</sup>
Anesthesia services	Yes	Yes	Yes	R <sup>2/</sup>
Audiology (hearing exams)	Yes	Yes	HK only	No
Blood/blood derivatives/				
Blood administration	Yes <sup>3/</sup>	Yes <sup>3/</sup>	Yes <sup>3/</sup>	R <sup>2/</sup> - <sup>3/</sup>
Case management - maternity	L <sup>4/</sup>	No	L <sup>4/</sup>	No
Chiropractic care	HK only	No	HK only	No
Clinic services	Yes	Yes	Yes	No
Community mental health centers	Yes	L <sup>5/</sup>	Yes	No
Dental services	Yes	No	Yes	No
Dentures only	Yes	Yes	Yes	No
Detoxification	Yes	Yes	Yes	Yes <sup>2/</sup>
Drugs and pharmaceutical supplies	Yes	Yes	Yes	No
Elective surgery	Yes	Yes	Yes	No
Emergency room services	Yes	Yes	Yes	R <sup>2/</sup>
Emergency surgery	Yes	Yes	Yes	R <sup>2/</sup>
Eyeglasses and exams	Yes <sup>6/</sup>	Yes <sup>6/</sup>	Yes <sup>6/</sup>	No
Family planning services <sup>7/</sup>	Yes	Yes	Yes	No
Healthy kids (HK) (EPSDT)	Yes	No	Yes	No
Hearing aids	Yes	Yes	HK only	No
Home health services	Yes	Yes	Yes	No
Hospice	Yes	No	Yes	No
Indian health clinics	Yes	No	Yes	No
Inpatient hospital care	Yes	Yes	Yes	R <sup>2/</sup>
Intermediate care facility/services for mentally retarded	Yes	Yes	Yes	N/A
Involuntary commitment	Yes	Yes	Yes	Yes <sup>2/</sup>
Maternity support services	Yes	No	Yes	No
Medical equipment, durable (DME)	Yes	Yes	Yes	No
Midwife services	Yes	Yes	Yes	R <sup>2/</sup>
Neuromuscular centers	Yes	No	Yes	No
Nursing facility services	Yes	Yes	Yes	Yes <sup>2/</sup>
Nutrition therapy	HK only	No	HK only	No
Optometry	Yes	Yes	Yes	No
Organ transplants	Yes	Yes	Yes	R <sup>2/</sup>

MEDICAL SERVICES	CN <sup>1/</sup>	MCS	MN	MI
Out-of-state care	Yes	No	Yes	No
Outpatient hospital care	Yes	Yes	Yes	R <sup>2/</sup>
Oxygen/respiratory therapy	Yes	Yes	Yes	R <sup>2/</sup>
Pain management (chronic)	Yes	Yes	Yes	No
Personal care services	Yes <sup>8/</sup>	No	HK only <sup>8/</sup>	No
Physical/speech/occupational therapy	Yes	Yes	HK and L <sup>9/</sup>	No
Physical medicine and rehabilitation	Yes	Yes	Yes	R <sup>2/</sup>
Physician	Yes	Yes	Yes	R <sup>2/</sup>
Podiatry	Yes	Yes	Yes	No
Private duty nursing	L <sup>10/</sup>	L <sup>10/</sup>	L <sup>10/</sup>	No
Prosthetic devices/mobility aids	Yes	Yes	Yes	R <sup>2/</sup>
Psychiatric services	Yes	No	Yes	No
Psychological evaluation	L <sup>11/</sup>	L <sup>11/</sup>	L <sup>11/</sup>	No
Rural health services and Federally qualified health centers (FQHC)	Yes	Yes	Yes	No
School medical services <sup>12/</sup>	Yes	No	Yes	No
Substance abuse/outpatient	Yes	No	Yes	No
Surgical appliances	Yes	Yes	Yes	R <sup>2/</sup>
Total enteral/parenteral nutrition	Yes	Yes	Yes	No
Transportation other than ambulance	Yes	Yes	Yes	No
X-ray and lab services	Yes	Yes	Yes	R <sup>2/</sup>

(1) Notation <sup>1/</sup> indicates that the CN column applies to all categorically needy (CN) programs, the state-funded children's health program. It also describes the services available to pregnant women who are undocumented aliens.

(2) Notation <sup>2/</sup> restricts the coverage to those services directly connected to an emergency medical condition which requires hospital services. Emergency requirements are described in WAC 388-438-0100.

(3) Notation <sup>3/</sup> indicates that services are limited as described in WAC 388-87-045.

(4) Notation <sup>4/</sup> indicates that the services are limited to pregnant women who have been identified as being in a "high-risk" circumstance under WAC 388-86-017.

(5) Notation <sup>5/</sup> indicates that clients must meet the program definitions and program priorities of the community mental health act. Limited grants are available to counties for the funding of these services.

(6) Notation <sup>6/</sup> indicates that eyeglasses are limited under WAC 388-86-030. Special circumstances and specific approval apply to more frequent services than those specified in WAC 388-86-030.

(7) Notation <sup>7/</sup> indicates that family planning services are available to all clients of the medical programs except for the medically indigent program. Some clients are eligible only for family planning services which is noted on the medical identification card. These services are described in WAC 388-462-0015.

(8) Notation <sup>8/</sup> indicates that services which are not medical services may be covered under certain qualifying conditions. These benefits are covered under the direction of the aging and adult services administration for CN eligible adults under home and community based programs; the division of developmental disabilities; or the children's services administration under WAC 388-86-087.

(9) Notation <sup>9/</sup> indicates that the services are not normally provided to clients, however, they are covered when

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the client is receiving department approved home health care services as described in WAC 388-86-045.

(10) Notation <sup>10/</sup> indicates that services are authorized according to the conditions listed in WAC 388-86-071.

(11) Notation <sup>11/</sup> indicates that the department limits services as described in WAC 388-86-067 and 388-86-095.

(12) Notation <sup>12/</sup> indicates a special medical program for children who are Medicaid eligible under an individualized education plan under the special education program of a school. This medical program is described further in WAC 388-86-022.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-529-0200, filed 7/31/98, effective 9/1/98. Formerly WAC 388-086-0015 and 388-086-0080.]

## Chapter 388-530 WAC PHARMACY SERVICES

WAC	
388-530-1000	The medical assistance administration (MAA) drug program.
388-530-1050	Definitions.
388-530-1100	Covered drugs, devices, and pharmaceutical supplies.
388-530-1125	Drug rebate program.
388-530-1150	Noncovered drugs and pharmaceutical supplies and reimbursement limitations.
388-530-1200	Prior authorization program.
388-530-1250	Prior authorization process.
388-530-1260	Therapeutic consultation service.
388-530-1300	General reimbursement methodology.
388-530-1350	Estimated acquisition cost (EAC) methodology.
388-530-1360	Certified average wholesale price (CAWP).
388-530-1400	Maximum allowable cost (MAC) methodology.
388-530-1405	Automated maximum allowable cost (AMAC).
388-530-1410	Federal upper limit (FUL) methodology.
388-530-1425	Payment methodology for drugs purchased under the Public Health Service (PHS) Act.
388-530-1450	Dispensing fee determination.
388-530-1500	Reimbursement for compounded prescriptions.
388-530-1550	Unit dose drug delivery systems.
388-530-1600	Unit dose pharmacy billing requirements.
388-530-1625	Compliance packaging services.
388-530-1650	Reimbursement for pharmaceutical supplies.
388-530-1700	Drugs and drug-related supplies from nonpharmacy providers.

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MEDICAL SERVICES	CN <sup>1/</sup>	MCS	MN	MI
Out-of-state care	Yes	No	Yes	No
Outpatient hospital care	Yes	Yes	Yes	R <sup>2/</sup>
Oxygen/respiratory therapy	Yes	Yes	Yes	R <sup>2/</sup>
Pain management (chronic)	Yes	Yes	Yes	No
Personal care services	Yes <sup>8/</sup>	No	HK only <sup>8/</sup>	No
Physical/speech/occupational therapy	Yes	Yes	HK and L <sup>9/</sup>	No
Physical medicine and rehabilitation	Yes	Yes	Yes	R <sup>2/</sup>
Physician	Yes	Yes	Yes	R <sup>2/</sup>
Podiatry	Yes	Yes	Yes	No
Private duty nursing	L <sup>10/</sup>	L <sup>10/</sup>	L <sup>10/</sup>	No
Prosthetic devices/mobility aids	Yes	Yes	Yes	R <sup>2/</sup>
Psychiatric services	Yes	No	Yes	No
Psychological evaluation	L <sup>11/</sup>	L <sup>11/</sup>	L <sup>11/</sup>	No
Rural health services and Federally qualified health centers (FQHC)	Yes	Yes	Yes	No
School medical services <sup>12/</sup>	Yes	No	Yes	No
Substance abuse/outpatient	Yes	No	Yes	No
Surgical appliances	Yes	Yes	Yes	R <sup>2/</sup>
Total enteral/parenteral nutrition	Yes	Yes	Yes	No
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X-ray and lab services	Yes	Yes	Yes	R <sup>2/</sup>

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## Chapter 388-530 WAC PHARMACY SERVICES

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388-530-1625	Compliance packaging services.
388-530-1650	Reimbursement for pharmaceutical supplies.
388-530-1700	Drugs and drug-related supplies from nonpharmacy providers.

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388-530-1750	Drugs and pharmaceutical supplies for clients with any third-party coverage.
388-530-1800	Requirements for pharmacy claim payment.
388-530-1850	Drug utilization and education (DUE) council.
388-530-1900	Drug utilization and claims review.
388-530-1950	Point-of-sale (POS) system/prospective drug utilization review (Pro-DUR).
388-530-2050	Reimbursement for out-of-state prescriptions.

**WAC 388-530-1000 The medical assistance administration (MAA) drug program.** (1) The medical assistance administration (MAA) reimburses providers for prescription drugs and pharmaceutical supplies according to department rules and subject to the exceptions and restrictions listed in this chapter.

(2) MAA reimburses only pharmacies that:

(a) Are MAA-enrolled providers; and

(b) Meet the general requirements for providers described under WAC 388-502-0020.

(3) To be both covered and reimbursed under this chapter, prescription drugs must be:

(a) Medically necessary as defined in WAC 388-500-0005;

(b) Within the scope of coverage of an eligible client's medical assistance program. Refer to chapter 388-529 WAC for scope of coverage information;

(c) For a medically accepted indication appropriate to the client's condition;

(d) Billed according to the conditions under WAC 388-502-0150 and 388-502-0160; and

(e) Billed according to the conditions and requirements of this chapter.

(4) Acceptance and filling of a prescription for a client eligible for a medical care program constitutes acceptance of MAA's rules and fees. See WAC 388-502-0100 for general conditions of payment.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1000, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1000, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1000, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1050 Definitions.** The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this chapter.

**"Active ingredient"** means the chemical component of a drug responsible for a drug's prescribed/intended therapeutic effect. The medical assistance administration (MAA) limits coverage of active ingredients to those with a national drug code (NDC) and those specifically authorized by MAA.

**"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, such as prompt payment discounts;

(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 by the medical assistance administration (MAA) for a multiple-source drug that is not on the maximum allowable cost (MAC) list and that is designated by two or more products at least one of which must be under a federal drug rebate contract.

**"Average wholesale price (AWP)"** means the average price of a drug product that is calculated from wholesale prices nationwide at a point in time and reported to the medical assistance administration (MAA) by MAA's drug pricing file contractor.

**"Certified average wholesale price (CAWP)"** means the price certified by the First Data Bank to be the actual average wholesale price of an infusion, injectable, or inhalation drug marketed by a manufacturer or labeler who is subject to a consent order with the United States Department of Justice regarding the reporting of average wholesale price(s).

**"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.

**"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 the medical assistance administration (MAA) sets to reimburse pharmacy providers for dispensing MAA covered prescriptions. The fee is MAA's maximum reimbursement for expenses involved in the practice of pharmacy and is in addition to MAA's payment for the costs of covered ingredients.

**"Drug Evaluation Unit (DEU)"** means a unit or group designated by the medical assistance administration (MAA) that makes drug coverage recommendations after studying the clinical and pharmacoeconomic attributes of drugs using the Academy of Managed Care Pharmacy drug review submission process. The DEU has physician and pharmacist staff and an advisory committee of actively practicing physicians and pharmacists.



**"Drug file"** means a list of drug products, pricing and other information 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 the medical assistance administration (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 nondrug items necessary for the administration, delivery, or monitoring of a drug or drug regimen.

**"Drug utilization review (DUR)"** means a review of 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 each nursing facility's client population and is for use during those hours when pharmacy services are unavailable.

**"Estimated acquisition cost (EAC)"** means the medical assistance administration'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 (EPA)"** means the process for authorizing selected drugs in which providers use a set of numeric codes to indicate to the medical assistance administration (MAA) the acceptable indications, conditions, diagnoses, and criteria that are applicable to a particular request for drug authorization.

**"Experimental drugs"** means drugs the Food and Drug Administration (FDA) has not approved, or approved drugs when used for medical indications other than those listed by the FDA.

**"Expired drug"** means a drug for which the shelf life expiration date has been reached.

**"Federal upper limit (FUL)"** means the maximum allowable payment set by the Centers for Medicare and Medicaid Services (CMS) (formerly known as 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 code number sequence number"** means a number used by the medical assistance administration's drug

file contractor to group together products that have the same ingredients, route of administration, drug strength, and dosage form. It is applied to all manufacturers and package sizes.

**"Generic drug"** means a nonproprietary drug that is required to meet the same bioequivalency tests as the original brand name drug.

**"Inactive ingredient"** means a drug component that remains chemically unchanged during compounding but serves as the:

- (1) Necessary vehicle for the delivery of the therapeutic effect; or
- (2) Agent for the intended method or rate of absorption for the drug's active therapeutic agent.

**"Ingredient cost"** means the portion of a prescription's cost attributable to the covered drug ingredients or chemical components.

**"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 a drug regimen a client receives or will receive continuously through and beyond ninety days.

**"Maximum allowable cost (MAC)"** means the maximum amount that the medical assistance administration pays for a specific dosage form and strength of a multiple-source drug product.

**"Medically accepted indication"** means any use for a covered outpatient drug:

- (1) Which is approved under the federal Food, Drug, and Cosmetic Act; or
- (2) The use of which is supported by one or more citations included or approved for inclusion in any of the compendia of drug information, as defined in this chapter.

**"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 a shorter period of 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. The NDC is composed of digits in 5-4-2 groupings. The first five digits comprise the labeler code assigned to the manufacturer by the Food and Drug Administration (FDA). The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the 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.

**"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 sold or dispensed.

**"Peer reviewed medical literature"** means a research study, report, or findings regarding the specific use of a drug that has been submitted to one or more professional journals, reviewed by experts with appropriate credentials, and subsequently published by a reputable professional journal. A clinical drug study used as the basis for the publication must be a double blind, randomized, placebo or active control study.

**"Pharmacist"** means a person licensed in the practice of pharmacy by the state in which the prescription is filled.

**"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 drugs;
- (3) Dispensing, labeling, administering, and distributing of drugs and devices;
- (4) 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;
- (5) Monitoring of drug therapy and use;
- (6) Proper and safe storage of drugs and devices;
- (7) Documenting and maintaining records;
- (8) 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
- (9) Participating in drug utilization reviews and drug product selection.

**"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 a 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 client 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. Reconstitution is not compounding.

**"Retrospective drug utilization review (Retro-DUR)"** means the process in which client's 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 of a drug or drug regimen 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 Food and Drug Administration (FDA).

**"Substitute"** means to replace a prescribed drug, with the prescriber's authorization, with:

- (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 NDC"** means a national drug code (NDC) that is discontinued by the manufacturer for any reason. The NDC may be terminated immediately due to health or safety issues or it may be phased out based on the product's shelf life.

**"Therapeutic alternative"** means a drug product that contains a different chemical structure than the drug prescribed, but is in the same pharmacologic or therapeutic class and can be expected to have a similar therapeutic effect and adverse reaction profile 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 a medical assistance administration (MAA)

designated clinical pharmacist jointly review prescribing activity when drug claims for a medical assistance client exceed program limitations.

**"Therapeutically equivalent"** means drug products that contain different chemical structures but have the same efficacy and safety when administered to an individual, as determined by:

- (1) Information from the Food and Drug Administration (FDA);
- (2) Published and peer-reviewed scientific data;
- (3) Randomized controlled clinical trials; or
- (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 the 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 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1050, filed 8/9/02, effective 9/9/02. 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 388-530-1100 Covered drugs, devices, and pharmaceutical supplies.** (1) The medical assistance administration (MAA) covers medically necessary drugs, devices, and pharmaceutical supplies when they are prescribed for medically accepted indications, subject to the restrictions described in this section and other published WAC. For exceptions to the prescription requirement, see subsection (4) of this section.

(2) MAA reimburses a provider for medically necessary drugs only when the manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to the drug rebate requirement are described in WAC 388-530-1125 which describes the drug rebate program.

(3) MAA covers the following medically necessary drugs, devices, and supplies:

- (a) Outpatient drugs, generic or brand name.
- (b) Over-the-counter (OTC) drugs when the drug:
  - (i) Is prescribed by a provider with prescribing authority (see exceptions in subsection (4) of this section);
  - (ii) Is not excluded from coverage under WAC 388-530-1150;
  - (iii) Is a less costly therapeutic alternative; and
  - (iv) Does not require prior authorization.
- (c) Drugs requiring prior authorization when:
  - (i) Prior authorized by MAA; or
  - (ii) They meet MAA's published expedited prior authorization (EPA) criteria and the dispensing pharmacist follows the EPA process described in WAC 388-530-1250(4).

(d) Oral, topical and/or injectable drugs, vaccines for immunizations, and biologicals, prepared or packaged for individual use.

(e) Drugs with obsolete national drug codes (NDCs) for up to two years from the date the NDC is designated obsolete, unless the drug is expired as defined in WAC 388-530-1050.

(f) Drugs and supplies used in conjunction with family planning under subsection (4) of this section and under chapter 388-532 WAC, including drugs dispensed for emergency contraception and nonprescribed OTC contraceptive supplies.

(g) Drugs, devices, and supplies provided under unusual and extenuating circumstances to clients by providers who request and receive MAA approval.

(h) Drug-related supplies as determined in consultation with federal guidelines.

(4) MAA covers family planning drugs, devices, and supplies per chapter 388-532 WAC and as follows:

(a) MAA covers certain over-the-counter (OTC) family planning drugs, devices, and supplies without a prescription when they meet the criteria of WAC 388-530-1200(3); and

(b) MAA may cover family planning drugs that do not meet the federal drug rebate requirement in WAC 388-530-1125 on a case-by-case basis, under the provisions of subsection (6) of this section.

(5) MAA determines if certain drugs are medically necessary and covered with or without restrictions based on evidence contained in compendia of drug information and peer-reviewed medical literature.

(a) Decisions regarding restrictions are based on, but are not limited to:

- (i) Client safety;
  - (ii) FDA-approved indications;
  - (iii) Quantity;
  - (iv) Client age and/or gender; and
  - (v) Cost.
- (b) Restrictions apply, but are not limited to:
- (i) Drugs covered in the nursing facility per diem rate;
  - (ii) Number of refills within a calendar month; and
  - (iii) Refills requested before seventy-five percent of the previously dispensed supply is scheduled to be exhausted.

(6) MAA evaluates requests for drugs, devices, and pharmaceutical supplies that are subject to limitations or other restrictions in this chapter on a case-by-case basis. MAA approves the requested services that are beyond the stated limits or restrictions of this chapter when MAA determines that the services are medically necessary, under subsection (5) of this section and under the standards for covered services in WAC 388-501-0165.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1100, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1100, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1100, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1125 Drug rebate program.** The medical assistance administration (MAA) covers only those outpatient prescription drugs and over-the-counter (OTC) drugs supplied by manufacturers who have a drug rebate contract with the Department of Health and Human Services (DHHS).

MAA may make exceptions to the drug rebate requirement based on medical necessity on a case-by-case basis. Exceptions to this requirement must be prior authorized by MAA. MAA may exempt the following from the drug rebate requirement in WAC 388-530-1100(2):

- (1) Family planning drugs as provided by WAC 388-530-1100(4); and
- (2) Other drugs approved under WAC 388-501-0165.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1125, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1125, filed 12/7/00, effective 1/7/01.]

**WAC 388-530-1150 Noncovered drugs and pharmaceutical supplies and reimbursement limitations.** (1) The medical assistance administration (MAA) does not cover:

(a) Brand or generic drugs, when the manufacturer has not signed a rebate agreement with the federal Department of Health and Human Services. Refer to WAC 388-530-1125 for information on the drug rebate program.

(b) A drug prescribed:

- (i) For weight loss or gain;
- (ii) For infertility, frigidity, impotency, or sexual dysfunction;
- (iii) For cosmetic purposes or hair growth; or
- (iv) To promote smoking cessation, except as described in WAC 388-533-0400(21), smoking cessation for pregnant women.

(c) Over-the-counter (OTC) drugs and supplies, except as described under WAC 388-530-1100.

(d) Prescription vitamins and mineral products, except:

- (i) When prescribed for clinically documented deficiencies;
- (ii) Prenatal vitamins, only when prescribed and dispensed to pregnant women; or
- (iii) Fluoride preparations for children under the early and periodic screening, diagnosis, and treatment (EPSDT) program.

(e) A drug prescribed for an indication that is not evidence based as determined by:

- (i) MAA in consultation with federal guidelines; or
- (ii) The Drug Utilization and Education (DUE) Council; and

(iii) MAA medical consultants and MAA pharmacist(s).

(f) Drugs listed in the federal register as "less-than-effective" ("DESI" drugs) or which are identical, similar, or related to such drugs.

(g) Drugs that are:

- (i) Not approved by the Food and Drug Administration (FDA); or
- (ii) Prescribed for non-FDA approved indications or dosing, unless prior authorized; or
- (iii) Unproven for efficacy or safety.

(h) Outpatient drugs for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee.

(i) Drugs requiring prior authorization for which MAA authorization has been denied.

(j) Preservatives, flavoring and/or coloring agents.

(k) Less than a one-month supply of drugs for long-term therapy.

(l) A drug with an obsolete National Drug Code (NDC) more than two years from the date the NDC is designated obsolete by the manufacturer.

(m) Products or items that do not have an eleven-digit NDC.

(2) MAA does not reimburse enrolled providers for:

(a) Outpatient drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:

- (i) Diagnosis-related group (DRG);
- (ii) Ratio of costs-to-charges (RCC);
- (iii) Nursing facility per diem;
- (iv) Managed care capitation rates;
- (v) Block grants; or

(vi) Drugs prescribed for clients who are on the MAA hospice program when the drugs are related to the client's terminal condition.

(b) Any drug regularly supplied as an integral part of program activity by other public agencies (e.g., immunization vaccines for children).

(c) Prescriptions written on pre-signed prescription blanks filled out by nursing facility operators or pharmacists. MAA may terminate the core provider agreement of pharmacies involved in this practice.

(d) Drugs used to replace those taken from nursing facility emergency kits.

(e) Drugs used to replace a physician's stock supply.

(f) Free pharmaceutical samples.

(g) A drug product after the product's national drug code (NDC) termination date.

(h) A drug product whose shelf life has expired.

(3) MAA evaluates each request for a noncovered drug under WAC 388-530-1100(5) and under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1150, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1150, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1150, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1200 Prior authorization program.**

(1) The medical assistance administration (MAA) pharmacist(s), medical consultants, and drug utilization review team evaluate drugs to determine prior authorization status on the drug file. MAA may consult with a drug evaluation unit, the Drug Utilization and Education (DUE) Council, and/or participating MAA providers in this evaluation.

(2) To facilitate the evaluation process for a drug product, a drug manufacturer may send the MAA pharmacist(s) a written request and the following supporting documentation:

- (a) Background data about the drug;
- (b) Product package information;
- (c) Any pertinent clinical studies;
- (d) Outcome and effectiveness data using the Academy of Managed Care Pharmacy's drug review submission process; and
- (e) Any additional information the manufacturer considers appropriate.

(3) MAA evaluates a drug based on, but not limited to, the following criteria:

- (a) Whether the manufacturer has signed a federal drug rebate agreement except as specified in WAC 388-530-1125;
- (b) Whether the drug is a less-than-effective drug;
- (c) The drug's risk/benefit ratio;
- (d) Whether like drugs are on MAA's drug file list and there are less costly therapeutic alternative drugs;
- (e) Whether the drug falls into one of the categories authorized by federal law to be excluded from coverage;
- (f) The drug's potential for abuse; and
- (g) Whether outcome data demonstrate that the drug is cost effective.

(4) MAA updates and reviews the drug file list as necessary and periodically publishes a list of drugs not requiring prior authorization.

(5) Manufacturers may seek review of MAA's prior authorization decisions by writing to MAA's chief medical officer.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1200, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1200, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1200, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1250 Prior authorization process.** (1) The medical assistance administration (MAA) requires pharmacies to obtain prior authorization for:

- (a) Drugs with a prior authorization indicator on the MAA drug file list;
- (b) Drugs that exceed specific dosage or unit limits as indicated by the Food and Drug Administration (FDA); and
- (c) Additional fills in a calendar month for drugs dispensed for a less than thirty-four day supply when:
  - (i) Two fills for the same prescription have been dispensed, except for:
    - (A) Over-the-counter (OTC) contraceptives; or
    - (B) Drugs prescribed to a suicidal patient or a patient at risk for potential drug abuse; or
  - (ii) Four fills in the same calendar month for the same prescription have been dispensed for any of the following:
    - (A) Antibiotics;
    - (B) Anti-asthmatics;
    - (C) Schedule II and III drugs;
    - (D) Antineoplastic agents;
    - (E) Topical preparations; or
    - (F) Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations.

(2) The pharmacy provider must make a request to MAA for a drug requiring prior authorization before dispensing the drug. The pharmacy provider must:

- (a) Ensure the request states the medical diagnosis and includes medical justification for the drug; and
- (b) Keep on file documentation of the prescriber's medical justification that is communicated to the pharmacy by the prescriber at the time the prescription is filled. The records must be retained for the period specified in WAC 388-502-0020 (1)(c).

(3) MAA evaluates a request for prior authorization based on, but not limited to:

- (a) Requirements in this section;
- (b) Requirements under WAC 388-530-1000, 388-530-1150, and 388-501-0165; and
- (c) The least costly alternative between two or more products of equal effectiveness.
- (4) MAA authorizes certain prescribed drugs through a process called "expedited prior authorization (EPA)." MAA determines which drugs can be authorized through the EPA process by using factors which include, but are not limited to:
  - (a) Product cost;
  - (b) Potential for clinical misuse;
  - (c) Narrow therapeutic indication; and
  - (d) Safety concerns.
- (5) MAA may authorize reimbursement at the brand name estimated acquisition cost (EAC) for a brand name multiple-source drug that would have been reimbursed at the maximum allowable cost (MAC) for that multiple-source drug, if:

- (a) The pharmacist calls for prior authorization; and
- (b) The prescriber indicates:
  - (i) "Dispense as written" on the prescription; and
  - (ii) That a specific brand is "medically necessary" for a particular client; or
- (c) The availability of generic equivalents in the marketplace is severely curtailed and the price disparity between the brand name EAC and the generic MAC reimbursement affects clients' access to the medication.

(6) MAA provides a response, by telephone or other telecommunication device, within twenty-four hours of a request for drugs that require prior authorization, if the request is received during normal state business hours. If a provider needs prior authorization to dispense a drug during a weekend or Washington state holiday, the provider may dispense the drug without prior authorization only when:

- (a) Given in an emergency;
- (b) MAA receives justification within seventy-two hours of the fill date, excluding weekends and Washington state holidays; and
- (c) MAA agrees with the justification and approves the request.
- (7) MAA's prior authorization:
  - (a) Is limited to a decision of medical appropriateness for a drug; and
  - (b) Does not guarantee payment.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1250, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1250, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1250, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1260 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.]

**WAC 388-530-1300 General reimbursement methodology.** (1) The medical assistance administration's (MAA) total reimbursement for a prescription drug must not exceed the lowest of:

(a) Estimated acquisition cost (EAC) plus a dispensing fee;

(b) Maximum allowable cost (MAC) plus a dispensing fee;

(c) Federal Upper Limit (FUL) plus a dispensing fee;

(d) Actual acquisition cost (AAC) plus a dispensing fee for drugs purchased under section 340 B of the Public Health Service (PHS) Act and dispensed to medical assistance clients;

(e) Automated maximum allowable cost (AMAC) plus a dispensing fee;

(f) Certified average wholesale price (CAWP) plus a dispensing fee; or

(g) The provider's usual and customary charge to the non-Medicaid population.



(2) MAA selects the sources for pricing information used to set EAC and MAC. These sources may include pharmaceutical wholesalers.

(3) MAA may solicit assistance from pharmacy providers, pharmacy benefit managers (PBM), other government agencies, actuaries, and/or other consultants when establishing EAC and/or MAC.

(4) If the pharmacy provider offers a discount, rebate, promotion or other incentive which directly relates to the reduction of the price of a prescription to the individual non-Medicaid customer, the provider must similarly reduce its charge to MAA for the prescription.

(5) If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAA when giving the free product to a medical assistance client.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1300, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1300, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1300, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1350 Estimated acquisition cost (EAC) methodology.** (1) The medical assistance administration (MAA) determines EAC as follows:

(a) When acquisition cost data are made available to MAA by drug wholesalers:

(i) MAA determines pharmacies' acquisition costs for the top 100 single-source drugs reimbursed by MAA as measured by the total dollars paid for each drug.

(ii) Establishes the actual acquisition cost (AAC) for each product on the sample list as a percentage of the published average wholesale price (AWP), determined for that product by MAA's drug pricing file contractor.

(iii) MAA averages the percentages obtained from the sample, and that average represents the EAC.

(b) When drug wholesalers do not make acquisition cost data available to MAA, MAA may set EAC using acquisition cost information provided, or rates set, by any of the following:

(i) Audit agencies, federal or state;

(ii) Other state health care purchasing agencies;

(iii) Pharmacy benefit managers;

(iv) Individual pharmacy providers participating in MAA's programs;

(v) Other third party payers; and/or

(vi) Actuaries or other consultants.

(2) MAA establishes EAC as a percentage of AWP, derived by applying a discount to AWP.

(3) MAA may set EAC for specified drugs or drug categories at a percentage of AWP other than that determined in subsection (1)(a) of this section when MAA considers it necessary. MAA ends the exemption when the necessity no longer exists.

The factors MAA considers in setting a rate for a class of drugs under this subsection include, but are not limited to:

(a) Product cost;

(b) MAA's documented clinical concerns; and

(c) MAA's budget limits.

(4) MAA bases EAC drug reimbursement on the actual package size dispensed.

(5) MAA uses the EAC as MAA's reimbursement for a drug when the EAC is the lowest of the rates calculated under the methods listed in WAC 388-530-1300(1), or when the conditions of WAC 388-530-1400(3) are met.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1350, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1350, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1350, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1360 Certified average wholesale price (CAWP).** (1) The medical assistance administration (MAA) reimburses providers the certified average wholesale price (CAWP) for selected infusion, injectable, and inhalation drugs manufactured and/or marketed by manufacturers/labelers who are subject to a consent order with the United States Department of Justice.

(2) The CAWP is determined by First Data Bank (FDB) through a survey of wholesale prices. FDB reports these prices to states and certifies that they accurately represent the price from wholesalers to retailers for these drugs.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1360, filed 8/9/02, effective 9/9/02.]

**WAC 388-530-1400 Maximum allowable cost (MAC) methodology.** (1) The medical assistance administration (MAA) establishes a maximum allowable cost (MAC) for a multiple-source drug which is available from at least two manufacturers/labelers.

(2) MAA determines the MAC for a multiple-source drug by:

(a) When drug wholesalers make acquisition cost data available to MAA, MAA:

(i) Identifies what products are available from wholesalers for each MAC drug;

(ii) Determines pharmacy subscribers' approximate acquisition costs for these products;

(iii) Ranks the products in descending order by approximate acquisition cost; and

(iv) Establishes the MAC at a level which gives pharmacists access to one product from a manufacturer with a qualified rebate agreement (see WAC 388-530-1125).

(b) When drug wholesalers do not make acquisition cost data available to MAA, MAA may set a MAC for a drug in the same manner described in WAC 388-530-1350 (1)(b).

(3) The MAC established for a multiple-source drug does not apply if the written prescription identifies that a specific brand is medically necessary for a particular client. In such cases EAC for the particular brand applies, provided prior authorization is obtained from MAA as specified under WAC 388-530-1250(5), Prior authorization.

(4) Except as provided in subsection (3) of this section, MAA reimburses providers for a multiple-source drug at the lowest of the rates calculated under the methods listed in WAC 388-530-1300(1).

(5) The MAC established for a multiple-source drug applies to all package sizes of that drug, including those identified as unit dose National Drug Codes (NDCs) by the manufacturer(s) of the drug.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1400, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1400, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1400, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1405 Automated maximum allowable cost (AMAC).** (1) The medical assistance administration (MAA) uses the automated maximum allowable cost (AMAC) pricing methodology for multiple-source drugs that are:

(a) Not on the published maximum allowable cost (MAC) or federal upper limit (FUL) lists; and

(b) Produced by two or more manufacturers/labelers, at least one of which must have a federal drug rebate agreement.

(2) MAA establishes AMAC as a specified percentage of the published average wholesale price (AWP). MAA may use different percentage discounts from AWP for the estimated acquisition cost (EAC) and AMAC.

(3) MAA sets the percentage discount from AWP for AMAC reimbursement using any of the information sources identified in WAC 388-530-1350 (1)(b).

(4) MAA may set AMAC reimbursement at different percentage discounts from AWP for different multiple source drugs. MAA considers the same factors as those in WAC 388-530-1350(3).

(5) AMAC reimbursement for all products within a generic code number sequence number is at the AMAC determined for the second lowest priced product in that sequence, or the AMAC of the lowest priced drug under a federal rebate agreement.

(6) MAA recalculates AMAC each time the drug file contractor provides a pricing update to any product in a GCN sequence.

(7) Except as provided in WAC 388-530-1400(3), MAA reimburses at the lowest of the rates calculated under the methods listed in WAC 388-530-1300(1).

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1405, filed 8/9/02, effective 9/9/02.]

**WAC 388-530-1410 Federal upper limit (FUL) methodology.** (1) The medical assistance administration (MAA) adopts the federal upper limit (FUL) set by the Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA).

(2) MAA's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAA.

(3) Except as provided in WAC 388-530-1400(3), MAA uses the FUL as MAA's reimbursement rate for the drug when the FUL price is the lowest of the rates calculated under the methods listed in WAC 388-530-1300(1).

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1410, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1410, filed 12/7/00, effective 1/7/01.]

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**WAC 388-530-1425 Payment methodology for drugs purchased under the Public Health Service (PHS) Act.** (1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to medical assistance clients only by PHS-qualified health facilities. These medications must be billed using the actual acquisition cost (AAC) of the drug plus the appropriate dispensing fee.

(2) Providers dispensing drugs under this section are required to submit their valid MAA provider number(s) to the PHS Health Resources and Services Administration, Office of Pharmacy Affairs. This requirement is to ensure that claims for drugs dispensed under this section and paid by MAA are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs. See WAC 388-530-1125 for information on the drug rebate program.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1425, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1425, filed 12/7/00, effective 1/7/01.]

**WAC 388-530-1450 Dispensing fee determination.**

(1) Subject to the provisions of WAC 388-530-1300, the medical assistance administration (MAA) pays a dispensing fee for each prescribed and covered drug.

(2) MAA does not pay a dispensing fee for nondrug items, devices, or supplies.

(3) MAA adjusts the dispensing fee by considering factors including, but not limited to:

(a) Legislative appropriations for vendor rates;

(b) Input from provider and/or advocacy groups;

(c) Input from state-employed or contracted actuaries; and

(d) Dispensing fees paid by other third-party payers, including, but not limited to, health care plans and other states' Medicaid agencies.

(4) MAA uses a tiered dispensing fee system which reimburses higher volume pharmacies at a lower fee and lower volume pharmacies at a higher fee.

(5) MAA uses total annual prescription volume (both Medicaid and non-Medicaid) reported to MAA to determine each pharmacy's dispensing fee tier.

(a) A pharmacy which fills more than thirty-five thousand prescriptions annually is a high-volume pharmacy. MAA considers hospital-based pharmacies that serve both inpatient and outpatient clients as high-volume pharmacies.

(b) A pharmacy which fills between fifteen thousand one and thirty-five thousand prescriptions annually is a mid-volume pharmacy.

(c) A pharmacy which fills fifteen thousand or fewer prescriptions annually is a low-volume pharmacy.

(6) MAA determines a pharmacy's annual total prescription volume as follows:

(a) MAA sends out a prescription volume survey form to pharmacy providers during the first quarter of the calendar year;

(b) Pharmacies return completed prescription volume surveys to MAA by the date specified, typically April 15th of each year. Pharmacy providers not responding to the survey by the specified date are assigned to the high volume category;

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(c) Pharmacies must include all prescriptions dispensed from the same physical location in the pharmacy's total prescription count;

(d) MAA considers prescriptions dispensed to nursing facility clients as outpatient prescriptions;

(e) Assignment to a new dispensing fee tier is effective on the first of the month, (typically May 1st of each year) following the date specified by MAA.

(7) A pharmacy may request a change in dispensing fee tier during the interval between the annual prescription volume surveys. The pharmacy must substantiate such a request with documentation showing that the pharmacy's most recent six-month dispensing data, annualized, would qualify the pharmacy for the new tier. If MAA receives the documentation by the twentieth of the month, assignment to a new dispensing fee tier is effective on the first of the following month.

(8) MAA grants general dispensing fee rate increases only when authorized by the legislature. Amounts authorized for dispensing fee increases may be distributed nonuniformly (e.g., tiered dispensing fee based upon volume).

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1450, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1450, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1450, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1500 Reimbursement for compounded prescriptions.** (1) The medical assistance administration (MAA) covers a drug ingredient used for a compounded prescription only when the manufacturer has a signed rebate agreement with the federal Department of Health and Human Services (DHHS). MAA considers bulk chemical supplies used in compounded prescriptions as non-drug items, which do not require a drug rebate agreement. MAA covers such bulk chemical supplies only as specifically approved by MAA.

(2) MAA does not cover or reimburse for coloring agents, preservatives, and flavoring agents used in compounded prescriptions except when they are necessary as a complete vehicle for compounding (e.g., simple syrup).

(3) MAA does not consider reconstitution to be compounding.

(a) MAA reimburses pharmacists for compounding drugs only if the client's drug therapy needs are unable to be met by commercially available dosage strengths and/or forms of the medically necessary drug.

(b) The pharmacist must ensure the need for the adjustment of the drug's therapeutic strength and/or form is well documented in the client's file.

(c) The pharmacist must ensure that the ingredients used in a compounded prescription are for an approved use as defined in "medically approved indication" in WAC 388-530-1050.

(4) MAA requires that each drug ingredient used for a compounded prescription be billed to MAA using its eleven-digit national drug code (NDC) number.

(5) Compounded prescriptions are reimbursed as follows:

(a) MAA allows only the lowest cost for each covered ingredient, whether that cost is determined by actual acquisition cost (AAC), estimated acquisition cost (EAC), federal upper limit (FUL), maximum allowable cost (MAC), automated maximum allowable cost (AMAC), certified average wholesale price (CAWP), or amount billed.

(b) MAA applies current prior authorization requirements to drugs used as ingredients in compounded prescriptions, except as provided under subsection (5)(c) of this section. MAA denies payment for a drug requiring prior authorization used as an ingredient in a compounded prescription when prior authorization was not obtained.

(c) MAA may designate selected drugs as not requiring prior authorization when used for compounded prescriptions, but requiring prior authorization for other uses. For the list of selected drugs, refer to MAA's prescription drug program billing instructions.

(d) MAA reimburses a dispensing fee as described under WAC 388-530-1450 for:

(i) Each covered or prior authorized drug ingredient billed separately; and

(ii) Drugs used in compounding under subsection (5)(c) of this section.

(e) MAA does not pay a separate fee for compounding time.

(6) MAA requires pharmacists to document the need for each inactive ingredient added to the compounded prescription. MAA limits reimbursement to those that meet the following criteria. To be reimbursed by MAA, each inactive ingredient must be:

(a) A necessary component of a compounded drug; and

(b) Listed in MAA's prescription drug program billing instructions.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1500, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1500, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1500, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1550 Unit dose drug delivery systems.**

(1) The medical assistance administration (MAA) pays for unit dose drug delivery systems only for clients residing in nursing facilities, except as provided in subsections (7) and (8) of this section.

(2) Unit dose delivery systems may be either true or modified unit dose.

(3) MAA pays pharmacies that provide unit dose delivery service MAA's highest allowable dispensing fee for each unit dose prescription dispensed to clients in nursing facilities. MAA reimburses ingredient costs for drugs under unit dose systems as described in WAC 388-530-1500 (5)(a).

(4) MAA pays a pharmacy that dispenses drugs in bulk containers or multidose form to clients in nursing facilities the regular dispensing fee applicable to the pharmacy's total annual prescription volume tier. Drugs MAA considers not deliverable in unit dose form include, but are not limited to, liquids, creams, ointments, ophthalmic and otic solutions. MAA reimburses ingredient costs as described in WAC 388-530-1500 (5)(a).

(5) MAA pays a pharmacy that dispenses drugs prepackaged by the manufacturer in unit dose form to clients in nursing facilities the regular dispensing fee applicable under WAC 388-530-1450(5). MAA reimburses ingredient costs for drugs prepackaged by the manufacturer in unit dose form as described in WAC 388-530-1500 (5)(a).

(6) MAA limits its coverage and payment for manufacturer-designated unit dose packaging to the following conditions:

(a) The drug is a single source drug and a multidose package for the drug is not available;

(b) The drug is a multiple source drug but there is no other multidose package available among the drug's generic equivalents; or

(c) The manufacturer-designated unit dose package is the most cost-effective package available or it is the least costly alternative form of the drug.

(7) MAA reimburses a pharmacy provider for manufacturer-designated unit dose drugs dispensed to clients not residing in nursing facilities only when such drugs:

(a) Are available in the marketplace only in manufacturer-designated unit dose packaging; and

(b) Would otherwise have been covered outpatient drugs. The unit dose dispensing fee does not apply in such cases. MAA pays the pharmacy the dispensing fee applicable to the pharmacy's total annual prescription volume tier.

(8) MAA may pay for unit dose delivery systems for developmentally disabled (DD) clients residing in approved community living arrangements.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1550, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1550, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1550, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1600 Unit dose pharmacy billing requirements.** (1) To be eligible for a unit dose dispensing fee from the medical assistance administration (MAA), a pharmacy must:

(a) Notify MAA in writing of its intent to provide unit dose service;

(b) Identify the nursing facility(ies) to be served;

(c) Indicate the approximate date unit dose service to the facility(ies) will commence; and

(d) Follow department requirements for unit dose reimbursement.

(2) Under a unit dose delivery system, a pharmacy must bill only for the number of drug units actually used by the medical assistance client in the nursing facility, except as provided in subsections (3), (4), and (5) of this section. It is the unit dose pharmacy provider's responsibility to coordinate with nursing facilities to ensure that the unused drugs the pharmacy dispensed to MAA clients are returned to the pharmacy for credit.

(3) The pharmacy must submit an adjustment form or claims reversal of the charge to MAA for the cost of all unused drugs returned to the pharmacy from the nursing facility on or before the sixtieth day following the date the drug was dispensed, except as provided in subsection (5) of this section. Such adjustment must conform to the nursing

facility's monthly log as described in subsection (7) of this section.

(4) MAA pays a unit dose provider a dispensing fee when a provider-packaged unit dose prescription is returned, in its entirety, to the pharmacy. A dispensing fee is not paid if the returned prescription is for a drug with a manufacturer-designated unit dose national drug code (NDC). In addition to the dispensing fee paid under this subsection, the provider may bill MAA one unit of the tablet or capsule but must credit MAA for the remainder of the ingredient costs for the returned prescription.

(5) Unit dose providers do not have to credit MAA for federally designated schedule two drugs which are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

(6) Pharmacies must not charge clients or MAA a fee for repackaging a client's bulk medications in unit dose form. The costs of repackaging are the responsibility of the nursing facility when the repackaging is done:

(a) To conform with a nursing facility's drug delivery system; or

(b) For the nursing facility's convenience.

(7) The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each nursing facility served, including but not limited to the following information:

(a) Facility name and address;

(b) Client's name and patient identification code (PIC);

(c) Drug name/strength;

(d) National Drug Code (NDC);

(e) Quantity and date dispensed;

(f) Quantity and date returned;

(g) Value of returned drugs or amount credited;

(h) Explanation for no credit given or nonreusable returns; and

(i) Prescription number.

(8) Upon MAA's request, the pharmacy must submit copies of the logs referred to in subsection (7) of this section.

(9) When the pharmacy submits the completed annual prescription volume survey to MAA, it must include an updated list of all nursing facilities currently served under unit dose systems.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1600, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1600, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.04.050, 74.08.090, 42 CFR 447.333 and Attachment 4.19-B, Page 2-b of the State Plan under Title XIX of the Social Security Act. 98-14-005, § 388-530-1600, filed 6/18/98, effective 7/19/98. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1600, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1625 Compliance packaging services.**

(1) The medical assistance administration (MAA) reimburses pharmacies for compliance packaging services provided to clients considered at risk for adverse drug therapy outcomes. Clients who are eligible for compliance packaging services must not reside in a nursing home or other inpatient facility, and must meet (a) and either (b) or (c) of this subsection. The client must:

(a) Have one or more of the following representative disease conditions:

- (i) Alzheimer's disease;
- (ii) Blood clotting disorders;
- (iii) Cardiac arrhythmia;
- (iv) Congestive heart failure;
- (v) Depression;
- (vi) Diabetes;
- (vii) Epilepsy;
- (viii) HIV/AIDS;
- (ix) Hypertension;
- (x) Schizophrenia; or
- (xi) Tuberculosis.

(b) Concurrently consume two or more prescribed medications for chronic medical conditions, that are dosed at three or more intervals per day; or

(c) Have demonstrated a pattern of noncompliance that is potentially harmful to the client's health. The client's pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider's file.

(2) Compliance packaging services include:

- (a) Reusable hard plastic containers of any type (e.g., medisets); and
- (b) Nonreusable compliance packaging devices (e.g., blister packs).

(3) MAA pays a filling fee and reimburses pharmacies for the compliance packaging device and/or container. The frequency of fills and number of payable compliance packaging devices per client is subject to limits specified by MAA. MAA does not pay filling or preparation fees for blister packs.

(4) Pharmacies must use the HCFA-1500 claim form to bill MAA for compliance packaging services.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1625, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1625, filed 12/7/00, effective 1/7/01.]

**WAC 388-530-1650 Reimbursement for pharmaceutical supplies.** (1) The medical assistance administration (MAA) reimburses for selected covered pharmaceutical supplies that are not included in MAA's drug claim payment system, called the point-of-sale (POS) system.

(2) MAA bases reimbursement of pharmaceutical items or supplies that are not payable through the POS on MAA-published fee schedules.

(3) MAA uses any or all of the following methodologies to set the maximum allowable reimbursement rate for pharmaceutical items, devices, and supplies:

(a) A pharmacy provider's acquisition cost. Upon review of the claim, MAA may require an invoice which must show the name of the item, the manufacturer, the product description, the quantity, and the cost including any free goods associated with the invoice;

(b) Medicare's reimbursement for the item; or

(c) A specified discount off the item's list price or manufacturer's suggested retail price (MSRP).

(4) MAA does not pay a dispensing fee for nondrug items, devices, or supplies. See WAC 388-530-1450(2).

(2003 Ed.)

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1650, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1650, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1650, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1700 Drugs and drug-related supplies from nonpharmacy providers.** The medical assistance administration (MAA) reimburses for covered drugs, supplies, and devices provided or administered by nonpharmacy providers under specified conditions.

(1) MAA reimburses actual acquisition cost (AAC) to a physician or ARNP for a covered drug (oral, topical or injectable) prepared or packaged for individual use and provided or administered to a client during an office visit. When the cost of the drug provided or administered to the client exceeds the established fee, the physician or ARNP may submit to MAA a photocopy of the invoice for the actual drug cost. The invoice must show the name of the drug, the manufacturer, the National Drug Code (NDC), drug strength, quantity, and cost.

(2) MAA reimburses drugs and supplies provided to clients by local health departments according to its established fee schedules.

(3) MAA does not reimburse providers for the cost of vaccines obtained through the state department of health (DOH); MAA does pay physicians and ARNPs a fee for administering the vaccine.

(4) MAA reimburses family planning clinics:

(a) For oral contraceptives, the lesser of the family planning clinic's certified full fee or MAA's maximum allowable fee per cycle of birth control pills. The certified full fee is the clinic's acquisition cost for each cycle of birth control pills, as reported annually by the clinic to DOH;

(b) For contraceptive supplies and devices, the clinic's actual acquisition cost or MAA's maximum allowable fee, whichever is specified by MAA; and

(c) For other drugs, supplies, and devices, according to MAA's established fee schedules.

(5) MAA may request family planning clinics and other nonpharmacy providers to submit an invoice for the actual cost of the drug, supply, or device billed. If an invoice is requested, the invoice must show the:

(a) Name of the drug, supply, or device;

(b) Drug or product manufacturer;

(c) NDC of the product(s);

(d) Drug strength;

(e) Product description;

(f) Quantity; and

(g) Cost, including any free goods associated with the invoice.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1700, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1700, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1700, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1750 Drugs and pharmaceutical supplies for clients with any third-party coverage.** (1) The medical assistance administration (MAA) requires pharmacy

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providers to meet the third party requirements of WAC 388-501-0200.

(2) Except as specified under MAA's managed care contracts, MAA does not reimburse providers for any drugs or pharmaceutical supplies provided to clients who have pharmacy benefits under MAA-contracted managed care plans. The managed care plan is responsible for payment.

(3) The following definitions apply to this section:

(a) "Closed pharmacy network" means an arrangement made by an insurer which restricts prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy that is not included on the exclusive list.

(b) "Private point-of-sale (POS) authorization system" means an insurer's system, other than the MAA POS system, which requires that coverage be verified by or submitted to the insurer's agent for authorization at the time of service and at the time the prescription is filled.

(4) This subsection applies to MAA clients who have a third-party resource that is a managed care entity other than an MAA-contracted plan, or have other insurance that requires the use of "closed pharmacy networks" or "private point-of-sale authorization." MAA will not pay pharmacies for prescription drug claims until the pharmacy provider submits an explanation of benefits from the private insurance that demonstrates that the pharmacy provider has complied with the terms of the third-party's coverage.

(a) If the private insurer pays a fee based on the incident of care, the pharmacy provider must file a claim with MAA consistent with MAA's billing requirements.

(b) If the private insurer pays the pharmacy provider a monthly capitation fee for all prescription costs related to the client, the pharmacy provider must submit a claim to MAA for the amount of the client copayment, coinsurance, and/or deductible. MAA pays the provider the lesser of:

- (i) The billed amount; or
- (ii) MAA's maximum allowable fee for the prescription.

(5) For clients eligible for both Medicare and medical assistance, MAA reimburses providers for:

(a) An amount up to MAA's maximum allowable fee for drugs Medicare does not cover, but MAA covers; or

(b) Deductible and/or coinsurance amounts up to Medicare's or MAA's maximum allowable fee, whichever is less, for drugs Medicare and MAA cover; or

(c) Deductible and/or coinsurance amounts for clients under the qualified Medicare beneficiary (QMB) program for drugs Medicare covers but MAA does not cover.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1750, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.09.035. 00-14-071, § 388-530-1750, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1750, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1800 Requirements for pharmacy claim payment.** (1) When billing the medical assistance administration (MAA) for pharmacy services, providers must:

(a) Use the appropriate department claim form or electronic billing specifications;

(b) Include the actual eleven-digit National Drug Code (NDC) number of the product dispensed; and

(c) Bill MAA using metric decimal quantities which is the National Council for Prescription Drug Programs (NCPDP) billing unit standard.

(2) When billing drugs requiring authorization, providers must insert the authorization number in the appropriate data field on the drug claim.

(3) When billing drugs under the expedited authorization process, providers must insert the authorization number which includes the corresponding criteria code(s) in the appropriate data field on the drug claim.

(4) Pharmacy services for clients on restriction under WAC 388-501-0135 must be prescribed by the client's primary care provider and are paid only to the client's primary pharmacy, except in cases of:

- (a) Emergency;
- (b) Family planning services; or
- (c) Services properly referred from the client's assigned pharmacy or physician/ARNP.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1800, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-530-1800, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1800, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1850 Drug utilization and education (DUE) council.** The medical assistance administration (MAA) establishes a drug utilization and education (DUE) council and determines membership rotation.

(1) The DUE council:

(a) Has a minimum of eight and a maximum of ten members, representing actively practicing health care professionals who have recognized knowledge and expertise in one or more of the following:

- (i) The clinically appropriate prescribing of covered outpatient drugs;
- (ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs;
- (iii) Drug use review, evaluation, and intervention;
- (iv) Medical quality assurance; and
- (v) Disease state management.

(b) Is made up of at least one-third but not more than fifty-one percent physicians, and at least one-third but not more than fifty-one percent pharmacists; and

(c) Includes an advanced registered nurse practitioner and a physician assistant.

(2) The DUE council meets periodically to:

- (a) Advise MAA on drug utilization review activities;
- (b) Review provider and patient profiles;
- (c) Recommend adoption of standards and treatment guidelines for drug therapy;
- (d) Provide interventions targeted toward therapy problems; and
- (e) Produce an annual report.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1850, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1850, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1850, filed 10/9/96, effective 11/9/96.]



**WAC 388-530-1900 Drug utilization and claims review.** (1) The medical assistance administration's (MAA's) drug utilization review (DUR) consists of:

(a) A prospective drug utilization review (Pro-DUR) that requires all pharmacy providers to:

- (i) Obtain patient histories of allergies, idiosyncrasies, or chronic condition(s) which may relate to drug utilization;
- (ii) Screen for potential drug therapy problems; and
- (iii) Counsel the patient in accordance with existing state pharmacy laws and federal regulations; and

(b) A retrospective drug utilization review (Retro-DUR), in which MAA provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.

(2) MAA performs a periodic sampling of claims to determine if drugs are appropriately dispensed and billed. If a review of the sample finds that a provider is inappropriately dispensing or billing for drugs, MAA may implement corrective action that includes, but is not limited to:

(a) Educating the provider regarding the problem practice(s);

(b) Requiring the provider to maintain specific documentation in addition to the normal documentation requirements regarding the provider's dispensing or billing actions;

(c) Recouping the payment for the drug(s); and/or

(d) Terminating the provider's core provider agreement.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1900, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1900, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1900, filed 10/9/96, effective 11/9/96.]

**WAC 388-530-1950 Point-of-sale (POS) system/prospective drug utilization review (Pro-DUR).** (1) Pharmacy claims for drugs and other products listed in the medical assistance administration (MAA) drug file list and billed to MAA by National Drug Code (NDC) are adjudicated by the MAA point-of-sale (POS) system. Claims must be submitted for payment using the billing unit standard identified in WAC 388-530-1800.

(2) All pharmacy drug claims processed through the POS system undergo a system-facilitated prospective drug utilization review (Pro-DUR) screening as a complement to the Pro-DUR screening required of pharmacists.

(3) If the MAA POS system identifies a potential drug therapy problem during Pro-DUR screening, a message will alert the pharmacy provider indicating the type of potential problem.

The alerts regarding possible drug therapy problems include, but are not limited to:

(a) Therapeutic duplication;

(b) Duration of therapy exceeds the recommended maximum period;

(c) Drug-to-drug interaction;

(d) Drug disease precaution;

(e) High dose;

(f) Ingredient duplication;

(g) Drug-to-client age conflict;

(h) Drug-to-client gender conflict; or

(i) Refill too soon.

(4) MAA provides pharmacy providers with a list of codes from which to choose in overriding MAA POS system alert messages. The override codes come from the national council for prescription drug programs (NCPDP).

(5) The dispensing pharmacist evaluates the potential drug therapy conflict and chooses one of the following:

(a) If the conflict is resolved, the pharmacy may process the claim using the applicable NCPDP override code.

(b) If the conflict is not resolved, MAA requires prior authorization. This includes all claims for which an alert message is triggered in the POS system and an NCPDP override code is not appropriate.

(6) MAA requires providers to retain documentation of the justification for the use of payment system override codes as described in subsections (4) and (5) of this section. MAA requires the documentation be retained for the same period as that described in WAC 388-502-0020.

(7) POS/Pro-DUR screening is not applicable to pharmacy claims included in the managed care capitated rate.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1950, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1950, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-08-018 (Order 3960), § 388-530-1950, filed 3/26/96, effective 4/26/96.]

**WAC 388-530-2050 Reimbursement for out-of-state prescriptions.** (1) The medical assistance administration (MAA) reimburses out-of-state pharmacies for prescription drugs provided to an eligible client within the scope of the client's medical care program if the pharmacy:

(a) Contracts with MAA to be an enrolled provider; and

(b) Meets the same criteria MAA requires for in-state pharmacy providers.

(2) MAA considers pharmacies located in bordering areas listed in WAC 388-501-0175 the same as in-state pharmacies.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-2050, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-2050, filed 12/7/00, effective 1/7/01; 00-01-088, § 388-530-2050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-2050, filed 10/9/96, effective 11/9/96.]

## Chapter 388-531 WAC

### PHYSICIAN-RELATED SERVICES

#### WAC

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388-531-1350	Prolonged physician-related service.
388-531-1400	Psychiatric physician-related services.
388-531-1450	Radiology physician-related services.
388-531-1500	Sleep studies.
388-531-1550	Sterilization physician-related services.
388-531-1600	Structured weight loss physician-related services.
388-531-1650	Substance abuse detoxification physician-related services.
388-531-1700	Surgical physician-related services.
388-531-1750	Transplant coverage for physician-related services.
388-531-1800	Transplant coverage—Medical criteria to receive transplants.
388-531-1850	Payment methodology for physician-related services—General and billing modifiers.
388-531-1900	Reimbursement—General requirements for physician-related services.

**WAC 388-531-0050 Physician-related services definitions.** The following definitions and abbreviations and those found in WAC 388-500-0005, apply to this chapter. Defined words and phrases are bolded the first time they are used in the text.

**"Acquisition cost"** means the cost of an item excluding shipping, handling, and any applicable taxes.

**"Acute care"** means care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015).

**"Acute physical medicine and rehabilitation (PM&R)"** means a comprehensive inpatient and rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four hour specialized nursing services and an intense level of specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 388-550-2501).

**"Add-on procedure(s)"** means secondary procedure(s) that are performed in addition to another procedure.

**"Admitting diagnosis"** means the medical condition responsible for a hospital admission, as defined by ICD-9-M diagnostic code.

**"Advanced registered nurse practitioner (ARNP)"** means a registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

**"Aging and adult services administration (AASA)"** means the administration that administers directly or con-

tracts for long-term care services, including but not limited to nursing facility care and home and community services. See WAC 388-15-202.

**"Allowed charges"** means the maximum amount reimbursed for any procedure that is allowed by MAA.

**"Anesthesia technical advisory group (ATAG)"** means an advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

**"Base anesthesia units (BAU)"** means a number of anesthesia units assigned to a surgical procedure that includes the usual pre-operative, intra-operative, and post-operative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

**"Bundled services"** means services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

**"Bundled supplies"** means supplies which are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

**"By report (BR)"** means a method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

**"Call"** means a face-to-face encounter between the client and the provider resulting in the provision of services to the client.

**"Cast material maximum allowable fee"** means a reimbursement amount based on the average cost among suppliers for one roll of cast material.

**"Certified registered nurse anesthetist (CRNA)"** means an advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the National Certification and scope of practice.

**"Children's health insurance plan (CHIP),"** see chapter 388-542 WAC.

**"Clinical Laboratory Improvement Amendment (CLIA)"** means regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

**"Conversion factors"** means dollar amounts MAA uses to calculate the maximum allowable fee for physician-related services.

**"Covered service"** means a service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

**"CPT,"** see "current procedural terminology."

**"Critical care services"** means physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given

in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"**Current procedural terminology (CPT)**" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"**Diagnosis code**" means a set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

"**Emergency medical condition(s)**" means a medical condition(s) that manifests itself by acute symptoms of sufficient severity so that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"**Emergency services**" means medical services required by and provided to a patient experiencing an emergency medical condition.

"**Estimated acquisition cost (EAC)**" means the department's best estimate of the price providers generally and currently pay for drugs and supplies.

"**Evaluation and management (E&M) codes**" means procedure codes which categorize physician services by type of service, place of service, and patient status.

"**Expedited prior authorization**" means the process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"**Experimental**" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of safety and effectiveness. See WAC 388-531-0500. A service is not "experimental" if the service:

- (1) Is generally accepted by the medical profession as effective and appropriate; and
- (2) Has been approved by the FDA or other requisite government body, if such approval is required.

"**Fee-for-service**" means the general payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MAA's healthy options program or children's health insurance program (CHIP) programs.

"**Flat fee**" means the maximum allowable fee established by MAA for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"**Geographic practice cost index (GPCI)**" as defined by Medicare, means a Medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"**Global surgery reimbursement**," see WAC 388-531-1700.

"**HCPCS Level II**" means a coding system established by the HCFA to define services and procedures not included in CPT.

"**Health Care Financing Administration (HCFA)**" means the agency within the federal Department of Health and Human Services (DHHS) with oversight responsibility for the Medicare and Medicaid programs.

"**Health Care Financing Administration Common Procedure Coding System (HCPCS)**" means the name used for the Health Care Financing Administration codes made up of CPT and HCPCS level II codes.

"**Health care team**" means a group of health care providers involved in the care of a client.

"**Hospice**" means a medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"**ICD-9-CM**," see "International Classification of Diseases, 9th Revision, Clinical Modification."

"**Informed consent**" means that an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- (1) Disclosed and discussed the client's diagnosis; and
- (2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and
- (3) Given the client a copy of the consent form; and
- (4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and
- (5) Given the client oral information about all of the following:
  - (a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and
  - (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
  - (c) The procedure itself, including potential risks, benefits, and consequences.

"**Inpatient hospital admission**" means an acute hospital stay for longer than twenty-four hours when the medical care record shows the need for inpatient care beyond twenty-four hours. All admissions are considered inpatient hospital admissions, and are paid as such, regardless of the length of stay, in the following circumstances:

- (1) The death of a client;
- (2) Obstetrical delivery;
- (3) Initial care of a newborn; or
- (4) Transfer to another acute care facility.

"**International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)**" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alphabetical designations (coding).

"**Investigational**" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of benefit for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, in which the potential risks and potential benefits are examined, demonstrating the proposed service to be of greater overall benefit to the client in the particular circumstance than another, generally available service.

**"Life support"** means mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

**"Limitation extension"** means a process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization.

**"Maximum allowable fee"** means the maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

**"Medically necessary,"** see WAC 388-500-0005.

**"Medicare Physician Fee Schedule Data Base (MPFSDB)"** means the official HCFA publication of the Medicare policies and RVUs for the RBRVS reimbursement program.

**"Medicare Program Fee Schedule for Physician Services (MPFS)"** means the official HCFA publication of the Medicare fees for physician services.

**"Medicare Clinical Diagnostic Laboratory Fee Schedule"** means the fee schedule used by Medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

**"Mentally incompetent"** means a client who has been declared mentally incompetent by a federal, state, or local court.

**"Modifier"** means a two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

**"Outpatient"** means a client who is receiving medical services in other than an inpatient hospital setting.

**"Peer-reviewed medical literature"** means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

**"Physician care plan"** means a written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

**"Physician standby"** means physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

**"Physician's current procedural terminology,"** see "CPT, current procedural terminology."

**"PM&R,"** see acute physical medicine and rehabilitation.

**"Podiatric service"** means the diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

**"Pound indicator (#)"** means a symbol (#) indicating a CPT procedure code listed in MAA fee schedules that is not routinely covered.

**"Preventive"** means medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

**"Prior authorization"** means a process by which clients or providers must request and receive MAA approval for certain medical services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

**"Professional component"** means the part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

**"Prognosis"** means the probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

**"Prolonged services"** means face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

**"Provider,"** see WAC 388-500-0005.

**"Radioallergosorbent test" or "RAST"** means a blood test for specific allergies.

**"RBRVS,"** see resource based relative value scale.

**"RVU,"** see relative value unit.

**"Reimbursement"** means payment to a provider or other MAA-approved entity who bills according to the provisions in WAC 388-502-0100.

**"Reimbursement steering committee (RSC)"** means an interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, MAA, and department of labor and industries.

**"Relative value guide (RVG)"** means a system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

**"Relative value unit (RVU)"** means a unit which is based on the resources required to perform an individual service or intervention.

**"Resource based relative value scale (RBRVS)"** means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

**"RBRVS RVU"** means a measure of the resources required to perform an individual service or intervention. It is set by Medicare based on three components - physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

**"RSC RVU"** means a unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

**"Stat laboratory charges"** means charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

**"State unique procedure codes"** means procedure codes established by the RSC to define services or procedures not contained in CPT or HCPCS level II.

**"Sterile tray"** means a tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by HCFA to be nonroutine and reimbursed separately.

**"Technical advisory group (TAG)"** means an advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, MAA, and department of labor and industries.

**"Technical component"** means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0050, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0100 Scope of coverage for physician-related services—General and administrative.** (1) **The medical assistance administration (MAA)** covers medical services, equipment, and supplies when they are both:

(a) Within the scope of an eligible client's medical care program. Refer to chapter 388-529 WAC; and

(b) **Medically necessary** as defined in 388-500-0005.

(2) MAA evaluates a request for any service that is listed as noncovered in WAC 388-531-0150 under the provisions of WAC 388-501-0165.

(3) MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165 which related to medical necessity.

(4) MAA evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165.

(5) MAA covers the following physician-related services, subject to the conditions in subsection (1), (3), and (4) of this section:

(a) Allergen immunotherapy services;

(b) Anesthesia services;

(c) Dialysis and end stage renal disease services (refer to chapter 388-540 WAC);

(d) Emergency physician services;

(e) ENT (ear, nose, and throat) related services;

(f) Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 388-534-0100);

(g) Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when recommended after a multidisciplinary evaluation including at least urology, endocrinology, and psychiatry;

(h) Family planning services (refer to chapter 388-532 WAC);

(i) **Hospital** inpatient services (refer to chapter 388-550 WAC);

(j) Maternity care, delivery, and newborn care services (refer to chapter 388-533 WAC);

(k) Office visits;

(l) Vision-related services, per chapter 388-544 WAC;

(m) Osteopathic treatment services;

(n) Pathology and laboratory services;

(o) Physiatry and other rehabilitation services (refer to chapter 388-550 WAC);

(p) Podiatry services;

(q) Primary care services;

(r) Psychiatric services, provided by a psychiatrist;

(s) Pulmonary and respiratory services;

(t) Radiology services;

(u) Surgical services;

(v) Surgery to correct defects from birth, illness, or trauma, or for mastectomy reconstruction; and

(w) Other **outpatient** physician services.

(6) MAA covers physical examinations for MAA clients only when the physical examination is one or more of the following:

(a) A screening exam covered by the EPSDT program (see WAC 388-534-0100);

(b) An annual exam for clients of the division of developmental disabilities; or

(c) A screening pap smear, mammogram, or prostate exam.

(7) By providing covered services to a client eligible for a medical care program, a provider who has signed an agreement with MAA accepts MAA's rules and fees as outlined in the agreement, which includes federal and state law and regulations, billing instructions, and MAA issuances.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0100, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0150 Noncovered physician-related services—General and administrative.** (1) Except as provided in WAC 388-531-0100 and subsection (2) of this section, MAA does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(e) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 388-501-0165;

(f) Hair transplantation;

(g) Marital counseling or sex therapy;

(h) More costly services when MAA determines that less costly, equally effective services are available;

(i) Vision-related services listed as noncovered in chapter 388-544 WAC;

(j) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 388-531-1750;

(k) Physician-supplied medication, except those drugs administered by the physician in the physician's office;

(l) Physical examinations or routine checkups, except as provided in WAC 388-531-0100;

(m) Routine foot care. This does not include clients who have a medical condition that affects the feet, such as diabetes or arteriosclerosis obliterans. Routine foot care includes, but is not limited to:

(i) Treatment of mycotic disease;

(ii) Removal of warts, corns, or calluses;

(iii) Trimming of nails and other hygiene care; or

(iv) Treatment of flat feet;

(n) Except as provided in WAC 388-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, or the application of associated services.

(o) Nonmedical equipment; and

(p) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas.

(2) MAA covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A Medicaid program for qualified **Medicare** beneficiaries (QMBs); or

(c) A waiver program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0150, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0200 Physician-related services requiring prior authorization.** (1) MAA requires **prior authorization** for certain services. Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE)**. See WAC 388-501-0165.

(2) The EPA process is designed to eliminate the need for telephone prior authorization for selected admissions and procedures.

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(a) The provider must create an authorization number using the process explained in MAA's physician-related billing instructions.

(b) Upon request, the provider must provide supporting clinical documentation to MAA showing how the authorization number was created.

(c) Selected nonemergent admissions to contract hospitals require EPA. These are identified in MAA billing instructions.

(d) Procedures requiring expedited prior authorization include, but are not limited to, the following:

(i) Bladder repair;

(ii) Hysterectomy for clients age forty-five and younger, except with a diagnosis of cancer(s) of the female reproductive system;

(iii) Outpatient magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA);

(iv) Reduction mammoplasties/mastectomy for gynecomastia; and

(v) Strabismus surgery for clients eighteen years of age and older.

(3) MAA evaluates new technologies under the procedures in WAC 388-531-0550. These require prior authorization.

(4) Prior authorization is required for the following:

(a) Abdominoplasty;

(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R)**;

(c) Cochlear implants, which also:

(i) For coverage, must be performed in an ambulatory surgery center (ASC) or an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim;

(d) Diagnosis and treatment of eating disorders for clients twenty-one years of age and older;

(e) Osteopathic manipulative therapy in excess of MAA's published limits;

(f) Panniculectomy;

(g) Surgical procedures related to weight loss or reduction; and

(h) Vagus nerve stimulator insertion, which also:

(i) For coverage, must be performed in an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim.

(5) MAA may require a second opinion and/or consultation before authorizing any elective surgical procedure.

(6) Children six year of age and younger do not require authorization for hospitalization.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0200, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0250 Who can provide and bill for physician-related services.** (1) The following enrolled providers are eligible to provide and bill for physician-related medical services which they provide to eligible clients:

(a) Advanced registered nurse practitioners (ARNP);

(b) Federally qualified health centers (FQHCs);

(c) Health departments;

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(d) Hospitals currently licensed by the department of health;

(e) Independent (outside) laboratories CLIA certified to perform tests. See WAC 388-531-0800;

(f) Licensed radiology facilities;

(g) Medicare-certified ambulatory surgery centers;

(h) Medicare-certified rural health clinics;

(i) Providers who have a signed agreement with MAA to provide screening services to eligible persons in the EPSDT program;

(j) Registered nurse first assistants (RNFA); and

(k) Persons currently licensed by the state of Washington department of health to practice any of the following:

(i) Dentistry (refer to chapter 388-535 WAC);

(ii) Medicine and osteopathy;

(iii) Nursing;

(iv) Optometry; or

(v) Podiatry.

(2) MAA does not reimburse for services performed by any of the following practitioners:

(a) Acupuncturists;

(b) Christian Science practitioners or theological healers;

(c) Counselors;

(d) Herbalists;

(e) Homeopaths;

(f) Massage therapists as licensed by the Washington state department of health;

(g) Naturopaths;

(h) Sanipractors;

(i) Those who have a master's degree in social work (MSW), except those employed by an FQHC;

(j) Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010; or

(k) Any other licensed practitioners providing services which the practitioner is not:

(i) Licensed to provide; and

(ii) Trained to provide.

(3) MAA reimburses practitioners listed in subsection (2) of this section for physician-related services if those services are mandated by, and provided to, clients who are eligible for one of the following:

(a) The EPSDT program;

(b) A Medicaid program for qualified Medicare beneficiaries (QMB); or

(c) A waiver program.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-0250, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0300 Anesthesia providers and covered physician-related services.** MAA bases coverage of anesthesia services on Medicare policies and the following rules:

(1) MAA reimburses providers for covered anesthesia services performed by:

(a) Anesthesiologists;

(b) **Certified registered nurse anesthetists (CRNAs);**

(c) Oral surgeons with a special agreement with MAA to provide anesthesia services; and

(d) Other providers who have a special agreement with MAA to provide anesthesia services.

(2) MAA covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) MAA covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions;

(b) Maternity per subsection (9) of this section. See WAC 388-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC 388-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

(a) Perform a pre-anesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) MAA does not allow the anaesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by Medicare instructions.

(6) MAA requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, MAA reimburses the base anesthesia units (BAU) for the major procedure only.

(b) MAA does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, MAA reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive fifty percent of the allowed amount.

(ii) For anesthesia provided by a team, MAA limits reimbursement to one hundred percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) MAA pays CRNAs or anesthesiologists for pain management services.

(b) MAA allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) MAA does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC 388-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter 388-533 WAC for more information about maternity-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0300, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0350 Anesthesia services—Reimbursement for physician-related services.** (1) MAA reimburses anesthesia services on the basis of base anesthesia units (BAU) plus time.

(2) MAA calculates payment for anesthesia by adding the BAU to the time units and multiplying that sum by the conversion factor. The formula used in the calculation is:  $(BAU \times fifteen) + time \times (conversion\ factor\ divided\ by\ fifteen) = reimbursement$ .

(3) MAA obtains BAU values from the relative value guide (RVG), and updates them annually. MAA and/or the anesthesia technical advisory group (ATAG) members establish the base units for procedures for which anesthesia is appropriate but do not have BAUs established by RVSP and are not defined as add-on.

(4) MAA determines a budget neutral anesthesia conversion factor by:

(a) Determining the BAUs, time units, and expenditures for a **base period** for the provided procedure. Then,

(b) Adding the latest BAU RVSP to the time units for the base period to obtain an estimate of the new time unit for the procedure. Then,

(c) Multiplying the time units obtained in (b) of this subsection for the new period by a conversion factor to obtain estimated expenditures. Then,

(d) Comparing the expenditures obtained in (c) of this subsection with base period expenditure levels obtained in (a) of this subsection. Then,

(e) Adjusting the dollar amount for the anesthesia conversion factor and the projected time units at the new BAUs equals the allocated amount determined in (a) of this subsection.

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(5) MAA calculates anesthesia time units as follows:

(a) One minute equals one unit.

(b) The total time is calculated to the next whole minute.

(c) Anesthesia time begins when the anesthesiologist, surgeon, or CRNA begins physically preparing the client for the induction of anesthesia; this must take place in the operating room or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be added together as long as there is continuous monitoring. Examples of this include, but are not limited to, the following:

(i) The time a client spends in an anesthesia induction room; or

(ii) The time a client spends under the care of an operating room nurse during a surgical procedure.

(d) Anesthesia time ends when the anesthesiologist, surgeon, or CRNA is no longer in constant attendance (i.e., when the client can be safely placed under post-operative supervision).

(6) MAA changes anesthesia **conversion factors** if the legislature grants a vendor rate increase, or other increase, and if the effective date of that increase is not the same as MAA's annual update.

(7) If the legislatively authorized vendor rate increase or other increase becomes effective at the same time as MAA's annual update, MAA applies the increase after calculating the budget-neutral conversion factor.

(8) When more than one surgical procedure is performed at the same operative session, MAA uses the BAU of the major procedure to determine anesthesia **allowed charges**. MAA reimburses add-on procedures as defined by CPT only for the time spent on the add-on procedure that is in addition to the time spent on the major procedure.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0350, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0400 Client responsibility for reimbursement for physician-related services.** Clients may be responsible to reimburse the provider, as described under WAC 388-501-0100, for services that are not covered under the client's medical care program. Clients whose care is provided under CHIP may be responsible for copayments as outlined in chapter 388-542 WAC. Also, see WAC 388-502-0160, Billing the client.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0400, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0450 Critical care—Physician-related services.** (1) MAA reimburses the following physicians for critical care services:

(a) The attending physician who assumes responsibility for the care of a client during a life-threatening episode;

(b) More than one physician if the services provided involve multiple organ systems; or

(c) Only one physician for services provided in the emergency room.

(2) MAA reimburses preoperative and postoperative critical care in addition to a **global surgical package** when all the following apply:

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(a) The client is critically ill and the physician is engaged in work directly related to the individual client's care, whether that time is spent at the immediate bedside or elsewhere on the floor;

(b) The critical injury or illness acutely impairs one or more vital organ systems such that the client's survival is jeopardized;

(c) The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and

(d) The provider uses any necessary, appropriate modifier when billing MAA.

(3) MAA limits payment for critical care services to a maximum of three hours per day, per client.

(4) MAA does not pay separately for certain services performed during a critical care period when the services are provided on a per hour basis. These services include, but are not limited to, the following:

(a) Analysis of information data stored in computers (e.g., ECG, blood pressure, hematologic data);

(b) Blood draw for a specimen;

(c) Blood gases;

(d) Cardiac output measurement;

(e) Chest X-rays;

(f) Gastric intubation;

(g) Pulse oximetry;

(h) Temporary transcutaneous pacing;

(i) Vascular access procedures; and

(j) Ventilator management.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0450, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0500 Emergency physician-related services.** (1) MAA reimburses for E&M services provided in the hospital emergency department to clients who arrive for immediate medical attention.

(2) MAA reimburses emergency physician services only when provided by physicians assigned to the hospital emergency department or the physicians on call to cover the hospital emergency department.

(3) MAA pays a provider who is called back to the emergency room at a different time on the same day to attend a return visit the same client. When this results in multiple claims on the same day, the time of each encounter must be clearly indicated on the claim.

(4) MAA does not pay emergency room physicians for **hospital admission** charges or additional service charges.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0500, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0550 Experimental and investigational services.** (1) When MAA makes a determination as to whether a proposed service is experimental or investigational, MAA follows the procedures in this section. The policies and procedures and any criteria for making decisions are available upon request.

(2) The determination of whether a service is experimental and/or investigational is subject to a case-by-case review under the provisions of WAC 388-501-0165 which relate to medical necessity. MAA also considers the following:

(a) Evidence in **peer-reviewed medical literature**, as defined in WAC 388-531-0050, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications;

(b) Whether evidence indicates the service or treatment is more likely than not to be as beneficial as existing conventional treatment alternatives for the treatment of the condition in question;

(c) Whether the service or treatment is generally used or generally accepted for treatment of the condition in the United States;

(d) Whether the service or treatment is under continuing scientific testing and research;

(e) Whether the service or treatment shows a demonstrable benefit for the condition;

(f) Whether the service or treatment is safe and efficacious;

(g) Whether the service or treatment will result in greater benefits for the condition than another generally available service; and

(h) If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

(3) MAA applies consistently across clients with the same medical condition and health status, the criteria to determine whether a service is experimental. A service or treatment that is not experimental for one client with a particular medical condition is not determined to be experimental for another enrollee with the same medical condition and health status. A service that is experimental for one client with a particular medical condition is not necessarily experimental for another, and subsequent individual determinations must consider any new or additional evidence not considered in prior determinations.

(4) MAA does not determine a service or treatment to be experimental or investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of greater overall benefit to the client in question than another generally available service.

(5) All determinations that a proposed service or treatment is "experimental" or "investigation" are subject to the review and approval of a physician who is:

(a) Licensed under chapter 18.57 RCW or an osteopath licensed under chapter 18.71 RCW;

(b) Designated by MAA's medical director to issue such approvals; and

(c) Available to consult with the client's treating physician by telephone.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0550, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0600 HIV/AIDS Counseling and testing as physician-related services.** MAA covers one pre- and one post-HIV/AIDS counseling/testing session per client each time the client is tested for HIV/AIDS.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-0600, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0650 Hospital physician-related services not requiring authorization when provided in MAA-approved centers of excellence or hospitals authorized to provide the specific services.** MAA covers the following services without prior authorization when provided in MAA-approved centers of excellence. MAA issues periodic publications listing centers of excellence. These services include the following:

- (1) All transplant procedures specified in WAC 388-550-1900;
- (2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400. See also WAC 388-531-0700;
- (3) Sleep studies including but not limited to polysomnograms for clients one year of age and older. MAA allows sleep studies only in outpatient hospital settings as described under WAC 388-550-6350. See also WAC 388-531-1500;
- (4) Diabetes education, in a DOH-approved facility, per WAC 388-550-6300; and
- (5) MAA-approved structured weight loss programs. See also WAC 388-531-1600.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-0650, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0700 Inpatient chronic pain management physician-related services.** (1) MAA covers inpatient chronic pain management services only when the services are obtained through an MAA-approved chronic pain facility.

- (2) A client qualifies for inpatient chronic pain management services when all of the following apply:
  - (a) The client has had chronic pain for at least three months, that has not improved with conservative treatment, including tests and therapies;
  - (b) At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and
  - (c) Clients with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs or alcohol for six months.
- (3) For chronic pain management, MAA limits coverage to only one inpatient hospital stay per client's lifetime, up to a maximum of twenty-one days.
- (4) MAA reimburses for only the chronic pain management services and procedures that are listed in the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-0700, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0750 Inpatient hospital physician-related services.** (1) MAA separately reimburses the attending provider for inpatient hospital professional services rendered by the attending provider during the surgical follow-up

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period only if the services are performed for an emergency condition or a diagnosis that is unrelated to the inpatient stay.

(2) MAA reimburses for only one inpatient hospital call per client, per day for the same or related diagnoses. If a call is included in the **global surgery reimbursement**, MAA does not reimburse separately.

(3) MAA reimburses a hospital admission related to a planned surgery through the global fee for surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-0750, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0800 Laboratory and pathology physician-related services.** (1) MAA reimburses providers for laboratory services only when:

- (a) The provider is certified according to Title XVII of the Social Security Act (Medicare), if required; and
  - (b) The provider has a clinical laboratory improvement amendment (CLIA) certificate and identification number.
- (2) MAA includes a handling, packaging, and mailing fee in the reimbursement for lab tests and does not reimburse these separately.
- (3) MAA reimburses only one blood drawing fee per client, per day. MAA allows additional reimbursement for an independent laboratory when it goes to a nursing facility or a private home to obtain a specimen.
- (4) MAA reimburses only one catheterization for collection of a urine specimen per client, per day.
- (5) MAA reimburses automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not all tests are performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, MAA reimburses the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

- (i) A clinic;
- (ii) A hospital laboratory;
- (iii) An independent laboratory; or
- (iv) A physician's office.

(6) MAA allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed **STAT**.

(a) MAA reimburses **STAT** charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed **STAT**.

(b) Tests generated in the emergency room do not automatically justify a **STAT** order, the physician must specifically order the tests as **STAT**.

(c) Refer to the fee schedule for a list of **STAT** procedures.

(7) MAA reimburses for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) MAA does not reimburse for drug screens for clients in the division of alcohol and substance abuse (DASA)-con-

tracted methadone treatment programs. These are reimbursed through a contract issued by DASA.

(9) MAA does not cover for drug screens to monitor any of the following:

(a) Program compliance in either a residential or outpatient drug or alcohol treatment program;

(b) Drug or alcohol abuse by a client when the screen is performed by a provider in private practice setting; or

(c) Suspected drug use by clients in a residential setting, such as a group home.

(10) MAA may require a drug or alcohol screen in order to determine a client's suitability for a specific test.

(11) An independent laboratory must bill MAA directly. MAA does not reimburse a medical practitioner for services referred to or performed by an independent laboratory.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-0800, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0850 Laboratory and pathology physician-related services reimbursement.** (1) MAA pays for clinical diagnostic laboratory procedures based on the **Medicare clinical diagnostic laboratory fee schedule (MCDLF)** for the state of Washington. MAA obtains information used to update fee schedule regulations from Program Memorandum and Regional Medicare Letters as published by HCFA.

(2) MAA updates budget-neutral fees each July by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Determining in total the ratio of current MAA fees to existing Medicare fees. Then,

(c) Determining new MAA fees by adjusting the new Medicare fee by the ratio. Then,

(d) Multiplying the units of service by the new MAA fee to obtain total estimated expenditures. Then,

(e) Comparing the expenditures in subsection (14)(d) of this section to the base period expenditures. Then,

(f) Adjusting the new ratio until estimated expenditures equals the base period amount.

(3) MAA calculates maximum allowable fees (MAF) by:

(a) Calculating fees using methodology described in subsection (2) of this section for procedure codes that have an applicable Medicare clinical diagnostic laboratory fee (MCDLF).

(b) Establishing RSC fees for procedure codes that have no applicable MCDLF.

(c) Establishing maximum allowable fees, or "**flat fees**" for procedure codes that have no applicable MCDLF or RSC fees. MAA updates flat fee reimbursement only when authorized by the legislature.

(d) MAA reimbursement for clinical laboratory diagnostic procedures does not exceed the regional MCDLF schedule.

(4) MAA increases fees if the legislature grants a vendor rate increase or other increase. If the legislatively authorized increase becomes effective at the same time as MAA's annual update, MAA applies the increase after calculating budget-neutral fees.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-0850, filed 12/6/00, effective 1/6/01.]

(2003 Ed.)

**WAC 388-531-0900 Neonatal intensive care unit (NICU) physician-related services.** (1) MAA pays the physician directing the care of a neonate or infant in an NICU, for NICU services.

(2) NICU services include, but are not limited to, any of the following:

(a) Patient management;

(b) Monitoring and treatment of the neonate, including nutritional, metabolic and hematologic maintenance;

(c) Parent counseling; and

(d) Personal direct supervision by the **health care team** of activities required for diagnosis, treatment, and supportive care of the patient.

(3) Payment for NICU care begins with the date of admission to the NICU.

(4) MAA reimburses a provider for only one NICU service per client, per day.

(5) A provider may bill for NICU services in addition to **prolonged services** and newborn resuscitation when the provider is present at the delivery.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-0900, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-0950 Office and other outpatient physician-related services.** (1) MAA reimburses for the following:

(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and

(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 388-531-0500.

(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (1) of this section.

(3) See physician billing instructions for procedures that are included in the office call and cannot be billed separately.

(4) Using selected diagnosis codes, MAA reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.

(5) MAA may reimburse providers for injection procedures and/or injectable drug products only when:

(a) The injectable drug is administered during an office visit; and

(b) The injectable drug used is from office stock and purchased by the provider from a pharmacist or drug manufacturer as described in WAC 388-530-1200.

(6) MAA does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) MAA does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; MAA does reimburse an administrative fee. If the immunization is given in a health department and is the only service provided, MAA reimburses a minimum E&M service.

(8) MAA reimburses immunizations at **estimated acquisition costs (EAC)** when the immunizations are not part of the vaccine for children program. MAA reimburses a sepa-

rate administration fee for these immunizations. Covered immunizations are listed in the fee schedule.

(9) MAA reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) MAA does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. MAA does pay separately for the administration of these injections when they are provided on the same day as an E&M service. MAA does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. MAA reimburses separately for the drug(s).

(b) MAA does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same day as an E&M service. If the injection is the only service provided, MAA pays an administrative fee. MAA reimburses separately for the drug.

(c) MAA reimburses injectable drugs at **acquisition cost**. The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by MAA. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing MAA for the following drugs:

(i) Classified drugs where the billed charge to MAA is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to MAA is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) MAA reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent times, MAA reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) MAA covers the antigen, the antigen preparation, and an administration fee.

(e) MAA reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) MAA reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) MAA reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on the Medicare pricing method for calculating the estimated acquisition cost (EAC), or maximum allowable cost (MAC) when generics are available;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

(ii) The dosage and strength used; and

(iii) The national drug code (NCD).

(12) Notwithstanding the provisions of this section, MAA reserves the option of determining drug pricing for any particular drug based on the best evidence available to MAA, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) MAA may request an invoice as necessary.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0950, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1000 Ophthalmic physician-related services.** Refer to chapter 388-544 WAC for ophthalmic and vision-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1000, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1050 Osteopathic manipulative treatment.** (1) MAA reimburses osteopathic manipulative therapy (OMT) only when OMT is provided by an osteopathic physician licensed under chapter 18.71 RCW.

(2) MAA reimburses OMT only when the provider bills using the appropriate CPT codes that involve the number of body regions involved.

(3) MAA allows an osteopathic physician to bill MAA for an E&M service in addition to the OMT when one of the following apply:

(a) The physician diagnoses the condition requiring manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require manipulative therapy.

(4) MAA limits reimbursement for manipulations to ten per client, per calendar year. Reimbursement for each manipulation includes a brief evaluation as well as the manipulation.

(5) MAA does not reimburse for physical therapy services performed by osteopathic physicians.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1050, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1100 Out-of-state physician services.** (1) MAA covers medical services provided to eligible clients who are temporarily located outside the state, subject to the provisions of this chapter and WAC 388-501-0180.



(2) Out-of-state border areas as described under WAC 388-501-0175 are not subject to out-of-state limitations. MAA considers physicians in border areas as providers in the state of Washington.

(3) In order to be eligible for reimbursement, out-of-state physicians must meet all criteria for, and must comply with all procedures required of in-state physicians, in addition to other requirements of this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1100, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1150 Physician care plan oversight services.** (1) MAA covers **physician care plan** oversight services only when:

- (a) A physician provides the service; and
- (b) The client is served by a home health agency, a nursing facility, or a **hospice**.

(2) MAA reimburses for physician care plan oversight services when both of the following apply:

- (a) The facility/agency has established a plan of care; and
  - (b) The physician spends thirty or more minutes per calendar month providing oversight for the client's care.
- (3) MAA reimburses only one physician per client, per month, for physician care plan oversight services.

(4) MAA reimburses for physician care plan oversight services during the global surgical reimbursement period only when the care plan oversight is unrelated to the surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1150, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1200 Physician office medical supplies.** (1) Refer to RBRVS billing instructions for a list of:

- (a) Supplies that are a routine part of office or other outpatient procedures and that cannot be billed separately; and
- (b) Supplies that can be billed separately and that MAA considers nonroutine to office or outpatient procedures.

(2) MAA reimburses at acquisition cost certain supplies under fifty dollars that do not have a maximum allowable fee listed in the fee schedule. The provider must retain invoices for these items and make them available to MAA upon request.

(3) Providers must submit invoices for items costing fifty dollars or more.

(4) MAA reimburses for **sterile tray** for certain surgical services only. Refer to the fee schedule for a list of covered items.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1200, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1250 Physician standby services.** (1) MAA reimburses **physician standby** services only when the standby physician does not provide care or service to other clients during this period, and either:

- (a) The services are provided in conjunction with newborn care history and examination, or result in an admission to a neonatal intensive care unit on the same day; or

(b) A physician requests another physician to stand by, resulting in the prolonged attendance by the second physician without face-to-face client contact.

(2) MAA does not reimburse physician standby services when any of the following occur:

- (a) The standby ends in a surgery or procedure included in a global surgical reimbursement;
- (b) The standby period is less than thirty minutes; or
- (c) Time is spent proctoring another physician.

(3) One unit of physician standby service equals thirty minutes. MAA reimburses subsequent periods of physician standby service only when full thirty minutes of standby is provided for each unit billed. MAA rounds down fractions of a thirty-minute time unit.

(4) The provider must clearly document the need for physician standby services in the client's medical record.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1250, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1300 Podiatric physician-related services.** (1) MAA covers podiatric services as listed in this section when provided by any of the following:

- (a) A medical doctor;
- (b) A doctor of osteopathy; or
- (c) A podiatric physician.

(2) MAA reimburses for the following:

(a) Nonroutine foot care when a medical condition that affects the feet (such as diabetes or arteriosclerosis obliterans) requires that any of the providers in subsection (1) of this section perform such care;

(b) One treatment in a sixty-day period for debridement of nails. MAA covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) Impression casting. MAA includes ninety-day follow-up care in the reimbursement;

(d) A surgical procedure performed on the ankle or foot, requiring a local nerve block, and performed by a qualified provider. MAA does not reimburse separately for the anesthesia, but includes it in the reimbursement for the procedure; and

(e) Custom fitted and/or custom molded orthotic devices:

(i) MAA's fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) MAA includes an E&M fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical record.

(3) MAA does not reimburse podiatrists for any of the following radiology services:

- (a) X-rays for soft tissue diagnosis;
- (b) Bilateral x-rays for a unilateral condition;
- (c) X-rays in excess of two views;
- (d) X-rays that are ordered before the client is examined;

or

(e) X-rays for any part of the body other than the foot or ankle.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1300, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1350 Prolonged physician-related service.** (1) MAA reimburses prolonged services based on established Medicare guidelines. The services provided may or may not be continuous. The services provided must meet both of the following:

- (a) Consist of face-to-face contact between the physician and the client; and
  - (b) Be provided with other services.
- (2) MAA allows reimbursement for a prolonged service procedure in addition to an E&M procedure or consultation, up to three hours per client, per diagnosis, per day, subject to other limitations in the CPT codes that may be used. The applicable CPT codes are indicated in the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1350, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1400 Psychiatric physician-related services.** (1) MAA limits psychotherapy to one hour per day, per client, up to a total of twelve hours per calendar year. This includes family or group psychotherapy. Psychotherapy must be provided by a psychiatrist in the office, in the client's home, or in a nursing facility.

(2) MAA reimburses only one hospital call for direct psychiatric client care, per client, per day. Psychiatrists must bill the total time spent on direct psychiatric client care during each visit. Making rounds is considered direct client care and includes any one of the following:

- (a) Brief (up to one hour), individual psychotherapy;
- (b) Family/group therapy;
- (c) Electroconvulsive therapy; or
- (d) Pharmacologic management.

(3) MAA reimburses psychiatrists for either hospital care or psychotherapy, but not for both on the same day.

(4) MAA reimburses psychiatrists for a medical physical examination in the hospital in addition to a psychiatric diagnostic or evaluation interview examination.

(5) MAA reimburses only one psychiatric diagnostic interview examination in a calendar year unless a significant change in the client's circumstances renders an additional evaluation medically necessary.

(6) MAA requires psychiatrists to use hospital E&M codes when billing for daily rounds.

(7) MAA does not cover for psychiatric sleep therapy.

(8) Medication adjustment is the only psychiatric service for which MAA reimburses psychiatric ARNPs.

(9) MAA reimburses for one interactive or insight oriented call per client, per day, in an office or outpatient setting. Individual psychotherapy, interactive services may be billed only for clients age twenty and younger.

(10) DSHS providers must comply with chapters 275-55 and 275-57 WAC for hospital inpatient psychiatric admissions, and must follow rules adopted by the division of mental health or the appropriate regional support network (RSN). MAA does not reimburse for those psychiatric services that are eligible for reimbursement under those agencies.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1400, filed 12/6/00, effective 1/6/01.]

[Title 388 WAC—p. 856]

**WAC 388-531-1450 Radiology physician-related services.** (1) MAA reimburses radiology services subject to the limitations in this section and under WAC 388-531-0300.

(2) MAA does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

- (a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;
- (b) A history of asthma or allergy;
- (c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- (d) Generalized severe debilitation;
- (e) Sickle cell disease;
- (f) Pre-existing renal insufficiency; and/or
- (g) Other clinical situations where use of any media except LOCM would constitute a danger to the health of the client.

(3) MAA reimburse separately for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures. Providers must submit invoices for these procedures when requested by MAA, and reimbursement is at acquisition cost.

(4) MAA reimburses general anesthesia for radiology procedures. See WAC 388-531-0300.

(5) MAA reimburses radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC 388-531-1700. The procedures must meet all of the following conditions:

- (a) Performed on the same day;
- (b) Performed on the same client; and
- (c) Performed by the same physician or more than one member of the same group practice.

(6) MAA reimburses consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate **professional component** modifier.

(7) MAA reimburses for portable x-ray services furnished in the client's home or in nursing facilities, limited to the following:

- (a) Chest or abdominal films that do not involve the use of contract media;
- (b) Diagnostic mammograms; and
- (c) Skeletal films involving extremities, pelvis, vertebral column or skull.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1450, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1500 Sleep studies.** (1) MAA covers sleep studies only when all of the following apply:

- (a) The study is done to establish a diagnosis of narcolepsy or of sleep apnea;
- (b) The study is done only at an MAA-approved sleep study center that meets the standards and conditions in subsections (2), (3), and (4) of this section; and
- (c) An ENT consultation has been done for a client under ten years of age.

(2003 Ed.)

(2) In order to become an MAA-approved sleep study center, a sleep lab must send MAA verification of both of the following:

(a) Sleep lab accreditation by the American Academy of Sleep Medicine; and

(b) Physician's Board Certification by the American Board of Sleep Medicine.

(3) Registered polysomnograph technicians (PSGT) must meet the accreditation standards of the American Academy of Sleep Medicine.

(4) When a sleep lab changes directors, MAA requires the provider to submit accreditation for the new director. If an accredited director moves to a facility that MAA has not approved, the provider must submit certification for the facility.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1500, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1550 Sterilization physician-related services.** (1) For purposes of this section, sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. A hysterectomy is a surgical procedure or operation for the purpose of removing the uterus. Hysterectomy results in sterilization, but MAA does not cover hysterectomy performed solely for that purpose. Both hysterectomy and sterilization procedures require the use of specific consent forms.

#### STERILIZATION

(2) MAA covers sterilization when all of the following apply:

(a) The client is at least eighteen years of age at the time consent is signed;

(b) The client is a mentally competent individual;

(c) The client has voluntarily given **informed consent** in accordance with all the requirements defined in this subsection; and

(d) At least thirty days, but not more than one hundred eighty days, have passed between the date the client gave informed consent and the date of the sterilization.

(3) MAA does not require the thirty-day waiting period, but does require at least a seventy-two hour waiting period, for sterilization in the following circumstances:

(a) At the time of premature delivery, the client gave consent at least thirty days before the expected date of delivery. The expected date of delivery must be documented on the consent form;

(b) For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

(4) MAA waives the thirty-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, and completes a sterilization consent form. One of the following circumstances must apply:

(a) The client became eligible for **medical assistance** during the last month of pregnancy;

(b) The client did not obtain medical care until the last month of pregnancy; or

(c) The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery.

(2003 Ed.)

(5) MAA does not accept informed consent obtained when the client is in any of the following conditions:

(a) In labor or childbirth;

(b) Seeking to obtain or obtaining an abortion; or

(c) Under the influence of alcohol or other substances that affect the client's state of awareness.

(6) MAA has certain consent requirements that the provider must meet before MAA reimburses sterilization of a **mentally incompetent** or institutionalized client. MAA requires both of the following:

(a) A court order; and

(b) A sterilization consent form signed by the legal guardian, sent to MAA at least thirty days prior to the procedure.

(7) MAA reimburses epidural anesthesia in excess of the six-hour limit for sterilization procedures that are performed in conjunction with or immediately following a delivery. MAA determines total billable units by:

(a) Adding the time for the sterilization procedure to the time for the delivery; and

(b) Determining the total billable units by adding together the delivery BAUs, the delivery time, and the sterilization time.

(c) The provider cannot bill separately for the BAUs for the sterilization procedure.

(8) The physician identified in the "consent to sterilization" section of the DSHS-approved sterilization consent form must be the same physician who completes the "physician's statement" section and performs the sterilization procedure. If a different physician performs the sterilization procedure, the client must sign and date a new consent form at the time of the procedure that indicates the name of the physician performing the operation under the "consent for sterilization" section. This modified consent must be attached to the original consent form when the provider bills MAA.

(9) MAA reimburses all attending providers for the sterilization procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. MAA reimburses after the procedure is completed.

#### HYSTERECTOMY

(10) Hysterectomies performed for medical reasons may require expedited prior authorization as explained in WAC 388-531-0200(2).

(11) MAA reimburses hysterectomy without prior authorization in either of the following circumstances:

(a) The client has been diagnosed with cancer(s) of the female reproductive organs; and/or

(b) The client is forty-six years of age or older.

(12) MAA reimburses all attending providers for the hysterectomy procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. If a prior authorization number is necessary for the procedure, it must be on the claim. MAA reimburses after the procedure is completed.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1550, filed 12/6/00, effective 1/6/01.]

[Title 388 WAC—p. 857]

**WAC 388-531-1600 Structured weight loss physician-related services.** MAA covers structured outpatient weight loss only through an MAA-approved program.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-1600, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1650 Substance abuse detoxification physician-related services.** (1) MAA reimburses substance abuse detoxification services under state-unique codes.

(2) MAA covers physician services for three-day alcohol detoxification or five-day drug detoxification services for a client eligible for medical care program services in an MAA-enrolled hospital-based detoxification center.

(3) MAA covers treatment in programs qualified under chapter 275-25 WAC and certified under chapter 275-19 WAC or its successor.

(4) MAA covers detoxification and medical stabilization services to chemically using pregnant (CUP) women for up to twenty-seven days in an inpatient hospital setting.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-1650, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1700 Surgical physician-related services.** (1) MAA's global surgical reimbursement for all covered surgeries includes all of the following:

- (a) The operation itself;
- (b) Postoperative dressing changes, including:
  - (i) Local incision care and removal of operative packs;
  - (ii) Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints;
  - (iii) Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; or
  - (iv) Change and removal of tracheostomy tubes.
- (c) All additional medical or surgical services required because of complications that do not require additional operating room procedures.

(2) MAA's global surgical reimbursement for major surgeries, includes all of the following:

- (a) Preoperative visits, in or out of the hospital, beginning on the day before surgery; and
- (b) Services by the primary surgeon, in or out of the hospital, during a standard ninety-day postoperative period.

(3) MAA's global surgical reimbursement for minor surgeries includes all of the following:

- (a) Preoperative visits beginning on the day of surgery; and
- (b) Follow-up care for zero or ten days, depending on the procedure.

(4) When a second physician provides follow-up services for minor procedures performed in hospital emergency departments, MAA does not include these services in the global surgical reimbursement. The physician may bill these services separately.

(5) MAA's global surgical reimbursement for multiple surgical procedures is as follows:

- (a) Payment for multiple surgeries performed on the same client on the same day equals one hundred percent of MAA's allowed fee for the highest value procedure. Then,

(b) For additional surgical procedures, payment equals fifty percent of MAA's allowed fee for each procedure.

(6) MAA allows separate reimbursement for any of the following:

- (a) The initial evaluation or consultation;
- (b) Preoperative visits more than one day before the surgery;
- (c) Postoperative visits for problems unrelated to the surgery; and

(d) Postoperative visits for services that are not included in the normal course of treatment for the surgery.

(7) MAA's reimbursement for endoscopy is as follows:

(a) The global surgical reimbursement fee includes follow-up care for zero or ten days, depending on the procedure.

(b) Multiple surgery rules apply when a provider bills multiple endoscopies from different endoscopy groups. See subsection (4) of this section.

(c) When a physician performs more than one endoscopy procedure from the same group on the same day, MAA pays the full amount of the procedure with the highest maximum allowable fee.

(d) MAA pays the procedure with the second highest maximum allowable fee at the maximum allowable fee minus the base diagnostic endoscopy procedure's maximum allowed amount.

(e) MAA does not pay when payment for other codes within an endoscopy group is less than the base code.

(8) MAA restricts reimbursement for surgery assists to selected procedures as follows:

(a) MAA applies multiple surgery reimbursement rules for surgery assists apply. See subsection (4) of this section.

(b) Surgery assists are reimbursed at twenty percent of the maximum allowable fee for the surgical procedure.

(c) A surgical assist fee for a registered nurse first assistant (RNFA) is reimbursed if the nurse has been assigned a provider number.

(d) A provider must use a modifier on the claim with the procedure code to identify surgery assist.

(9) MAA bases payment splits between preoperative, intraoperative, and postoperative services on Medicare determinations for given surgical procedures or range of procedures. MAA pays any procedure that does not have an established Medicare payment split according to a split of ten percent - eighty percent - ten percent respectively.

(10) For preoperative and postoperative critical care services provided during a global period refer to WAC 388-531-0450.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-1700, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1750 Transplant coverage for physician-related services.** MAA covers transplants when performed in an MAA-approved center of excellence. See WAC 388-550-1900 for information regarding transplant coverage.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-1750, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1800 Transplant coverage—Medical criteria to receive transplants.** See WAC 388-550-2000 for information about medical criteria to receive transplants.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1800, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1850 Payment methodology for physician-related services—General and billing modifiers.**  
**GENERAL PAYMENT METHODOLOGY**

(1) MAA bases the payment methodology for most physician-related services on Medicare's RBRVS. MAA obtains information used to update MAA's RBRVS from the MPFSFS.

(2) MAA updates and revises the following RBRVS areas each January prior to MAA's annual update.

(3) MAA determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a **base period**. Then,

(b) Applying the latest Medicare RVU obtained from the MPFSDB, as published in the MPFSFS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels.

(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) MAA calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable Medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GCPI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable Medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GCPI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GCPI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, MAA establishes maximum allowable fees, also known as "flat" fees.

(i) MAA does not use the conversion factor for these codes.

(ii) MAA updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at EAC. (See WAC 388-530-1050 for explanation of EAC.) When the provider receives immunization materials from the department

of health, MAA pays the provider a flat fee only for administering the immunization.

(B) A **cast material maximum allowable fee** is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, MAA reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) MAA reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The **technical advisory group** reviews RBRVS changes.

(6) MAA also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as MAA's annual update.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, MAA applies the increase after calculating budget-neutral fees. MAA pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) MAA does not allow separate reimbursement for bundled services. However, MAA allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

**CPT/HCFA MODIFIERS**

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for MAA to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1850, filed 12/6/00, effective 1/6/01.]

**WAC 388-531-1900 Reimbursement—General requirements for physician-related services.** (1) MAA reimburses physicians and related providers for covered services provided to eligible clients on a fee-for-service basis, subject to the exceptions, restrictions, and other limitations listed in this chapter and other published issuances.

(2) In order to be reimbursed, physicians must bill MAA according to the conditions of payment under WAC 388-501-0150 and other issuances.

(3) MAA does not separately reimburse certain administrative costs or services. MAA considers these costs to be included in the reimbursement. These costs and services include the following:

- (a) Delinquent payment fees;
- (b) Educational supplies;
- (c) Mileage;
- (d) Missed or canceled appointments;
- (e) Reports, client charts, insurance forms, copying expenses;
- (f) Service charges;
- (g) Take home drugs; and
- (h) Telephoning (e.g., for prescription refills).

(4) MAA does not routinely pay for procedure codes which have a "#" indicator in the fee schedule. MAA reviews these codes for conformance to Medicaid program policy only as an exception to policy or as a limitation extension. See WAC 388-501-0160 and 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-1900, filed 12/6/00, effective 1/6/01.]

### Chapter 388-532 WAC FAMILY PLANNING SERVICES

#### WAC

388-532-050	Family planning definitions.
388-532-100	Family planning services.
388-532-700	TAKE CHARGE demonstration and research program.
388-532-710	TAKE CHARGE—Definitions.
388-532-720	TAKE CHARGE—Client eligibility.
388-532-730	TAKE CHARGE—Provider requirements.
388-532-740	TAKE CHARGE—Covered services.
388-532-750	TAKE CHARGE—Noncovered services.
388-532-760	TAKE CHARGE—Documentation requirements.
388-532-780	TAKE CHARGE—Payment limitations.
388-532-790	TAKE CHARGE—Good cause for coverage despite third party availability.

#### WAC 388-532-050 Family planning definitions.

"Family planning services" means the services, including the use of contraceptive techniques, that a client uses to plan the number and spacing of the client's children.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-050, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, 00-14-066, § 388-532-050, filed 7/5/00, effective 8/5/00.]

**WAC 388-532-100 Family planning services.** (1) The department informs eligible clients about available family planning services. This service includes, but is not limited to, information about the synthetic progestin capsule implant form of contraception.

(2) For eligible clients, except those participating in the TAKE CHARGE demonstration and research program (see WAC 388-532-700 through 388-532-790 for complete program description), the department provides the following services when needed in conjunction with family planning:

- (a) Physicians' services;
- (b) Advanced registered nurse practitioners' (ARNP) services;

[Title 388 WAC—p. 860]

- (c) Clinic or hospital services;
- (d) Laboratory services; and
- (e) Contraceptive supplies and/or prescription drugs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-100, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, 00-14-066, § 388-532-100, filed 7/5/00, effective 8/5/00.]

**WAC 388-532-700 TAKE CHARGE demonstration and research program.** (1) The medical assistance administration (MAA) is conducting a five-year family planning demonstration and research program called "TAKE CHARGE." The program will run from July 1, 2001, through June 30, 2006 (unless terminated or extended prior to June 30, 2006). TAKE CHARGE is approved by the federal government under a Medicaid program waiver.

(2) The TAKE CHARGE program:

(a) Pays for family planning services for eligible men and women as described in WAC 388-532-720;

(b) Requires providers to meet all general MAA provider requirements and the requirements of WAC 388-532-730; and

(3) Contains a research and evaluation component for clients and providers as described in WAC 388-532-730 (1)(f).

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-700, filed 10/8/02, effective 11/8/02.]

**WAC 388-532-710 TAKE CHARGE—Definitions.** The following definitions and abbreviations apply only to the medical assistance administration's (MAA's) TAKE CHARGE demonstration and research program.

"Ancillary services" means those family planning services that are given to TAKE CHARGE clients that are performed by the medical assistance administration's contracted providers who are not TAKE CHARGE providers. These services include, but are not limited to, family planning pharmacy services, family planning laboratory services and sterilization surgical services.

"Application assistance" means the process a TAKE CHARGE provider follows in helping a client be determined eligible for the TAKE CHARGE demonstration and research program.

"Education, counseling and risk reduction service" or "ECRR" means a set of medical assistance administration designated services (see WAC 388-532-740 (1)(c)) that strengthen a client's decision-making skills to make the best choice of contraceptive method and reduce the risk of unintended pregnancy.

"Family planning services" means medical care and educational services, which enable individuals to plan and space the number of children by using contraceptive methods to avoid an unintended pregnancy.

"Good cause" means that the medical assistance administration (MAA) has determined that an applicant for TAKE CHARGE has a valid reason for not using comprehensive third party family planning coverage that is available to the applicant for TAKE CHARGE. When good cause has been determined by MAA, the applicant is considered for TAKE CHARGE



without regard to the available third party family planning coverage.

**"Intensive follow-up services"** or **"IFS"** means those supplemental services specified in some TAKE CHARGE provider contracts that support clients in the successful use of contraceptive methods. DSHS-selected TAKE CHARGE providers perform IFS as part of the research component of the TAKE CHARGE demonstration and research program (see WAC 388-532-730 (1)(f)).

**"Principal purpose diagnosis"** means the reason given by the licensed medical provider for the TAKE CHARGE service. The TAKE CHARGE program is limited to a principal purpose diagnosis of family planning.

**"TAKE CHARGE"** means the medical assistance administration's five-year demonstration and research program approved by the federal government under a Medicaid program waiver to provide family planning services. See WAC 388-532-700.

**"TAKE CHARGE provider"** means a provider who is approved by the medical assistance administration (MAA) to participate in TAKE CHARGE by:

- (1) Having a core provider agreement with MAA;
- (2) Being approved to participate in MAA's long-standing family planning programs; and
- (3) Having a supplemental TAKE CHARGE agreement to provide TAKE CHARGE demonstration and research program family planning services to eligible clients under the terms of the federally approved Medicaid waiver for the TAKE CHARGE demonstration and research program.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-710, filed 10/8/02, effective 11/8/02.]

#### **WAC 388-532-720 TAKE CHARGE—Client eligibility.**

(1) To be eligible for the TAKE CHARGE program, a client must:

- (a) Be a United States citizen, U.S. national, or qualified alien of the U.S.A. as described in WAC 388-424-0005(1);
- (b) Be a resident of the state of Washington as described in WAC 388-468-0005;
- (c) Have income at or below two hundred percent of the federal poverty level as described in WAC 388-478-0075;
- (d) Apply voluntarily for family planning services with a TAKE CHARGE provider; and
- (e) Need family planning services but have:
  - (i) No family planning coverage through health insurance or another medical assistance administration (MAA) program;
  - (ii) Family planning coverage that does not cover all family planning methods or services; or
  - (iii) Good cause for not using family planning coverage through health insurance. See WAC 388-532-790 for information on good cause.

(2) To be eligible for the TAKE CHARGE program, a client must not be:

- (a) Eligible for the requested TAKE CHARGE family planning services under another MAA medical program;
- (b) Pregnant; or
- (c) Currently sterilized.

(2003 Ed.)

(3) A client is authorized for TAKE CHARGE coverage for one year from the date MAA determines eligibility. Upon reapplication for TAKE CHARGE by the client, MAA may renew the coverage for additional periods of up to one year each, for the duration of the demonstration and research program.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-720, filed 10/8/02, effective 11/8/02.]

#### **WAC 388-532-730 TAKE CHARGE—Provider requirements.** (1) A TAKE CHARGE provider must:

- (a) Have a current medical assistance administration (MAA) core provider agreement to provide family planning services to eligible MAA clients;
- (b) Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to MAA's TAKE CHARGE program guidelines;
- (c) Participate in MAA's specialized training for the TAKE CHARGE demonstration and research program prior to providing TAKE CHARGE services;
- (d) Comply with the required general MAA and TAKE CHARGE provider policies, procedures, and administrative practices as detailed in MAA's billing instructions;
- (e) Obtain both:
  - (i) Authorization from clients for release of information related to this program; and
  - (ii) Informed consents as defined in WAC 388-531-0050 and as required by WAC 388-531-1550, as necessary.

(f) If requested by MAA, participate in the research and evaluation component of the TAKE CHARGE demonstration and research program. If selected by DSHS for the research and evaluation component, the provider must accept assignment to either:

- (i) A randomly selected group of providers that give intensive follow-up service (IFS) to TAKE CHARGE clients under a TAKE CHARGE research component client services contract. See WAC 388-532-740(3) for a related limitation; or
- (ii) A randomly selected control group of providers subject to a TAKE CHARGE research component client services contract.

(2) MAA providers (e.g., pharmacies, laboratories, surgeons performing sterilization procedures) who are not TAKE CHARGE providers may furnish family planning ancillary services, as defined in this chapter, to eligible TAKE CHARGE clients. MAA reimburses for these services under the rules and fee schedules applicable to the specific services provided under MAA's other programs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-730, filed 10/8/02, effective 11/8/02.]

#### **WAC 388-532-740 TAKE CHARGE—Covered services.**

(1) The medical assistance administration (MAA) covers the following TAKE CHARGE services for men and women:

- (a) One session of application assistance per client, per year;

[Title 388 WAC—p. 861]

(b) All Food and Drug Administration (FDA) approved prescription and non-prescription contraceptives as provided in chapter 388-530 WAC;

(c) One initial education, counseling, and risk reduction (ECRR) service to include the following elements:

- (i) Assisting the client evaluate contraceptive methods;
- (ii) Preconception counseling if no contraceptive method is chosen or planned;
- (iii) Planning for contingencies including emergency contraception;
- (iv) Evaluation of client risk factors;
- (v) Scheduling of follow-up visits; and
- (vi) Assisting male clients understand their role in contraception.

(d) Follow-up ECRR services as described above and at intervals specified in subsection (2) of this section;

(e) One surgical sterilization service that meets the requirements of WAC 388-531-1550(1), if the service is:

- (i) Requested by the TAKE CHARGE client; and
- (ii) Performed in an ambulatory surgery center or hospital outpatient setting only.

(f) Testing for sexually transmitted diseases/infections (STD-I) when performed in conjunction with a principle purpose diagnosis of family planning;

(g) Treatment of STD-I when medically required as part of the client's selected contraceptive method(s).

(2) MAA covers follow-up ECRR services under the TAKE CHARGE demonstration and research program at the following intervals:

(a) For women, one ECRR service ten months after the initial ECRR service and one every ten months thereafter; and

(b) For men, one ECRR service per calendar year, after the initial ECRR service.

(3) MAA covers intensive follow-up services (IFS) for certain clients as part of the research component of the TAKE CHARGE demonstration and research program. Only those clients served by MAA's randomly selected research sites receive IFS (see WAC 388-532-730 (1)(f)(i)). The specific elements of IFS are negotiated with each research site.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-740, filed 10/8/02, effective 11/8/02.]

**WAC 388-532-750 TAKE CHARGE—Noncovered services.** The medical assistance administration (MAA) does not cover certain services under the TAKE CHARGE demonstration and research program. These services include, but are not limited to, the following:

(1) Hospital inpatient services of any kind (see WAC 388-532-780(8) for related information);

(2) Pregnancy services, with the exception of an initial pregnancy test performed by a TAKE CHARGE provider to rule out an existing pregnancy. Excluded pregnancy services include:

(a) Services that are ancillary to an existing pregnancy; or

(b) Abortions, services related to pregnancy termination, or services required due to complications from pregnancy termination.

[Title 388 WAC—p. 862]

(3) Reproductive health services not performed in relation to a principal purpose diagnosis of family planning, such as:

(a) Infertility diagnosis, treatments, or drugs;

(b) Hysterectomies;

(c) Treatment for menopause; or

(d) Cancer screening or treatment, other than those services that are related to a contraceptive method or other service with a principal purpose diagnosis of family planning.

(4) Testing or treatment for sexually transmitted diseases/infections (STD-I), AIDS, or HIV unless the testing and/or treatment is:

(a) Done in conjunction with a principal purpose diagnosis of family planning; and

(b) Required as an essential component of the family planning services being delivered to the client.

(5) Genetic counseling; and

(6) Any service not specifically listed in MAA's TAKE CHARGE program billing instructions unless MAA's specific advance approval is obtained in writing.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-750, filed 10/8/02, effective 11/8/02.]

**WAC 388-532-760 TAKE CHARGE—Documentation requirements.** In addition to the documentation requirements in WAC 388-502-0020, the medical assistance administration (MAA) requires a TAKE CHARGE provider to keep the following records:

(1) TAKE CHARGE pre-application worksheet form(s) and application(s);

(2) The reason for the visit (the principal reason for the visit must be for family planning to be covered under TAKE CHARGE);

(3) Contraceptive methods discussed with the client;

(4) Notes on any discussions of emergency contraception and needed prescription(s);

(5) The client's plan for the contraceptive method to be used, or the reason for no client plan;

(6) Documentation of the education, counseling and risk reduction (ECRR) service, including all elements in WAC 388-532-740 (1)(c);

(7) Copies of referrals to or from other providers as necessary;

(8) An MAA approved form signed by the client authorizing release of information for referral purposes, as necessary; and

(9) Copies of the informed consent for sterilization form (see WAC 388-531-1550) signed by the client, as necessary.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-760, filed 10/8/02, effective 11/8/02.]

**WAC 388-532-780 TAKE CHARGE—Payment limitations.** (1) The medical assistance administration (MAA) limits reimbursement under the TAKE CHARGE program to those services that are the result of client visits having a principal purpose diagnosis of family planning. The diagnosis must be made by a qualified licensed medical practitioner.

(2003 Ed.)

(2) Except as noted in subsection (3) of this section, MAA reimburses providers for covered TAKE CHARGE services according to the same fee schedules used under MAA's primary programs (e.g., resource based relative value system (RBRVS), pharmacies, laboratories).

(3) For those TAKE CHARGE services not listed in MAA's primary fee schedules described in subsection (2) of this section, MAA provides a TAKE CHARGE fee schedule.

(4) MAA limits reimbursement for TAKE CHARGE intensive follow-up services (IFS) to those randomly selected research sites described in WAC 388-532-740(3). See WAC 388-532-730 (1)(f)(i) for related information.

(5) Federally qualified health centers (FQHCs), rural health centers (RHCs), and Indian health providers who choose to become TAKE CHARGE providers must bill MAA for TAKE CHARGE services without regard to their special rates and fee schedules. MAA does not reimburse FQHCs, RHCs or Indian health providers under the encounter rate structure for TAKE CHARGE services.

(6) MAA requires TAKE CHARGE providers to meet the billing requirements of WAC 388-502-0150 (billing time limits). In addition, all final billings and billing adjustments related to the TAKE CHARGE demonstration and research program must be completed no later than June 30, 2008, or no later than two years after the demonstration and research program terminates, whichever occurs first. MAA will not accept any new billings or any billing adjustments that increase expenditures for the TAKE CHARGE demonstration and research program after the cut-off date in this subsection.

(7) Providers are responsible to identify and refund to MAA any erroneous, excessive, or inappropriate payments. The time limits in subsection (6) of this section do not apply to overpayments owed to MAA.

(8) MAA does not cover inpatient services under the TAKE CHARGE program. However, inpatient charges may be incurred as a result of complications arising directly from a covered TAKE CHARGE service. Providers of TAKE CHARGE related inpatient services that are not otherwise covered by third parties or other medical assistance programs must submit to MAA a complete report of the circumstances and conditions that caused the need for inpatient services. From the complete report, MAA makes a determination of the extenuating circumstances and the potential payment sources (e.g., the TAKE CHARGE provider, the ancillary service provider(s) and/or MAA).

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-780, filed 10/8/02, effective 11/8/02.]

**WAC 388-532-790 TAKE CHARGE—Good cause for coverage despite third party availability.** (1) The medical assistance administration (MAA) requires applicants for TAKE CHARGE who have comprehensive third party family planning coverage but who choose not to use that third party coverage to demonstrate to MAA good cause for MAA not to consider that third party coverage in determining eligibility for TAKE CHARGE.

(2) Applicants may apply for a good cause exclusion of available and comprehensive third party coverage by demon-

strating that the use of the third party coverage would violate the applicant's privacy. Privacy is violated if:

(a) The third party routinely or randomly sends verification of services to the third party subscriber and that subscriber is other than the applicant;

(b) The third party requires the applicant to use a primary care provider who is likely to report the applicant's request for family planning services to another party.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12), 02-21-021, § 388-532-790, filed 10/8/02, effective 11/8/02.]

**Chapter 388-533 WAC  
MATERNITY-RELATED SERVICES**

**WAC**

388-533-0300	Enhanced benefits for pregnant women.
388-533-0350	Maternity case management.
388-533-0400	Maternity care and newborn delivery.
388-533-0500	Planned home births—Pilot project.
388-533-0600	Births in birthing centers.
388-533-1000	First Steps childcare program.

**WAC 388-533-0300 Enhanced benefits for pregnant women.** The medical assistance administration (MAA) provides enhanced services to eligible women during and after their pregnancy.

(1) Refer to WAC 388-462-0015 for client eligibility requirements.

(2) MAA requires providers to have specific MAA approval prior to becoming an approved maternity support services (MSS) provider. MSS services must be provided by professionals from all of the following fields:

- (a) Community health nursing;
- (b) Nutrition; and
- (c) Social work.

(3) MAA allows paraprofessional community health workers to provide MSS services to eligible clients when both of the following are met:

(a) The services are provided under the supervision of one of the qualified professionals described in subsection (2) of this section; and

(b) The services provided are limited to basic health education.

(4) A client may choose to receive MSS services from any MAA-approved MSS provider.

(5) In addition to the client's standard scope of care, MAA covers the following enhanced benefits (MSS) for eligible women during and after their pregnancy:

(a) One childbirth education course per pregnancy (see subsection (9) in this section);

(b) Assessment, counseling, education, and interventions by those qualified professionals described in subsections (2) and (3) of this section; and

(c) Child care for the client's children (see subsection (7) of this section).

(6) MSS providers refer a client who may need chemical dependency assessment to a provider who is contracted with the division of alcohol and substance abuse (DASA)(see chapter 440-22 WAC). Enhanced benefits for eligible pregnant women through DASA include:

(a) Assessment for alcohol/drug use;

(b) Parenting education; and

(c) Treatment for alcohol/drug use.

(7) MAA requires the MSS provider to do the following for child care under this section:

(a) Screen for the eligible woman's need for child care;

(b) Discuss and encourage a safe and healthy child care plan; and

(c) Authorize the child care. The MSS provider may authorize child care for any of the following reasons:

(i) Health care appointments for the client;

(ii) The maternity services medical provider ordered bed rest for the client; or

(iii) Other circumstances that the MSS provider considers necessary and are specifically approved by MAA.

(8) MAA covers up to ten MSS visits. If it is determined that a client is at high-risk for a poor birth outcome (see the maternity case management program), MAA may cover up to twenty visits. The MSS provider must maintain documentation of the high-risk circumstances in the client's file.

(9) MAA allows a provider to bill only once per client per pregnancy for childbirth education. The provider must document that the client attended at least one childbirth education session in order for MAA to reimburse for the service.

(10) MAA publishes MSS program billing instructions that contain specific process requirements for the MSS program.

[Statutory Authority: RCW 74.08.090, 74.09.770, and 74.09.800. 00-14-068, § 388-533-0300, filed 7/5/00, effective 8/5/00.]

**WAC 388-533-0350 Maternity case management.** (1)

The medical assistance administration's (MAA) maternity case management (MCM) services are designed to assist pregnant or parenting client(s) obtain needed medical, social, educational, and other services.

(2) To receive MCM services the client must be eligible for MAA's pregnancy and birth coverage under WAC 388-462-015. In addition, the client must:

(a) Be pregnant and at high risk for a poor birth outcome as documented by a completed MCM intake (see MAA's MCM billing instructions); or

(b) Have experienced a poor birth outcome and have the MCM intake completed as described in subsection (3)(b) or (c) of this section.

(3) The MCM intake that initiates MCM services must be completed:

(a) During the eligible client's pregnancy;

(b) By the day of discharge from the hospital of the eligible birth mother; or

(c) By the day of discharge from the hospital of the eligible newborn child.

(4) MAA considers a client to be at high risk for a poor birth outcome if the client meets any of the following conditions. The client:

(a) Is age seventeen years or younger;

(b) Uses alcohol or other drug(s);

(c) Is in an environment where alcohol or drugs pose a risk; or

(d) Demonstrates an inability to obtain needed resources or services and is experiencing any three of the following:

(i) Has an inadequate physical or emotional support system or has an uninvolved domestic partner;

(ii) Has two or more children at home, ages four and/or younger;

(iii) Has an eighth grade or less education;

(iv) Has a physical disability;

(v) Has medical factors that MAA recognizes as related to poor pregnancy or birth outcomes (e.g., diabetes; see MAA's specific program billing instructions);

(vi) Has refugee status;

(vii) Is mentally impaired (e.g., mental depression is interfering with daily functioning);

(viii) Is homeless;

(ix) Is in a household that has current or recent incidents of violence (i.e., physical or sexual abuse);

(x) Is limited English proficient;

(xi) Is eighteen or nineteen years of age; or

(xii) Entered into prenatal care after twenty-eight weeks gestation.

(5) MAA covers MCM services provided to the eligible woman for up to sixty days postpartum, and provided to the eligible infant until age one.

(6) MAA covers MCM services provided to high-risk clients in addition to the services described in WAC 388-533-0300, Enhanced benefits for pregnant women. A client may receive services under WAC 388-533-0300 and services under this section at the same time or at different times.

(7) MAA reimburses only those providers who have been specifically approved by and contracted with MAA to furnish MCM services. For approval, providers must contact:

The Medical Assistance Administration

Division of Program Support, Family Services Section

POB 45530, Olympia, Washington 98504-5530.

(8) MCM providers must document the qualifying high-risk factors in the client's MCM case file. There must be an active MCM service plan demonstrating client need for MCM services, and the provider must periodically review and update the plan. MCM providers must not bill MAA for MCM services once the client is able to obtain needed services or systems without MCM assistance.

(9) MAA's reimbursement for MCM services may vary, depending on the client's specific risk factors and need(s).

(10) MAA publishes MCM program billing instructions that contain specific process requirements for the MCM program.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-533-0350, filed 11/16/00, effective 12/17/00.]

**WAC 388-533-0400 Maternity care and newborn delivery.** (1) The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter.

Defined words and phrases are bolded the first time they are used in the text.

(a) **"Birthing center"** means a specialized facility licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC.

(b) **"Bundled services"** means those services that are integral to a major procedure that may be bundled with the major procedure for the purposes of reimbursement. Under

this chapter, certain bundled services must be billed separately (unbundled) when the services are provided by different providers.

(c) "**Facility fee**" means that portion of MAA's reimbursement that covers the hospital or birthing center charges. This does not include MAA's reimbursement for the professional fee defined below.

(d) "**Global fee**" means the fee MAA pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services and postpartum care.

(e) "**High-risk**" pregnancy means any pregnancy that poses a significant risk of a poor birth outcome.

(f) "**Professional fee**" means that portion of MAA's reimbursement that covers the services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. (See WAC 388-531-1850 for reimbursement methodology).

(2) MAA covers full scope maternity care and newborn delivery services to its clients who qualify for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-462-0015 for client eligibility). See subsection (21) of this section for client eligibility limitations for smoking cessation counseling provided as part of antepartum care services.

(3) MAA does not provide full scope maternity care and delivery services to its clients who qualify for medically indigent (MI) scope of care (see WAC 388-462-0015 for client eligibility). Clients who qualify for MI scope of care have hospital delivery coverage only.

(4) MAA does not provide maternity care and delivery services to its clients who are eligible for:

(a) Family planning only (a pregnant client under this program should be referred to the local community services office for eligibility review); or

(b) Any other program not listed in this section.

(5) MAA requires providers of maternity care and newborn delivery services to meet all of the following. Providers must:

(a) Be currently licensed by the state of Washington's department of health (DOH) and/or department of licensing;

(b) Have signed core provider agreements with MAA;

(c) Be practicing within the scope of their licensure; and

(d) Have valid certifications from the appropriate federal or state agency, if such is required to provide these services (e.g., federally qualified health centers (FQHCs), laboratories certified through the Clinical Laboratory Improvement Amendment (CLIA), etc.).

(6) MAA covers total obstetrical care services (reimbursed under a **global fee**). Total obstetrical care includes all of the following:

(a) Routine antepartum care that begins in any trimester of a pregnancy;

(b) Delivery (intrapartum care/birth) services; and

(c) Postpartum care. This includes family planning counseling.

(7) When an eligible client receives all the services listed in subsection (6) of this section from one provider, MAA reimburses that provider in one of the following ways:

(a) Through a global obstetrical fee; or

(b) Through separate fees in any combination:

(i) First trimester antepartum care;

(ii) Second trimester antepartum care;

(iii) Third trimester antepartum care;

(iv) Delivery services (intrapartum care); and

(v) Postpartum care.

(8) When an eligible client receives services from more than one provider, MAA reimburses each provider for the services furnished. The separate services that MAA reimburses appear in subsection (7)(b) of this section.

(9) MAA reimburses for antepartum care services in one of the following two ways:

(a) Under a global fee (for total obstetrical care); or

(b) Under separate trimester care fees.

(10) MAA's fees for antepartum care include all of the following:

(a) An initial and any subsequent patient history;

(b) All physical examinations;

(c) Recording and tracking the client's weight and blood pressure;

(d) Recording fetal heart tones;

(e) Routine chemical urinalysis (including all urine dipstick tests); and

(f) Maternity counseling.

(11) MAA covers certain antepartum services in addition to the **bundled services** listed in subsection (10) of this section. MAA reimburses separately for any the following:

(a) A prenatal assessment fee for a pregnant client (limited to one prenatal assessment fee per pregnancy per provider);

(b) An enhanced prenatal management fee (a monthly fee for medically necessary increased prenatal monitoring). MAA provides a list of diagnoses and/or conditions that MAA identifies as justifying more frequent monitoring visits. MAA reimburses for either (b) or (c) of this subsection, but not both;

(c) A prenatal management fee for "**high-risk**" maternity clients. This monthly fee is payable to either a physician or a certified nurse midwife. MAA reimburses for either (b) or (c) of this subsection, but not both;

(d) Necessary prenatal laboratory tests except routine chemical urinalysis, including all urine dipstick tests, as described in subsection (10)(e) of this section; and/or

(e) Treatment of medical problems that are not related to the pregnancy. MAA pays these fees to physicians or advanced registered nurse practitioners.

(12) MAA covers high-risk pregnancies. MAA considers a pregnant client to have a high-risk pregnancy when the client:

(a) Has any high-risk medical condition (whether or not it is related to the pregnancy); or

(b) Has a diagnosis of multiple births.

(13) MAA covers delivery services for clients with high-risk pregnancies, described in subsection (12) of this section, when the delivery services are provided in a hospital.

(14) MAA covers the **facility fee** for delivery services in the following settings:

(a) Inpatient hospital; or

(b) Birthing centers.

(15) MAA covers the **professional fee** for delivery services in the following settings:

(a) Hospitals, to a provider who meets the criteria in subsection (5) of this section and who has privileges in the hospital;

(b) Planned home birth settings for providers who are participating in MAA's home birth pilot project; or

(c) **Birthing centers**, as described in WAC 388-533-0600.

(16) MAA covers hospital delivery services for an eligible client as defined in subsections (2), (3), and (4)(b) of this section. MAA's bundled reimbursement for the professional fee for hospital delivery services include:

(a) The admissions history and physical examination;

(b) The management of uncomplicated labor (intrapartum care);

(c) The vaginal delivery of the newborn (with or without episiotomy or forceps); and

(d) Cesarean delivery of the newborn.

(17) MAA pays only a labor management fee to a provider who begins intrapartum care and unanticipated medical complications prevent that provider from following through with the birthing services.

(18) In addition to the MAA reimbursement for professional services in subsection (16) of this section, MAA may reimburse separately for services provided by any of the following professional staff:

(a) A stand-by physician in cases of high risk delivery and/or newborn resuscitation;

(b) A physician assistant when delivery is by cesarean section;

(c) A registered nurse - "first assist" when delivery is by cesarean section;

(d) A physician, advanced registered nurse practitioner, or licensed midwife for newborn examination as the delivery setting allows; and/or

(e) An obstetrician/gynecologist specialist for external cephalic version and consultation.

(19) In addition to the professional delivery services fee in subsection (16) or the global/total fees (i.e., those that include the hospital delivery services) in subsections (6) and (7) of this section, MAA allows additional fees for any of the following:

(a) High-risk vaginal delivery;

(b) Multiple vaginal births. MAA's typical reimbursement covers delivery of the first child. For each subsequent child, MAA reimburses at fifty percent of the provider's usual and customary charge, up to MAA's maximum allowable fee; or

(c) High-risk cesarean section delivery.

(20) MAA does not reimburse separately for any of the following:

(a) More than one child delivered by cesarean section during a surgery. MAA's cesarean section surgery fee covers one or multiple surgical births;

(b) Post-operative care for cesarean section births. This is included in the surgical fee. Post-operative care is not the same as or part of postpartum care.

(21) In addition to the services listed in subsection (11) of this section, MAA covers counseling for tobacco dependency for eligible pregnant women through two months post-

pregnancy. This service is commonly referred to as smoking cessation education or counseling.

(a) MAA covers smoking cessation counseling for only those fee-for-service clients who are eligible for categorically needy (CN) scope of care. See (f) of this subsection for limitations on prescribing pharmacotherapy for eligible CN clients. Clients enrolled in managed care may participate in a smoking cessation program through their plan.

(b) MAA pays a fee to certain providers who include smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination). MAA reimburses only the following providers for smoking cessation counseling:

(i) Physicians;

(ii) Physician assistants (PA) working under the guidance and billing under the provider number of a physician;

(iii) Advanced registered nurse practitioners (ARNP), including certified nurse midwives (CNM); and

(iv) Licensed midwives (LM).

(c) MAA covers one smoking cessation counseling session per client, per day, up to ten sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information in (e) of this subsection.

(d) MAA covers two levels of counseling. Counseling levels are:

(i) Basic counseling (fifteen minutes), which includes (e)(i), (ii), and (iii) of this subsection; and

(ii) Intensive counseling (thirty minutes), which includes the entirety of (e) of this subsection.

(e) Smoking cessation counseling consists of providing information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps (refer to MAA's physician-related services (RBRVS) and births and birthing centers billing instructions for specific counseling suggestions and billing requirements):

(i) Asking the client about her smoking status;

(ii) Advising the client to stop smoking;

(iii) Assessing the client's willingness to set a quit date;

(iv) Assisting the client to stop smoking, which includes developing a written quit plan with a quit date. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see (f) of this subsection); and

(v) Arranging to track the progress of the client's attempt to stop smoking.

(f) A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment is appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:

(i) MAA covers Zyban™ only;

(ii) The product must meet the rebate requirements described in WAC 388-530-1125;

(iii) The product must be prescribed by a physician, ARNP, or physician assistant;

(iv) The client for whom the product is prescribed must be eighteen years of age or older;



(v) The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and

(vi) The prescribing provider must include both of the following on the client's prescription:

(A) The client's estimated or actual delivery date; and

(B) Indication that the client is participating in smoking cessation counseling.

(g) MAA's reimbursement for smoking cessation counseling is subject to post-pay review. See WAC 388-502-0230, Provider review and appeal, and WAC 388-502-0240, Audits and the audit appeal process for contractors/providers, for information regarding review and appeal processes for providers.

[Statutory Authority: RCW 74.08.090, 74.09.760, 74.09.770. 02-07-043, § 388-533-0400, filed 3/13/02, effective 4/13/02. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, § 388-533-0400, filed 11/13/00, effective 12/14/00.]

**WAC 388-533-0500 Planned home births—Pilot project.** (1) MAA covers planned home births only as part of a pilot project.

(2) Prior to participating in the planned home birth pilot project providers must be approved by MAA.

(3) To meet minimum requirements for participation, a provider must have all of the following:

(a) A core provider agreement with MAA;

(b) A current license, in good standing, as a:

(i) Physician under chapter 18.57 or 18.71 RCW;

(ii) Nurse midwife under chapter 18.79 RCW; or

(iii) Midwife under chapter 18.50 RCW.

(c) A diploma of graduation from an accredited midwifery, nurse midwifery or medical school, or copy of current national certified professional midwife (CPM) certification, and additional documentation, if necessary, to show a minimum attendance of:

(i) Five births in a home setting as an observer; and

(ii) Ten births in a home setting as the primary attendant or primary under the supervision of a practitioner who meets or exceeds the requirements in this subsection. Three or more of these births must have been with a client for whom the applicant provided care during at least four prenatal visits, attended all stages (one-four) of labor and birth, performed a newborn exam, and conducted one postpartum home visit within seventy-two hours after birth.

(d) Current CPR certification for:

(i) Adult CPR; and

(ii) Neonatal resuscitation, including the use of positive pressure ventilation and chest compressions.

(e) Liability insurance coverage and documentation of liability insurance claims history;

(f) A written plan for consultation, emergency transfer, and transport of both the mother and newborn. The plan must:

(i) For the mother, specify a physician(s) who has complete obstetrical privileges, including cesarean sections, and who has admitting privileges to the closest appropriate hospital;

(ii) For the newborn, specify a physician(s) who has an active pediatric practice and admitting privileges to the closest appropriate hospital;

(iii) Identify the hospital(s) to which the mother and newborn will be transferred in the event of a maternal/neonatal emergency; and

(iv) Identify emergency transport providers that will be used to transport the mother and/or newborn to the hospital, including private ambulance, municipal aid car, and helicopter service.

(g) Arrangements for twenty-four hour per day coverage by an MAA-approved home birth provider;

(h) Documentation of contact with local area emergency medical services to determine the level of response capability in the area, and to facilitate communication; and

(i) An informed consent form to be signed by each client to indicate agreement to participate in a planned home birth.

(4) A provider may apply to participate in the project by submitting to MAA:

(a) A letter of interest;

(b) Verification of meeting the minimum requirements in subsection (3); and

(c) A signed statement of intent to comply with project requirements.

(5) The participating provider must do all of the following:

(a) Verify each client is eligible for the categorically needy program or medically needy program scope of care;

(b) Assure each client passes the risk screening criteria published in MAA's planned home birth pilot project billing instructions, and follow indications for consultation and referral;

(c) Plan for a home birth only if the client is expected to deliver vaginally and without complication;

(d) Prior to planning a home birth, obtain a signed consent form from the client agreeing to participate in a planned home birth, and keep the signed form in the client's file;

(e) Provide medically necessary equipment, supplies, and medications for each client;

(f) Make appropriate referral of the newborn for screening and medically necessary follow-up care;

(g) Inform parents of the benefits of a newborn blood screening test, and offer to send the newborn's blood sample to the department of health for testing;

(h) Refer the client or newborn to a physician or hospital when medically appropriate;

(i) Submit to the MAA-designated quality assurance/quality improvement (QA/QI) organization a completed planned home birth outcome report (on an MAA approved form) for each client for program evaluation. MAA requires the completed report before payment is made, even if the client is transferred to another provider or delivery setting and the provider is billing for only a portion of the maternity care.

(j) Notify MAA immediately of changes in licensure and/or provider status;

(k) Renew participation status every two years by submitting documentation to verify continued compliance with the minimum requirements in subsection (3); and

(l) Comply with the requirements in this chapter.

(6) MAA does not cover planned home births for women identified with any of the following conditions:

- (a) Previous cesarean section;
- (b) Current alcohol and/or drug addiction or abuse;
- (c) Significant hematological disorders/coagulopathies;
- (d) History of deep venous thromboses or pulmonary embolism;
- (e) Cardiovascular disease causing functional impairment;
- (f) Chronic hypertension;
- (g) Significant endocrine disorders including pre-existing diabetes (type I or type II);
- (h) Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests;
- (i) Isoimmunization, including evidence of Rh sensitization/platelet sensitization;
- (j) Neurologic disorders or active seizure disorders;
- (k) Pulmonary disease or active tuberculosis or severe asthma uncontrolled by medication;
- (l) Renal disease;
- (m) Collagen-vascular diseases;
- (n) Current severe psychiatric illness;
- (o) Cancer affecting site of delivery;
- (p) Known multiple gestation;
- (q) Known breech presentation in labor with delivery not imminent; or
- (r) Other significant deviations from normal as assessed by the home birth provider.

(7) The planned home birth pilot project will run for five years from the effective date of this rule, however:

- (a) MAA may terminate the project at an earlier date with written notice to participating providers if data reports indicate poor outcomes;
- (b) A provider may terminate participation in the pilot project at any time with written notice to MAA. The provider must offer to make a good faith effort to transfer ongoing cases to other participating providers.
- (c) MAA may terminate a provider's participation immediately if:
  - (i) The provider fails to comply with project requirements;
  - (ii) The provider's enrollment as a MAA provider is suspended or terminated (see WAC 388-502-0030); or
  - (iii) The MAA medical director determines the quality of care provided endangers the health and safety of one or more clients.

[Statutory Authority: RCW 74.08.090, 00-24-054, § 388-533-0500, filed 11/30/00, effective 12/31/00.]

**WAC 388-533-0600 Births in birthing centers.** (1) MAA covers births in birthing centers for its clients when the client and the maternity care provider choose an MAA-approved birthing center and the client:

- (a) Is eligible for CN or MN scope of care (see WAC 388-533-400(2));
- (b) Has a MAA-approved medical provider who has accepted responsibility for the birthing center birth as provided in this section;

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(c) Is expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and

(d) Passes MAA's risk screening criteria. MAA provides these risk-screening criteria to qualified medical services providers.

(2) Each participating birthing center must:

- (a) Be licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC;
- (b) Have a valid core provider agreement with MAA;
- (c) Be specifically approved by MAA to provide birthing center services; and
- (d) Maintain standards of care required by DOH for licensure.

(3) MAA suspends or terminates the core provider agreement of a birthing center if it fails to maintain DOH standards cited in subsection (2) of this section.

(4) MAA approves only the following provider types to provide MAA covered births in birthing centers:

- (a) Physicians licensed under chapters 18.57 or 18.71 RCW;
- (b) Nurse midwives licensed under chapter 18.79 RCW; and
- (c) Midwives licensed under chapter 18.50 RCW.

(5) Each provider using a birthing center must:

- (a) Obtain from the client a signed consent form in advance of the birthing center birth;
- (b) Follow MAA's risk screening criteria and consult with and/or refer the client or newborn to a physician or hospital when medically appropriate;
- (c) Have current, written, and appropriate plans for consultation, emergency transfer and transport of a client and/or newborn to a hospital;
- (d) Make appropriate referral of the newborn for screening and medically necessary follow-up care; and
- (e) Inform parents of the benefits of a newborn screening test and offer to send the newborn's blood sample to the department of health for testing.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800, 00-23-052, § 388-533-0600, filed 11/13/00, effective 12/14/00.]

**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

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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 388-534 WAC

#### EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

##### WAC

388-534-0100	EPSDT.
388-534-0200	Enhanced payments for EPSDT screens for children receiving foster care placement services from the department of social and health services (DSHS).

**WAC 388-534-0100 EPSDT.** (1) Persons who are eligible for Medicaid are eligible for coverage through the early and periodic screening, diagnosis, and treatment (EPSDT) program up through the day before their twenty-first birthday.

(2) Access and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B which were in effect as of January 1, 1998.

(a) The standard for coverage for EPSDT is that the services, treatment or other measures are:

- (i) Medically necessary;
- (ii) Safe and effective; and
- (iii) Not experimental.

(b) EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program. Examples of service limits which do not apply to the EPSDT program are the specific numerical limits in WAC 388-545-300, 388-545-500, and 388-545-700.

(c) Services not otherwise covered under the Medicaid program are available to children under EPSDT. The services, treatments and other measures which are available include but are not limited to:

- (i) Nutritional counseling;
- (ii) Chiropractic care;
- (iii) Orthodontics; and
- (iv) Occupational therapy (not otherwise covered under the MN program).

(d) Prior authorization and referral requirements are imposed on medical service providers under EPSDT. Such requirements are designed as tools for determining that a service, treatment or other measure meets the standards in subsection (2)(a) of this section.

(3) Transportation requirements of 42 CFR 441, Subpart B are met through a contract with transportation brokers throughout the state.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090; 42 C.F.R., Part 441, Subpart B, 02-07-016, § 388-534-0100, filed 3/8/02, effective 4/8/02. Statutory Authority: RCW 74.08.090, 01-02-076, § 388-534-0100, filed 12/29/00, effective 1/29/01; 00-11-183, recodified as § 388-534-0100, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-86-027, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090, 90-12-061 (Order 3019), § 388-86-027, filed 5/31/90, effective 7/1/90; 82-01-001 (Order 1725), § 388-86-027, filed 12/3/81; 81-10-015 (Order 1647), § 388-86-027, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-027, filed 10/9/80; 79-12-047 (Order 1457), § 388-86-027, filed 11/26/79; Order 1112, § 388-86-027, filed 4/15/76; Order 738, § 388-86-027, filed 11/22/72.]

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**WAC 388-534-0200 Enhanced payments for EPSDT screens for children receiving foster care placement services from the department of social and health services (DSHS).** The medical assistance administration (MAA) reimburses providers an enhanced flat fee for EPSDT screens provided to children receiving certain foster care placement services from the department of social and health services (DSHS). See MAA's EPSDT billing instructions for specific billing code requirements and the fee.

(1) For the purposes of this section, foster care is defined as twenty-four hour per day, temporary, substitute care for a child:

(a) Placed away from the child's parents or guardians in licensed, paid, out-of-home care; and

(b) For whom the department or a licensed or certified child placing agency has placement and care responsibility.

(2) MAA pays an enhanced flat fee to the providers listed in subsection (3) of this section for EPSDT screens provided to only those children receiving foster care placement services from DSHS.

(3) The following providers are eligible to perform EPSDT screens and bill MAA the enhanced rate for children receiving foster care placement services from DSHS:

- (a) EPSDT clinics;
- (b) Physicians;
- (c) Advanced registered nurse practitioners (ARNPs);
- (d) Physician assistants (PAs) working under the guidance and MAA provider number of a physician;
- (e) Nurses specially trained through the department of health (DOH) to perform EPSDT screens; and
- (f) Registered nurses working under the guidance and MAA provider number of a physician or ARNP.

(4) In order to be paid an enhanced fee, services furnished by the providers listed in subsection (3) of this section must meet the federal requirements for EPSDT screens at 42 CFR Part 441 Subpart B, which were in effect as of December 1, 2001.

(5) The provider must retain documentation of the EPSDT screens in the client's medical file. The provider must use the DSHS Well Child Exam forms or provide equivalent information. DSHS Well Child Exam forms are available at no charge by sending a request in writing or by fax to:

DSHS Warehouse  
PO Box 45816  
Olympia, WA. 98504-5816  
Fax: 360-664-0597

(6) MAA conducts evaluations of client files and payments made under this program. MAA may recover the enhanced payment amount when:

(a) The client was not receiving foster care placement services from DSHS as defined in subsection (1) of this section when the EPSDT screen was provided; or

(b) Documentation was not in the client's medical file (see subsection (5) of this section).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 42 C.F.R., Part 441, Subpart B, 02-07-016, § 388-534-0200, filed 3/8/02, effective 4/8/02.]

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**Chapter 388-535 WAC**  
**DENTAL-RELATED SERVICES**

## WAC

## GENERAL

- 388-535-1050 Dental-related definitions.
- COVERAGE**
- 388-535-1060 Clients who are eligible for dental-related services.  
388-535-1070 Dental-related services provider information.  
388-535-1080 Covered dental-related services.  
388-535-1100 Dental-related services not covered.  
388-535-1120 Coverage limits for dental-related services provided under state-only funded programs.  
388-535-1200 Dental services requiring prior authorization.  
388-535-1220 Obtaining prior authorization for dental services.  
388-535-1230 Crowns.  
388-535-1240 Dentures, partials, and overdentures.
- ABCD DENTAL PROGRAM**
- 388-535-1245 Access to baby and child dentistry (ABCD) program.
- PAYMENT**
- 388-535-1350 Payment methodology for dental-related services.  
388-535-1400 Payment for dental-related services.  
388-535-1450 Payment for denture laboratory services.  
388-535-1500 Payment for dental-related hospital services.  
388-535-1550 Payment for dental care provided out-of-state.

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

- 388-535-1000 Dental-related services—Scope of coverage. [Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1000, filed 12/6/95, effective 1/6/96.] Repealed by 99-07-023, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225.
- 388-535-1010 Dental-related program introduction. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1010, filed 3/10/99, effective 4/10/99.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225.
- 388-535-1150 Becoming a DSHS dental provider. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1150, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1150, filed 12/6/95, effective 1/6/96.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225.
- 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.
- 388-535-1260 Dental-related limits of state-only funded programs. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1260, filed 3/10/99, effective 4/10/99.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225.
- 388-535-1300 Access to baby and child dentistry (ABCD) program. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1300, filed

3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1300, filed 12/6/95, effective 1/6/96.] Repealed by 02-11-136, filed 5/21/02, effective 6/21/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and .225. Later promulgation, see WAC 388-535-1245.

## GENERAL

**WAC 388-535-1050 Dental-related definitions.** The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter. The medical assistance administration (MAA) also uses dental definitions found in the American Dental Association's Current Dental Terminology (CDT-3) and the American Medical Association's Physician's Current Procedural Terminology 2002 (CPT™ 2002). Where there is any discrepancy between the CDT-2 or CPT 2002 and this section, this section prevails. (CPT™ is a trademark of the American Medical Association.)

"Access to baby and child dentistry (ABCD)" is a program to increase access to dental services in targeted areas for Medicaid eligible infants, toddlers, and preschoolers up through the age of five. See WAC 388-535-1300 for specific information.

"Adult" for the general purposes of the medical assistance administration's (MAA) dental program, means a client twenty-one years of age or older (MAA's payment structure changes at age nineteen, which affects specific program services provided to adults or children).

"Anterior" means teeth in the front of the mouth.

(1) "Lower anterior," teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven; and

(2) "Upper anterior," teeth six, seven, eight, nine, ten, and eleven.

"Asymptomatic" means having or producing no symptoms.

"Base metal" means dental alloy containing little or no precious metals.

"Behavior management" means managing the behavior of a client during treatment using the assistance of additional professional staff, and professionally accepted restraints or sedative agent, to protect the client from self-injury.

"By report" - a method of payment for a covered service, supply, or equipment which:

(1) Has no maximum allowable established by MAA,

(2) Is a variation on a standard practice, or

(3) Is rarely provided.

"Caries" means tooth decay through the enamel.

"Child" for the general purposes of the medical assistance administration's (MAA) dental program, means a client twenty years of age or younger. (MAA's payment structure changes at age nineteen, which affects specific program services provided to children or adults.)

"Comprehensive oral evaluation" means a thorough evaluation and recording of the hard and soft tissues in and around the mouth, including the evaluation and recording of



the client's dental and medical history and a general health assessment.

**"Coronal"** is the portion of a tooth that is covered by enamel, and is separated from the root or roots by a slightly constricted region, known as the cemento-enamel junction.

**"Crown (artificial)"** means a restoration covering or replacing the major part, or the whole of, the clinical crown of a tooth.

**"Current dental terminology (CDT), third edition (CDT-3),"** a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

**"Current procedural terminology 2002 (CPT 2002),"** means a description of medical procedures and is available from the American Medical Association of Chicago, Illinois.

**"Dental general anesthesia"** means the use of agents to induce loss of feeling or sensation, a controlled state of unconsciousness, in order to allow dental services to be rendered to the client.

**"Dentures"** are a set of artificial teeth, including overdentures. See WAC 388-535-1240 for specific information.

**"Endodontic"** means a root canal treatment and related follow-up.

**"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.

**"Fluoride varnish or gel"** means a substance containing dental fluoride, applied to teeth.

**"Limited oral evaluation"** means an evaluation limited to a specific oral health condition or problem.

**"Major bone grafts"** means a transplant of solid bone tissue(s)

**"Medically necessary"** see WAC 388-500-0005.

**"Minor bone grafts"** means a transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.

**"Noble metal"** means a dental alloy containing at least twenty-five percent but less than sixty percent pure gold.

**"Oral evaluation"** is a comprehensive oral health and developmental history; an assessment of physical and oral health development and nutritional status; and health education, including anticipatory guidance.

**"Oral health assessment or screening"** means a screening of the hard and soft tissues in the mouth.

**"Oral hygiene instruction"** means instruction for home oral hygiene care, such as tooth brushing techniques or flossing.

**"Oral health status"** refers to the client's risk or susceptibility to dental disease at the time an oral evaluation or assessment is done by a dental practitioner. This risk is designated as low, moderate or high based on the presence or absence of certain indicators.

**"Partials" or "partial dentures"** means a removable appliance replacing one or more missing teeth in one jaw, and receiving its support and retention from both the underlying

tissues and some or all of the remaining teeth. See WAC 388-535-1240 for specific information.

**"Posterior"** means teeth and tissue towards the back of the mouth. Specifically, only these permanent teeth: One, two, three, four, five, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two.

**"Reline"** means to resurface the tissue side of a denture with new base material in order to achieve a more accurate fit.

**"Root planing"** is a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased cementum or dentin from the teeth's root surfaces and pockets.

**"Scaling"** means the removal of calculus material from the exposed tooth surfaces and that part of the teeth covered by the marginal gingiva.

**"Sealant"** is a material applied to teeth to prevent dental caries.

**"Symptomatic"** means having symptoms (e.g., pain, swelling, and infection).

**"Therapeutic pulpotomy"** means the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

**"Usual and customary"** means the fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill MAA.

**"Wisdom teeth"** means teeth one, sixteen, seventeen, and thirty-two.

**"Xerostomia"** means a dryness of the mouth.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1050, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 01-02-076, § 388-535-1050, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1050, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1050, filed 12/6/95, effective 1/6/96.]

## COVERAGE

**WAC 388-535-1060 Clients who are eligible for dental-related services.** (1) Subject to the specific limitations described in WAC 388-535-1080, Covered services, clients who receive services under the following programs are eligible for the dental-related services described in this chapter:

- (a) Categorically needy program (CN or CNP);
- (b) Children's health insurance program (CNP-CHIP);
- (c) Qualified Medicare beneficiary (CNP-QMB);
- (d) Limited casualty program/medically needy program (LCP-MNP);
- (e) Medically needy program - qualified Medicare beneficiary (MNP-QMB);
- (f) Children's health (the state-funded only program) through September 30, 2002 only; and
- (g) Pregnant undocumented aliens.

(2) Clients who receive services under the following state-funded only programs are covered as described in WAC 388-535-1120:

(a) General assistance unemployable (GAU); and

(b) Alcohol and drug abuse treatment and support act (ADATSA).

(3) Clients who receive services under the medically indigent (MI) program are covered for only those medical conditions that are acute and emergent and treated in a hospital.

(4) Clients who are enrolled in a managed care plan are eligible for medical assistance administration (MAA)-covered dental services that are not covered by their plan, under fee-for-service.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1060, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1060, filed 3/10/99, effective 4/10/99.]

**WAC 388-535-1070 Dental-related services provider information.** (1) The following providers are eligible to enroll with the medical assistance administration (MAA) to furnish and bill for dental-related services to eligible clients:

(a) Persons currently licensed by the state of Washington to:

(i) Practice dentistry or specialties of dentistry;

(ii) Practice medicine and osteopathy for:

(A) Oral surgery procedures; or

(B) Providing fluoride varnish under EPSDT;

(iii) Practice as dental hygienists;

(iv) Provide denture services;

(v) Practice anesthesia; or

(vi) Provide conscious sedation, when certified by the department of health and when providing that service in dental offices for dental treatments.

(b) Facilities that are:

(i) Hospitals currently licensed by the department of health;

(ii) Federally-qualified health centers (FQHCs);

(iii) Medicare-certified ambulatory surgical centers (ASCs);

(iv) Medicare-certified rural health clinics (RHCs); or

(v) Community health centers.

(c) Participating local health jurisdictions; and

(d) Border area or out-of-state providers of dental-related services who are qualified in their states to provide these services.

(2) MAA pays licensed providers participating in the MAA dental program for only those services that are within their scope of practice.

(3) See WAC 388-502-0020 for provider documentation and record retention requirements. MAA may require additional documentation under specific sections in this chapter.

(4) See WAC 388-502-0100 and 388-502-0150 for provider billing and payment requirements.

(5) See WAC 388-502-0160 for regulations concerning charges billed to clients.

(6) See WAC 388-502-0230 for provider review and appeal.

(7) See WAC 388-502-0240 for provider audits and the audit appeal process.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1070, filed 6/14/02, effective 7/15/02.]

**WAC 388-535-1080 Covered dental-related services.**

(1) The medical assistance administration (MAA) pays for covered dental and dental-related services listed in this section only when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary; and

(c) Within accepted dental or medical practice standards and are:

(i) Consistent with a diagnosis of dental disease or condition; and

(ii) Reasonable in amount and duration of care, treatment, or service.

(2) MAA covers the following dental-related services:

(a) Medically necessary services for the identification of dental problems or the prevention of dental disease, subject to the limitations of this chapter;

(b) Oral health evaluations and assessments, which must be documented in the client's file according to WAC 388-502-0020, as follows:

(i) MAA allows a comprehensive oral evaluation once per provider as an initial examination, and it must include:

(A) An oral health and developmental history;

(B) An assessment of physical and oral health status; and

(C) Health education, including anticipatory guidance.

(ii) MAA allows periodic oral evaluations once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(iii) MAA allows limited oral evaluations only when the provider performing the limited oral evaluation is not providing pre-scheduled dental services for the client. The limited oral evaluation must be:

(A) To provide limited or emergent services for a specific dental problem; or

(B) To provide an evaluation for a referral.

(c) Radiographs (x-rays) for children and adults, as follows:

(i) Intraoral (complete series, including bitewings) - once in a three-year period;

(ii) Bitewings - total of four every twelve months;

(iii) Panoramic, for oral surgical purposes only, as follows:

(A) Not allowed with an intraoral complete series; and

(B) Once in a three-year period, except for preoperative or postoperative surgery cases. Preoperative x-rays must be provided within fourteen days prior to surgery, and postoperative x-rays must be provided within thirty days after surgery.

(d) Fluoride treatment (either gel or varnish, but not both) as follows (additional applications require prior authorization):

(i) For children through age eighteen, topical application of:

(A) Fluoride gel, once every six months; or

(B) Fluoride varnish, up to three times in a twelve-month period.

(ii) For adults age nineteen through sixty-four, topical application of fluoride gel or varnish for xerostomia only; this requires prior authorization. See subsection (3) of this section for clients of the division of developmental disabilities;

(iii) For adults age sixty-five and older, topical application of fluoride gel or varnish for only:

(A) Rampant root surface decay; or

(B) Xerostomia.

(e) Sealants for children only, once per tooth in a three-year period for:

(i) The occlusal surfaces of:

(A) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one only; and

(B) Primary teeth A, B, I, J, K, L, S, and T only.

(ii) The lingual pits of teeth seven and ten; and

(iii) Teeth with no decay.

(f) Prophylaxis treatment, which is allowed:

(i) Once every twelve months for adults age nineteen and older, including nursing facility clients;

(ii) Once every six months for children age eight through eighteen;

(iii) Only as a component of oral hygiene instruction for children through age seven; and

(iv) For clients of the division of developmental disabilities, see subsection (3) of this section.

(g) Space maintainers, for children through age eighteen only, as follows:

(i) Fixed (unilateral type), one per quadrant;

(ii) Fixed (bilateral type), one per arch; and

(iii) Recementation of space maintainer, once per quadrant or arch.

(h) Amalgam or composite restorations, as follows:

(i) Once in a two-year period; and

(ii) For the same surface of the same tooth.

(i) Crowns as described in WAC 388-535-1230, Crowns; (j) Restoration of teeth and maintenance of dental health, subject to limitations of WAC 388-535-1100 and as follows:

(i) Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a multisurface restoration, and are reimbursed as such; and

(ii) Proximal restorations that do not involve the incisal angle in the anterior tooth are considered to be a two-surface restoration, and are reimbursed as such;

(k) Endodontic (root canal) therapies for permanent teeth except for wisdom teeth;

(l) Therapeutic pulpotomies, once per tooth, on primary teeth only;

(m) Pulp vitality test, as follows:

(i) Once per day (not per tooth);

(ii) For diagnosis of emergency conditions only; and

(iii) Not allowed when performed on the same date as any other procedure, with the exception of an emergency examination or palliative treatment.

(n) Periodontal scaling and root planing as follows:

(i) For clients age nineteen and older only. See subsection (3) of this section for clients of the division of developmental disabilities;

(ii) Only when the client has radiographic (x-ray) evidence of periodontal disease. There must be supporting documentation, including complete periodontal charting and a definitive periodontal diagnosis;

(iii) Once per quadrant in a twenty-four month period; and

(iv) Not allowed when performed on the same date of service as adult prophylaxis, gingivectomy, or gingivoplasty.

(o) Subject to WAC 388-535-1240 and as follows, complete and partial dentures, and necessary modifications, repairs, rebasing, relining, and adjustments of dentures (includes partial payment in certain situations for laboratory and professional fees for dentures and partials as specified in WAC 388-535-1240(5)). MAA covers:

(i) One set of dentures per client in a ten-year period, with the exception of replacement dentures which may be allowed as specified in WAC 388-535-1240(4); and

(ii) Partial dentures as specified in WAC 388-535-1240(2), once every five years.

(p) Complex orthodontic treatment for severe handicapped dental needs as specified in chapter 388-535A WAC, Orthodontic services;

(q) Occlusal orthotic appliance for temporomandibular joint disorder (TMJ) or bruxism, one in a two-year period;

(r) Medically necessary oral surgery when coordinated with the client's managed care plan (if any);

(s) Dental services or treatment necessary for the relief of pain and infections, including removal of symptomatic wisdom teeth. MAA does not cover routine removal of asymptomatic wisdom teeth without justifiable medical indications;

(t) Behavior management for children through age eighteen only, whose documented behavior requires the assistance of more than one additional dental professional staff to protect the client from self-injury during treatment. See subsection (3) of this section for clients of the division of developmental disabilities.

(u) Nitrous oxide for children through age eighteen only, when medically necessary. See subsection (3) of this section for clients of the division of developmental disabilities.

(v) Professional visits, as follows:

(i) Bedside call at a nursing facility or residence, at the physician's request - one per day (see subsection (7) of this section).

(ii) Hospital call, including emergency care - one per day.

(w) Emergency palliative treatment, as follows:

(i) Allowed only when no other definitive treatment is performed on the same day; and

(ii) Documentation must include tooth designation and a brief description of the service.

(3) For clients of the division of developmental disabilities, MAA allows services as follows:

(a) Fluoride application, either varnish or gel, but not both - three times per calendar year;

(b) Periodontal scaling and root planing - once every six months;

(c) Prophylaxis - three times per calendar year;

(d) Nitrous oxide;

(e) Behavior management that requires the assistance of more than one additional dental professional staff and the use of advanced behavior techniques; and

(f) Panoramic radiographs, with documentation that behavior management is required.

(4) MAA covers medically necessary services provided in a hospital under the direction of a physician or dentist for:

(a) The care or treatment of teeth, jaws, or structures directly supporting the teeth if the procedure requires hospitalization; and

(b) Short stays when the procedure cannot be done in an office setting. See WAC 388-550-1100(6), Hospital coverage.

(5) MAA covers anesthesia for medically necessary services as follows:

(a) The anesthesia must be administered by:

(i) An oral surgeon;

(ii) An anesthesiologist;

(iii) A Certified Registered Nurse Anesthetist (CRNA); or

(iv) A general dentist who has a current conscious sedation permit from the department of health (DOH).

(b) MAA reimburses for anesthesia services per WAC 388-535-1350.

(6) For clients residing in nursing facilities or group homes:

(a) Dental services must be requested by the client or a referral for services made by the attending physician, the director of nursing or the nursing facility supervisor, or the client's legal guardian;

(b) Mass screening for dental services of clients residing in a facility is not permitted; and

(c) Nursing facilities must provide dental-related necessary services per WAC 388-97-012, Nursing facility care.

(7) A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. MAA evaluates and approves requests for LE for dental-related services when medically necessary, under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1080, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1080, filed 3/10/99, effective 4/10/99.]

**WAC 388-535-1100 Dental-related services not covered.** (1) The medical assistance administration (MAA) does not cover dental-related services described in subsection (2) of this section unless the services are:

(a) Required by a physician as a result of an EPSDT screen as provided under chapter 388-534 WAC;

(b) Included in an MAA waived program; or

(c) Part of one of the Medicare programs for qualified Medicare beneficiaries (QMB) except for QMB-only, which is not covered.

(2) MAA does not cover:

(a) Any service specifically excluded by statute;

(b) More costly services when less costly, equally effective services as determined by the department are available;

(c) Services, procedures, treatment, devices, drugs, or application of associated services which the department or the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA)) consider investigative or experimental on the date the services were provided;

(d) Routine fluoride treatments (gel or varnish) for adults, unless the clients are:

(i) Clients of the division of developmental disabilities;

(ii) Diagnosed with xerostomia, in which case the provider must request prior authorization; or

(iii) High-risk adults sixty-five and over. High-risk means the client has at least one of the following:

(A) Rampant root surface decay; or

(B) Xerostomia.

(e) Crowns, as follows:

(i) For wisdom and peg teeth;

(ii) Laboratory processed crowns for posterior teeth;

(iii) Temporary crowns, including stainless steel crowns placed as temporary crowns; and

(iv) Post and core for crowns.

(f) Root canal services for primary or wisdom teeth;

(g) Root planing for children, unless they are clients of the division of developmental disabilities;

(h) Bridges;

(i) Transitional or treatment dentures;

(j) Teeth implants, including follow up and maintenance;

(k) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness;

(l) Porcelain margin extensions (also known as crown lengthening), due to receding gums;

(m) Extraction of asymptomatic teeth;

(n) Minor bone grafts;

(o) Nonemergent oral surgery for adults performed in an inpatient setting, except for the following:

(i) For clients of the division of developmental disabilities, or for children eighteen years of age or younger whose surgeries cannot be performed in an office setting. This requires written prior authorization for the inpatient hospitalization; or

(ii) As provided in WAC 388-535-1080(4).

(p) Dental supplies such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners;

(q) Dentist's time writing prescriptions or calling in prescriptions or prescription refills to a pharmacy;

(r) Educational supplies;

(s) Missed or canceled appointments;

(t) Nonmedical equipment, supplies, personal or comfort items or services;

(u) Provider mileage or travel costs;

(v) Service charges or delinquent payment fees;

(w) Supplies used in conjunction with an office visit;

(x) Take-home drugs;

(y) Teeth whitening; or

(z) Restorations for anterior or posterior wear with no evidence of decay.

(3) MAA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1100, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1100, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1100, filed 12/6/95, effective 1/6/96.]

**WAC 388-535-1120 Coverage limits for dental-related services provided under state-only funded programs.** (1) Clients who receive services under the following state-funded only programs receive only the limited coverage described in this section:

(a) General assistance unemployable (GAU); and  
(b) Alcohol and drug abuse treatment and support act (ADATSA) (GAU-W).

(2) The medical assistance administration (MAA) covers the dental services described and limited in this chapter for clients eligible for GAU or GAU-W only when those services are provided as part of a medical treatment for:

(a) Apical abscess verified by clinical examination, and treated by:

- (i) Open and drain palliative treatment;
- (ii) Tooth extraction; or
- (iii) Root canal;

(b) Cysts or tumor therapies;

(c) Maxillofacial fracture;

(d) Radiation therapy for cancer of the mouth, only for a total dental extraction performed prior to and because of that radiation therapy;

(e) Sequestrectomies;

(f) Systemic or presystemic cancer, only for oral hygiene related to those conditions; or

(g) Tooth fractures (limited to extraction).

(3) MAA may require prior authorization for any dental treatment provided to a GAU or GAU-W client.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1120, filed 6/14/02, effective 7/15/02.]

**WAC 388-535-1200 Dental services requiring prior authorization.** The following services require prior authorization:

(1) Nonemergent inpatient hospital dental admissions as described under WAC 388-535-1100 (2)(o) and 388-550-1100(1);

(2) Crowns as described in WAC 388-535-1230;

(3) Dentures as described in WAC 388-535-1240;

(4) Routine fluoride treatment (gel or varnish) for adults age nineteen through sixty-four who are diagnosed with xerostomia; and

(5) Selected procedures identified by the medical assistance administration (MAA) and published in its current dental billing instructions, which are available from MAA in Olympia, Washington.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1200, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1200, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1200, filed 12/6/95, effective 1/6/96.]

(2003 Ed.)

**WAC 388-535-1220 Obtaining prior authorization for dental services.** When the medical assistance administration (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 covered services at the time those services are provided.

(1) MAA requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611. The request must include at least all of the following:

(a) Physiological description of the disease, injury, impairment, or other ailment;

(b) X-ray(s);

(c) Treatment plan;

(d) Study model, if requested; and

(e) Photographs, if requested.

(2) MAA authorizes requested services that meet the criteria in WAC 388-535-1080.

(3) MAA denies a request for dental services when the requested service is:

(a) Not medically necessary; or

(b) A service, procedure, treatment, device, drug, or application of associated service which the department or the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA)) consider investigative or experimental on the date the service is provided.

(4) MAA may require second opinions and/or consultations before authorizing any procedure.

(5) Authorization is valid only if the client is eligible for covered services on the date of service.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1220, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1220, filed 3/10/99, effective 4/10/99.]

**WAC 388-535-1230 Crowns.** (1) Subject to the limitations in WAC 388-535-1100, the medical assistance administration (MAA) covers the following crowns without prior authorization:

(a) Stainless steel. MAA considers these as permanent crowns, and does not cover them as temporary crowns; 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) Resin (laboratory);

(b) Porcelain with ceramic substrate;

(c) Porcelain fused to high noble metal;

(d) Porcelain fused to predominantly base metal; and

(e) Porcelain fused to noble metal.

(4) Criteria for covered crowns as described in subsections (1) and (3) of this section:

[Title 388 WAC—p. 877]

(a) Crowns may be authorized when the crown is medically 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) Client 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 intra-coronal 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, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1230, filed 6/14/02, effective 7/15/02. 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 388-535-1240 Dentures, partials, and overdentures.** (1) Subject to the limitations in WAC 388-535-1100, the medical assistance administration (MAA) covers only one set of dentures per client in a ten-year period, and considers that set to be the first set. The exception to this is replacement dentures, which may be allowed as specified in subsection (4) of this section. Except as described in subsection (5) of this section, MAA does not require prior authorization for the first set of dentures. The first set of dentures may be any of the following:

(a) An immediate set (constructed prior to removal of the teeth);

(b) An initial set (constructed after the client has been without teeth for a period of time); or

(c) A final set (constructed after the client has received immediate or initial dentures).

(2) The first set of dentures must be of the structure and quality to be considered the primary set. MAA does not cover transitional or treatment dentures.

(3) MAA covers partials (resin and cast base) once every five years, except as noted in subsection (4) of this section, and subject to the following limits:

(a) Cast base partials only when replacing three or more teeth per arch excluding wisdom teeth; and

(b) No partials are covered when they replace wisdom teeth only.

(4) Except as stated below, MAA does not require prior authorization for replacement dentures or partials when:

(a) The client's existing dentures or partials meet any of the following conditions. MAA requires prior authorization for replacement dentures or partials requested within one year of the seat date. The dentures or partials must be:

(i) No longer serviceable and cannot be relined or rebased; or

(ii) Damaged beyond repair.

(b) The client's health would be adversely affected by absence of dentures;

(c) The client has been able to wear dentures successfully;

(d) The dentures or partials meet the criteria of medically necessary; and

(e) The dentures are replacing lost dentures, and the replacement set does not exceed MAA's limit of one set in a ten-year period as stated in subsection (1) of this section.

(5) MAA does not reimburse separately for laboratory and professional fees for dentures and partials. However, MAA may partially reimburse for these fees when the provider obtains prior authorization and the client:

(a) Dies;

(b) Moves from the state;

(c) Cannot be located; or

(d) Does not participate in completing the dentures.

(6) The provider must document in the client's medical or dental record:

(a) Justification for replacement of dentures;

(b) Charts of missing teeth, for replacement of partials; and

(c) Receipts for laboratory costs or laboratory records and notes.

(7) For billing purposes, the provider may use the impression date as the service date for dentures, including partials, only when:

(a) Related dental services including laboratory services were provided during a client's eligible period; and

(b) The client is not eligible at the time of delivery.

(8) For billing purposes, the provider may use the delivery date as the service date when the client is using the first set of dentures in lieu of noncovered transitional or treatment dentures after oral surgery.

(9) MAA includes the cost of relines and adjustments that are done within six months of the seat date in the reimbursement for the dentures.

(10) MAA covers one rebase in a five-year period; the dentures must be at least three years old.

(11) The requirements in this section also apply to overdentures.



[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1240, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1240, filed 3/10/99, effective 4/10/99.]

### ABCD DENTAL PROGRAM

**WAC 388-535-1245 Access to baby and child dentistry (ABCD) program.** The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services in targeted areas for Medicaid-eligible infants, toddlers, and preschoolers. Public and private sectors cooperate to administer the program.

(1) Client eligibility for the ABCD program is as follows:

(a) Clients must be five years of age or younger and reside in targeted areas selected by the medical assistance administration (MAA). Once enrolled in the ABCD program, an eligible client is covered until reaching age six.

(b) Eligible clients enrolled in a managed care plan are eligible for the ABCD program under fee-for-service.

(c) Eligible clients enrolled in the following medical assistance programs are eligible for the ABCD program:

- (i) Categorically needy (CN or CNP);
- (ii) Limited casualty program/medically needy program (LCP/MNP); and
- (iii) Children's health.

(2) Health care providers and community service programs in the targeted areas identify and refer eligible clients to the ABCD program. If enrolled, the client and family may receive:

- (a) An ABCD program identification card;
- (b) Oral health information;
- (c) Expectations of the client and family, including the importance of keeping appointments;
- (d) Assistance with obstacles to care, such as lack of transportation; and
- (e) Case management services, for families who do not cooperate with the training(s) in this subsection.

(3) Families who do not cooperate with the training(s) in subsection (2) of this section may be disqualified from the ABCD program. The client remains eligible for MAA dental coverage as described in this chapter.

(4) The University of Washington School of Pediatric Dentistry's continuing education program certifies dental providers to furnish ABCD program services.

(5) MAA pays enhanced fees to ABCD-certified participating providers for furnishing ABCD program services. In addition to services provided under MAA's dental care program, the ABCD program provides family oral health education, which is allowed twice per year, per family, and must include:

- (a) Risk assessment;
- (b) Oral health instruction/training;
- (c) Dietary counseling;
- (d) Fluoride supplements, if appropriate; and
- (e) Documentation in the client's file.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and .225. 02-11-136, § 388-535-1245, filed 5/21/02, effective 6/21/02.]

(2003 Ed.)

### PAYMENT

**WAC 388-535-1350 Payment methodology for dental-related services.** The medical assistance administration (MAA) uses the description of dental services described in the American Dental Association's Current Dental Terminology, third edition (CDT-3), and the American Medical Association's Physician's Current Procedure Terminology 2002 (CPT 2002). MAA uses state-assigned procedure codes to identify services not fully described in the CDT-3 or CPT 2002 descriptions. (CPT is a trademark of the American Medical Association.)

(1) For covered dental-related services provided to eligible clients, MAA pays dentists and related providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC 388-535-1100 and 388-535-1400.

(2) MAA sets maximum allowable fees for dental services provided to children as follows:

(a) MAA's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) MAA consults with representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) MAA consults with dental experts and public health professionals to identify and prioritize dental services and procedures for their effectiveness in improving or promoting children's dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for children's dental services are allocated to specific procedures based on the priorities identified in (c) of this subsection and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting children's dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the department's evaluation of utilization trends, effectiveness of interventions, and access issues.

(3) MAA reimburses dental general anesthesia services for eligible clients on the basis of base anesthesia units plus time. Payment for dental general anesthesia is calculated as follows:

(a) Dental procedures are assigned an anesthesia base unit of five;

(b) Fifteen minutes constitute one unit of time. When a dental procedure requiring dental general anesthesia results in multiple time units and a remainder (less than fifteen minutes), the remainder or fraction is considered as one time unit;

(c) Time units are added to the anesthesia base unit of five and multiplied by the anesthesia conversion factor;

(d) The formula for determining payment for dental general anesthesia is: (5.0 base anesthesia units + time units) x conversion factor = payment.

(4) When billing for anesthesia, the provider must show the actual beginning and ending times on the claim. Anesthesia time begins when the provider starts to physically prepare the client for the induction of anesthesia in the operating room area (or its equivalent), and ends when the provider is

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no longer in constant attendance (i.e., when the client can be safely placed under post-operative supervision).

(5) MAA may pay anesthesiologists for general dental anesthesia provided in dental offices. Only anesthesiologists specially contracted by the department are paid an additional fee for that service.

(6) Dental hygienists who have a contract with MAA are paid at the same rate as dentists who have a contract with MAA, for services allowed under The Dental Hygienist Practice Act, which is available from the department of health, Olympia, Washington.

(7) Licensed denturists who have a contract with MAA are paid at the same rate as dentists who have a contract with MAA, for providing dentures and partials.

(8) MAA makes fee schedule changes whenever the legislature authorizes vendor rate increases or decreases.

(9) MAA may adjust maximum allowable fees to reflect changes in services or procedure code descriptions.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1350, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1350, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1350, filed 12/6/95, effective 1/6/96.]

**WAC 388-535-1400 Payment for dental-related services.** (1) The medical assistance administration (MAA) considers that a provider who furnishes covered dental services to an eligible client has accepted MAA's rules and fees.

(2) Participating providers must bill MAA their usual and customary fees.

(3) Payment for dental services is based on MAA's schedule of maximum allowances. Fees listed in the MAA fee schedule are the maximum allowable fees.

(4) MAA pays the provider the lesser of the billed charge (usual and customary fee) or MAA's maximum allowable fee.

(5) MAA pays "by report" on a case-by-case basis, for a covered service that does not have a set fee.

(6) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partials as stated in WAC 388-535-1240.

(7) The client is responsible for payment of any dental treatment or service received during any period of ineligibility with the exception described in WAC 388-535-1240(4) even if the treatment was started when the client was eligible.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1400, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1400, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1400, filed 12/6/95, effective 1/6/96.]

**WAC 388-535-1450 Payment for denture laboratory services.** The medical assistance administration (MAA) does not directly reimburse denture laboratories. MAA's reimbursement for dentures, partials, and overdentures includes

laboratory fees. The provider is responsible to pay a denture laboratory for services furnished to the provider.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1450, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1450, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1450, filed 12/6/95, effective 1/6/96.]

**WAC 388-535-1500 Payment for dental-related hospital services.** The medical assistance administration (MAA) pays for medically necessary dental-related hospital inpatient and outpatient services in accord with WAC 388-550-1100.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1500, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1500, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1500, filed 12/6/95, effective 1/6/96.]

**WAC 388-535-1550 Payment for dental care provided out-of-state.** (1) Clients, except those receiving services under state-funded only programs, who are temporarily outside the state receive the same dental care services as clients in the state, subject to the same exceptions and limitations.

(2) The medical assistance administration (MAA) does not cover out-of-state dental care for clients receiving services under state-funded only programs.

(3) Eligible clients in MAA-designated border areas may receive the same dental services as if provided in state.

(4) Dental providers who are out-of-state must meet the same criteria for payment as in-state providers, including the requirements to contract with MAA. See WAC 388-535-1070, Dental-related services provider information.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1550, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1550, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1550, filed 12/6/95, effective 1/6/96.]

## Chapter 388-535A WAC ORTHODONTIC SERVICES

### WAC

388-535A-0010	Definitions for orthodontic services.
388-535A-0020	Eligibility for orthodontic services.
388-535A-0030	Providers of orthodontic services.
388-535A-0040	Orthodontic coverage.
388-535A-0050	Authorization, prior authorization, and expedited prior authorization for orthodontic services.
388-535A-0060	Reimbursement for orthodontic services.

**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) Arthrogyposis; 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 pre-maxilla 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 than 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 appli-

ance 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 388-537 WAC  
SCHOOL SERVICES**

**WAC**  
388-537-0100 School medical services for students in special education programs.

**WAC 388-537-0100 School medical services for students in special education programs.** (1) The medical assistance administration (MAA) pays school districts or educational service districts (ESD) for qualifying medical services provided to an eligible student. To be covered under this section, the student must be eligible for Title XIX (i.e., either the categorically needy or medically needy programs).

(2) To qualify for payment under this section, the medical services must be provided:

- (a) By the school district or the ESD; and
- (b) To the eligible special education student as part of the student's individualized education program (IEP) or individualized family service plan (IFSP).

(3) To qualify for payment under this section, the medical services must be provided by one of the following service providers:

- (a) A qualified Medicaid provider as described under WAC 388-502-0010;
- (b) A psychologist, licensed by the state of Washington or granted an educational staff associate (ESA) certificate by the state board of education;
- (c) A school guidance counselor, or a school social worker, who has been granted an ESA certificate by the state board of education; or
- (d) A person trained and supervised by any of the following:

- (i) A licensed registered nurse;
- (ii) A licensed physical therapist or physiatrist;
- (iii) A licensed occupational therapist; or
- (iv) A speech pathologist or audiologist who:
  - (A) Has been granted a certificate of clinical competence by the American speech, hearing, and language association;

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- (B) Is a person who completed the equivalent educational and work experience necessary for such a certificate; or
- (C) Is a person who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(4) Student service recommendations and referrals must be updated at least annually.

(5) The student does not need a provider prescription to receive services described under this section.

(6) MAA pays for school-based medical services according to the department-established rate or the billed amount, whichever is lower.

(7) MAA does not pay individual school practitioners who provide school-based medical services.

(8) For medical services billed to Medicaid, school districts or ESD, must pursue third-party resources.

[Statutory Authority: RCW 74.08.090, 01-02-076, § 388-537-0100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090, 00-01-088, § 388-537-0100, filed 12/14/99, effective 1/14/00.]

**Chapter 388-538 WAC  
MANAGED CARE**

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

388-538-001 Purpose. [Statutory Authority: RCW 74.08.090, 93-17-039 (Order 3621), § 388-538-001, filed 8/11/93, effective 9/11/93. Formerly WAC 388-83-010 (part).] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396(a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.  
388-538-066 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.  
388-538-090 Client's choice of primary care provider. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-090, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090, 93-17-039 (Order 3621), § 388-538-090, filed 8/11/93, effective 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396(a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.  
388-538-150 Managed care medical audit. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-150, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090, 93-17-039 (Order 3621), § 388-538-150, filed 8/11/93, effective 9/11/93.]

tive 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

**WAC 388-538-050 Definitions.** The following definitions and abbreviations and those found in WAC 388-500-0005, 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 chapter 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.

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(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

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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 enrollees 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,

[Title 388 WAC—p. 886]

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 388-538-067 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.]

(2003 Ed.)

**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:

$(\text{FQHC total costs}) - (\text{FFS reimbursements} + \text{HO reimbursements}) / (\text{FFS} + \text{HO reimbursements})$ .

(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/TRI-CARE, 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) enrollees [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 the 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 9/1/93.]

**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**

388-539-0200	AIDS—Health insurance premium payment program.
388-539-0300	Case management for persons living with HIV/AIDS.
388-539-0350	HIV/AIDS case management reimbursement information.

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

388-539-001	Purpose. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-001, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.
388-539-050	Definitions. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-050, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.
388-539-0500	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.
388-539-100	Eligibility. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-100, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.
388-539-150	Premium payment. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-150, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

**WAC 388-539-0200 AIDS—Health insurance premium payment program.** (1) The purpose of the AIDS health insurance premium payment program is to help individuals who are not eligible for MAA's medical programs and who are diagnosed with AIDS, pay their health insurance premiums.

(2) To be eligible for the AIDS health insurance premium payment program, individuals must:

- (a) Be diagnosed with AIDS as defined in WAC 246-100-011;
- (b) Be a resident of the state of Washington;
- (c) Be responsible for all, or part of, the health insurance premium payment (without MAA's help);
- (d) Not be eligible for one of MAA's other medical programs;
- (e) Not have personal income that exceeds three hundred seventy percent of the federal poverty level; and
- (f) Not have personal assets, after exemptions, exceeding fifteen thousand dollars. The following personal assets are exempt from the personal assets calculation:

- (i) A home used as the person's primary residence; and
- (ii) A vehicle used as personal transportation.

(3) MAA may contract with a not-for-profit community agency to administer the Aids health insurance premium payment program. MAA or its contractor determines an individual's initial eligibility and redetermines eligibility on a periodic basis. To be eligible, individuals must:

- (a) Cooperate with MAA's contractor;
- (b) Cooperate with eligibility determination and redetermination process; and
- (c) Initially meet and continue to meet the eligibility criteria in subsection (2) of this section.

(4) Individuals, diagnosed with AIDS, who are eligible for one of MAA's medical programs may ask MAA to pay their health insurance premiums under a separate process. The client's community services office (CSO) is able to assist the client with this process.

(5) Once an individual is eligible to participate in the AIDS health insurance premium payment program, eligibility would cease only when one of the following occurs. The individual:

- (a) Is deceased;
- (b) Voluntarily quits the program;
- (c) No longer meets the requirements of subsection (2) of this section; or
- (d) Has benefits terminated due to the legislature's termination of the funding for this program.

(6) MAA sets a reasonable payment limit for health insurance premiums. MAA sets its limit by tracking the charges billed to MAA for MAA clients who have AIDS. MAA does not pay health insurance premiums that exceed fifty percent of the average of charges billed to MAA for its clients with AIDS.

[Statutory Authority: RCW 74.08.090, 74.09.757. 00-14-070, § 388-539-0200, filed 7/5/00, effective 8/5/00.]

**WAC 388-539-0300 Case management for persons living with HIV/AIDS.** MAA provides HIV/AIDS case management to assist persons infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

- (1) To be eligible for MAA reimbursed HIV/AIDS case management services, the person must:
- (a) Have a current medical diagnosis of HIV or AIDS;

(b) Be eligible for Title XIX (Medicaid) coverage under either the categorically needy program (CNP) or the medically needy program (MNP); and

(c) Require:

(i) Assistance to obtain and effectively use necessary medical, social, and educational services; or

(ii) Ninety days of continued monitoring as provided in WAC 388-539-0350(2).

(2) MAA has an interagency agreement with the Washington state department of health (DOH) to administer the HIV/AIDS case management program for MAA's Title XIX (Medicaid) clients.

(3) HIV/AIDS case management agencies who serve MAA's clients must be approved to perform these services by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive persons of their statewide choice of available HIV/AIDS case management providers and document that notification in the client's record. This notification requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services.

(b) Have a current client-signed authorization to release/obtain information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA (see RCW 70.02.030). The fee referenced in RCW 70.02.030 is included in MAA's reimbursement to providers. MAA's clients may not be charged for services or documents related to covered services.

(c) Maintain sufficient contact to ensure the effectiveness of ongoing services per subsection (5) of this section. MAA requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the individual service plan (ISP).

(5) HIV/AIDS case management providers must document services as follows:

(a) Providers must initiate a comprehensive assessment within two working days of the client's referral to HIV/AIDS case management services. Providers must complete the assessment before billing for ongoing case management services. If the assessment does not meet these requirements, the provider must document the reason(s) for failure to do so. The assessment must include the following elements as reported by the client:

(i) Demographic information (e.g., age, gender, education, family composition, housing);

(ii) Physical status, the identity of the client's primary care provider, and current information on the client's medications/treatments;

(iii) HIV diagnosis (both the documented diagnosis at the time of assessment and historical diagnosis information);

(iv) Psychological/social/cognitive functioning and mental health history;

(v) Ability to perform daily activities;

(vi) Financial and employment status;

(vii) Medical benefits and insurance coverage;

(viii) Informal support systems (e.g., family, friends and spiritual support);

(ix) Legal status, durable power of attorney, and any self-reported criminal history; and

(x) Self-reported behaviors which could lead to HIV transmission or re-infection (e.g., drug/alcohol use).

(b) Providers must develop, monitor, and revise the client's individual service plan (ISP). The ISP identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs. The case manager and the client must develop the ISP within two days of the comprehensive assessment or the provider must document the reason this is not possible. An ISP must be:

(i) Signed by the client, documenting that the client is voluntarily requesting and receiving MAA reimbursed HIV/AIDS case management services; and

(ii) Reviewed monthly by the case manager through in-person or telephone contact with the client. Both the review and any changes must be noted by the case manager:

(A) In the case record narrative; or

(B) By entering notations in, initialing and dating the ISP.

(c) Maintained ongoing narrative records - These records must document case management services provided in each month for which the provider bills MAA. Records must:

(i) Be entered in chronological order and signed by the case manager;

(ii) Document the reason for the case manager's interaction with the client; and

(iii) Describe the plans in place or to be developed to meet unmet client needs.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0300, filed 11/16/00, effective 12/17/00.]

**WAC 388-539-0350 HIV/AIDS case management reimbursement information.** (1) MAA reimburses HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment - The assessment must cover the areas outlined in WAC 388-539-0300(1) and (5).

(i) MAA reimburses only one comprehensive assessment unless the client's situation changes as follows:

(A) There is a fifty percent change in need from the initial assessment; or

(B) The client transfers to a new case management provider.

(ii) MAA reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is Medicaid eligible and the ongoing case management has been provided.

(b) HIV/AIDS case management, full-month - Providers may request the full-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. MAA reimburses only one full-month case management fee per client in any one month.

(c) HIV/AIDS case management, partial-month - Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an ISP in place for fewer than twenty days in that month. Using the partial-month reim-

bursement, MAA may reimburse two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) MAA limits reimbursement to HIV/AIDS case managers when a client becomes stabilized and no longer needs an ISP with active service elements. MAA limits reimbursement for monitoring to ninety days past the time the last active service element of the ISP is completed. Case Management providers who are monitoring a stabilized client must meet all of the following criteria in order to bill MAA for up to ninety days of monitoring:

- (a) Document the client's history of recurring need;
- (b) Assess the client for possible future instability; and
- (c) Provide monthly monitoring contacts.

(3) MAA reinstates reimbursement for ongoing case management if a client shifts from monitoring status to active case management status due to documented need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g), 00-23-070, § 388-539-0350, filed 11/16/00, effective 12/17/00.]

## Chapter 388-540 WAC KIDNEY CENTERS

### WAC

388-540-001	Purpose.
388-540-005	Definitions.
388-540-010	Services.
388-540-020	Reimbursement.
388-540-030	KDP eligibility requirements.
388-540-040	Transfer of resources without adequate consideration.
388-540-050	Fiscal information.
388-540-060	KDP eligibility determination.

**WAC 388-540-001 Purpose.** The department administers state funds to assist eligible clients with medical care costs associated with **end stage renal disease (ESRD)**.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-001, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-001, filed 7/28/93, effective 8/28/93.]

**WAC 388-540-005 Definitions.** The following definitions and those found in WAC 388-500-0005, Medical definitions, apply to this chapter. Defined words and phrases are bolded in the text.

**"Adequate consideration"** means that the reasonable value of goods or services received in exchange for transferred property approximates the reasonable value of the property transferred;

**"Affiliate"** means a facility, hospital, unit, business, or person having an agreement with a **kidney center** to provide specified services to **ESRD** patients;

**"Application for kidney disease program (KDP) eligibility"** means the form provided by MAA, which the client completes and submits to the contracted **kidney center** to determine **KDP** eligibility;

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**"Assets"** means income, resources, or any real or personal property that a person or the person's spouse owns and could convert to cash to be used for support or maintenance;

**"Certification"** means the **kidney center** has determined a client eligible for the **KDP** for a defined period of time;

**"End stage renal disease (ESRD)"** means that stage of renal impairment which is irreversible and permanent, and requires dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life;

**"KDP application period"** means the time between the date of application and **certification**;

**"KDP client"** means a resident of the state who has a diagnosis of **ESRD** and meets the financial and medical criteria to be determined eligible by a contracted **kidney center**;

**"KDP contract manual"** is a set of policies and procedures for contracting **kidney centers**;

**"Kidney center"** means a facility as defined and certified by the federal government to:

- (1) Provide **ESRD** services;
- (2) Provide the services specified in this chapter; and
- (3) Promote and encourage home dialysis for a client when medically indicated;

**"Kidney disease program (KDP)"** is a public state program that helps eligible clients with the costs of **ESRD**-related medical care;

**"Recertifying client"** means a **KDP client** who was determined eligible the previous year for the **KDP** and will continue to qualify under this chapter;

**"Substantial financial change"** means:

- (1) The elimination of a client's required annual deductible amount; or
- (2) The increase or decrease of income or **assets** by fifteen hundred dollars.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-005, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-005, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-005, filed 7/28/93, effective 8/28/93.]

**WAC 388-540-010 Services.** The **kidney center** must provide, directly or through an **affiliate**, all physical facilities, professional consultation, personal instructions, medical treatment and care, drug products, and all supplies necessary for carrying out a medically-sound **ESRD** treatment program, including all of the following:

- (1) Dialysis for clients with **ESRD** when medically indicated;
- (2) Kidney transplantation treatment, either directly or by referral, for clients with **ESRD** when medically indicated;
- (3) Treatment for conditions directly related to **ESRD**;
- (4) Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment; and
- (5) Supplies and equipment for home dialysis.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-010, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-010, filed 7/28/93, effective 8/28/93.]

**WAC 388-540-020 Reimbursement.** MAA reimburses **kidney centers** for services according to this chapter and the **kidney center's** contract with the department to the extent the legislature has appropriated funds.

(1) To request reimbursement, the **kidney center** must submit documented evidence, satisfactory to MAA, showing:

(a) The services for which reimbursement is requested; and

(b) The client's financial eligibility for the state **KDP** under this chapter.

(2) MAA limits reimbursement for services provided to a client while visiting out-of-state to fourteen days per calendar year.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-020, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-020, filed 7/28/93, effective 8/28/93.]

**WAC 388-540-030 KDP eligibility requirements.** (1) The **kidney center** determines clients' eligibility annually on a case-by-case basis, according to this chapter and the **KDP contract manual**. To be eligible for the **KDP**, a client must:

(a) Be a Washington state resident;

(b) Have countable resources, not exempted under subsection (2) of this section, which are equal to or lower than fifteen thousand dollars;

(c) Have countable income as defined in WAC 388-500-0005, which is equal to or lower than three hundred percent of the federal poverty level (FPL); and

(d) Exhaust or be ineligible for all other resources providing similar benefits to meet the cost of **ESRD**-related medical care, such as:

(i) Government or private disability programs; or

(ii) Local funds raised for the purpose of providing financial support for a specified **ESRD** client.

(2) The following resources are exempt:

(a) A home, defined as real property owned by a client as a principal place of residence, together with surrounding and contiguous property not to exceed five acres;

(b) Household furnishings; and

(c) An automobile.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-030, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-030, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-030, filed 7/28/93, effective 8/28/93.]

**WAC 388-540-040 Transfer of resources without adequate consideration.** A person may be ineligible for the **KDP** if the person knowingly and willfully assigns or transfers nonexempt resources at less than fair market value within two years preceding the date of application, for the purpose of qualifying or continuing to qualify for the program.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-040, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-040, filed 7/28/93, effective 8/28/93.]

[Title 388 WAC—p. 896]

**WAC 388-540-050 Fiscal information.** The **kidney center** must provide fiscal information upon request by the department, including:

(1) Accounting information and documentation sufficient to establish the basis for fees for services and/or charges;

(2) Sources and amounts of resources allowing an individual client to verify financial eligibility;

(3) Evidence that all other available resources have been depleted before requests for reimbursement from the **KDP** are submitted to MAA; and

(4) Other information as MAA may require.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-050, filed 7/28/93, effective 8/28/93.]

**WAC 388-540-060 KDP eligibility determination.** The **kidney center** and client must comply with the following rules to determine **KDP** eligibility:

(1) The **kidney center** must:

(a) Inform the client of the requirements for **KDP** eligibility as defined in this chapter;

(b) Provide the client with necessary department forms and instructions in a timely manner;

(c) Review the **KDP application** and documentation;

(d) Determine client eligibility using department policies, rules, and instructions; and

(e) Forward the **KDP application** and documentation to the medical assistance administration (MAA). If necessary, MAA may amend or terminate a client's **certification** period within thirty days of receipt.

(2) A person applying for **KDP** must:

(a) Complete the **KDP application** and submit any documentation necessary to determine eligibility to the **kidney center**; and

(b) Apply for Medicaid, obtain a written Medicaid eligibility determination, and submit a copy to the **kidney center**.

(3) A client applying for recertification must:

(a) Apply for Medicaid forty-five days before the end of the **KDP certification** period, obtain a written Medicaid eligibility determination, and submit a copy to the **kidney center**; or

(b) Have applied for Medicaid within the previous five years and continue to be ineligible because the client:

(i) Was denied Medicaid due to:

(A) Failure to meet Medicaid categorical requirements; or  
(B) **Assets** which exceed Medicaid resource standards;

or

(C) Income which exceeds the categorically needy income standards; or

(ii) Does not meet the medically needy spenddown amount because the cost of medical care is:

(A) Less than the spenddown amount; or  
(B) Covered by third-party insurance.

(4) The **KDP application period** is:

(a) One hundred and twenty days for a new client; and

(b) Forty-five days prior to the end of a **certification** period for a client requesting recertification.



(5) The **kidney center** may request an extension of application time limits from MAA when extenuating circumstances prevent the client from completing the application or recertification process within the specified time limits.

(6) The **kidney center** certifies the client as **KDP** eligible for a period of one year from the first day of the month of application, unless the client:

(a) Needs medical coverage for less than one year; or

(b) Has a **substantial financial change**, in which case the client must complete a new **application for KDP eligibility**;

(7) The effective date of **KDP** eligibility is the first day of the month of **KDP** application if the client was eligible at any time during that month. The effective date of **KDP** eligibility may be a maximum of four months before the month of **KDP** application if the:

(a) Medical services received were covered; and

(b) Client would have been eligible had the client applied.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-060, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-060, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-060, filed 7/28/93, effective 8/28/93.]

**Chapter 388-542 WAC**

**CHILDREN'S HEALTH INSURANCE PLAN (CHIP)**

**WAC**

388-542-0050	Definitions for children's health insurance program (CHIP) terms.
388-542-0100	CHIP scope of care.
388-542-0125	Access to care.
388-542-0150	Client eligibility requirements for CHIP.
388-542-0200	CHIP enrollment.
388-542-0220	Ending CHIP client eligibility.
388-542-0250	CHIP client costs.
388-542-0275	Reimbursement.
388-542-0300	Waiting period for CHIP coverage following employer coverage.
388-542-0500	Managed care rules that apply to CHIP.

**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

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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.

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(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 creditable 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),

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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.]

(2003 Ed.)

**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**

<b>WAC</b>	
388-543-1000	Definitions for durable medical equipment (DME) and related supplies, prosthetics, and orthotics, medical supplies and related services.
388-543-1100	Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services.
388-543-1150	Limits and limitation extensions.
388-543-1200	Providers who are eligible to provide services.
388-543-1300	Equipment, related supplies, or other nonmedical supplies, and devices that are not covered.
388-543-1400	General reimbursement for DME and related services, prosthetics, orthotics, medical supplies and related services.
388-543-1500	When MAA purchases DME and related supplies, prosthetics, and orthotics.
388-543-1600	Items and services which require prior authorization.
388-543-1700	When MAA covers rented DME.
388-543-1800	Prior authorization—General policies for DME and related supplies, prosthetics, orthotics, medical supplies and related services.
388-543-1900	Expedited prior authorization criteria for DME and related supplies, prosthetics, orthotics, medical supplies, and related services.
388-543-2000	Wheelchairs.
388-543-2100	Wheelchairs—Reimbursement methodology.
388-543-2200	Speech generating devices (SGD).
388-543-2300	Bathroom/shower equipment.
388-543-2400	Hospital beds.
388-543-2500	Reimbursement methodology for other durable medical equipment.
388-543-2600	Prosthetics and orthotics.
388-543-2700	Prosthetics and orthotics—Reimbursement.
388-543-2800	Reusable and disposable medical supplies.
388-543-2900	Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology.
388-543-3000	DME and supplies provided in physician's office.

**WAC 388-543-1000 Definitions for durable medical equipment (DME) and related supplies, prosthetics, and orthotics, medical supplies and related services.** The fol-

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lowing definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter.

**"Artificial limb"** - See "prosthetic device."

**"Augmentative communication device (ACD)"** - See "speech generating device (SGD)."

**"Base year"** means the year of the data source used in calculating prices.

**"By report (BR)"** means a method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees.

**"Date of delivery"** means the date the client actually took physical possession of an item or equipment.

**"Disposable supplies"** means supplies which may be used once, or more than once, but are time limited.

**"Durable medical equipment (DME)"** means equipment that: (1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(4) Is appropriate for use in the client's place of residence.

**"EPSDT"** - See WAC 388-500-0005.

**"Expedited prior authorization (EPA)"** means the process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization.

**"Fee-for-service (FFS)"** means the general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs.

**"Health care financing administration common procedure coding system (HCPCS)"** means a coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

**"House wheelchair"** means a nursing facility wheelchair that is included in the nursing facility's per-patient-day rate under chapter 74.46 RCW.

**"Limitation extension"** means a process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization.

**"Nonreusable supplies"** are disposable supplies, which are used once and discarded.

**"Manual wheelchair"** - See "wheelchair - manual."

**"Medical supplies"** means supplies that are:

(1) Primarily and customarily used to service a medical purpose; and

(2) Generally not useful to a person in the absence of illness or injury.

**"Orthotic device"** or **"orthotic"** means a corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

**"Personal or comfort item"** means an item or service which primarily serves the comfort or convenience of the client.

**"Personal computer (PC)"** means any of a variety of electronic devices that are capable of accepting data and instructions, executing the instructions to process the data, and presenting the results. A PC has a central processing unit (CPU), internal and external memory storage, and various input/output devices such as a keyboard, display screen, and printer. A computer system consists of hardware (the physical components of the system) and software (the programs used by the computer to carry out its operations).

**"Power-drive wheelchair"** - See "wheelchair - power."

**"Prior authorization"** means a process by which clients or providers must request and receive MAA approval for certain medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are types of prior authorization. Also see WAC 388-501-0165.

**"Prosthetic device"** or **"prosthetic"** means a replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction;

or

(3) Support a weak or deformed portion of the body.

**"Resource based relative value scale (RBRVS)"** means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

**"Reusable supplies"** are supplies which are to be used more than once.

**"Scooter"** means a federally-approved, motor-powered vehicle that:

(1) Has a seat on a long platform;

(2) Moves on either three or four wheels;

(3) Is controlled by a steering handle; and

(4) Can be independently driven by a client.

**"Specialty bed"** means a pressure reducing support surface, such as foam, air, water, or gel mattress or overlay.

**"Speech generating device (SGD)"** means an electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

**"Three- or four-wheeled scooter"** means a three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

(1) Rear drive;

(2) A twenty-four volt system;

(3) Electronic or dynamic braking;

- (4) A high to low speed setting; and
- (5) Tires designed for indoor/outdoor use.

"**Trendelenburg position**" means a position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"**Usual and customary charge**" means the amount the provider typically charges to fifty percent or more of his or her non-Medicaid clients, including clients with other third-party coverage.

"**Warranty-wheelchair**" means a warranty, according to manufacturers' guidelines, of not less than one year from the date of purchase.

"**Wheelchair - manual**" means a federally-approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

- (1) Standard:
  - (a) Usually is not capable of being modified;
  - (b) Accommodates a person weighing up to two hundred fifty pounds; and
  - (c) Has a warranty period of at least one year.
- (2) Lightweight:
  - (a) Composed of lightweight materials;
  - (b) Capable of being modified;
  - (c) Accommodates a person weighing up to two hundred fifty pounds; and
  - (d) Usually has a warranty period of at least three years.
- (3) High strength lightweight:
  - (a) Is usually made of a composite material;
  - (b) Is capable of being modified;
  - (c) Accommodates a person weighing up to two hundred fifty pounds;
  - (d) Has an extended warranty period of over three years; and
  - (e) Accommodates the very active person.
- (4) Hemi:
  - (a) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and
  - (b) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.
- (5) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.
- (6) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.
- (7) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.
- (8) Heavy duty:
  - (a) Specifically manufactured to support a person weighing up to three hundred pounds; or
  - (b) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).
- (9) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.
- (10) Custom heavy duty:

(a) Specifically manufactured to support a person weighing over three hundred pounds; or

(b) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(11) Custom manufactured specially built:

(a) Ordered for a specific client from custom measurements; and

(b) Is assembled primarily at the manufacturer's factory.

"**Wheelchair - power**" means a federally-approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

(1) Custom power adaptable to:

(a) Alternative driving controls; and

(b) Power recline and tilt-in-space systems.

(2) Noncustom power: Does not need special positioning or controls and has a standard frame.

(3) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

[Statutory Authority: RCW 74.08.090, 74.09.530, 02-16-054, § 388-543-1000, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1000, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-1100 Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services.** The federal government deems **durable medical equipment (DME)** and related supplies, **prosthetics, orthotics, and medical supplies** as optional services under the **Medicaid** program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (**EPSDT**) program. The **department** may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(1) The medical assistance administration (MAA) covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when all of the following apply. They must be:

(a) Within the scope of an eligible client's medical care program (see chapter 388-529 WAC);

(b) Within accepted medical or physical medicine community standards of practice;

(c) Prior authorized as described in WAC 388-543-1600, 388-543-1800, and 388-543-1900;

(d) Prescribed by a qualified **provider**, acting within the scope of the provider's practice. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity;

(e) Billed to the department as the payor of last resort only. MAA does not pay first and then collect from Medicare;

(f) **Medically necessary** as defined in WAC 388-500-0005. The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:

(i) A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; or

(ii) Video and/or photograph(s) of the client demonstrating the impairments as well as client's ability to use the requested equipment, when applicable.

(2) MAA evaluates a request for any equipment or devices that are listed as noncovered in WAC 388-543-1300 under the provisions of WAC 388-501-0165.

(3) MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0050, under the provisions of WAC 388-501-0165 which relate to medical necessity.

(4) MAA evaluates requests for covered services in this chapter that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165.

(5) MAA does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under **fee-for-service (FFS)** when the client is any of the following:

(a) An inpatient hospital client;

(b) Eligible for both **Medicare** and **Medicaid**, and is staying in a **nursing facility** in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(6) MAA covers medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, repairs, and labor charges listed in MAA's published issuances, including Washington Administrative Code (WAC), billing instructions, and numbered memoranda.

(7) An interested party may request MAA to include new equipment/supplies in the billing instructions by sending a written request plus all of the following:

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

(c) Clinical research/case studies (including FDA approval, if required); and

(d) Any additional information the requester feels is important.

(8) MAA bases the decision to purchase or rent DME for a client, or to pay for repairs to client-owned equipment on medical necessity.

(9) MAA covers replacement batteries for purchased medically necessary DME equipment covered within this chapter.

(10) MAA covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician or other licensed practitioner of the healing arts, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;

(b) Wheelchairs and other DME;

(c) Prosthetic/orthotic devices;

(d) Surgical/ostomy appliances and urological supplies;

(e) Bandages, dressings, and tapes;

(f) Equipment and supplies for the management of diabetes; and

(g) Other medical equipment and supplies, as listed in MAA published issuances.

(11) MAA evaluates a **BR** item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.

(12) For a client in a **nursing facility**, MAA covers only the following when medically necessary. All other DME and supplies identified in MAA billing instructions are the responsibility of the nursing facility, in accordance with chapters 388-96 and 388-97 WAC. See also WAC 388-543-2900 (3) and (4). MAA covers:

(a) The purchase and repair of a speech generating device (SGD), a wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate, or a **specialty bed**; and

(b) The rental of a specialty bed.

(13) Vendors must provide instructions for use of equipment; therefore, instructional materials such as pamphlets and video tapes are not covered.

(14) Bilirubin lights are limited to rentals, for at-home newborns with jaundice.

[Statutory Authority: RCW 74.08.090, 74.09.530, 02-16-054, § 388-543-1100, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1100, filed 12/13/00, effective 1/13/01.]

#### 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 lamb's 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 non-woven, 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/adaptor; 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/adaptor, 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 388-543-1200 Providers who are eligible to provide services.** (1) MAA requires a provider who supplies DME and related supplies, prosthetics, orthotics, medical

supplies and related services to an MAA client to meet all of the following. The provider must:

- (a) Have the proper business license;
- (b) Have appropriately trained qualified staff; and
- (c) Be certified, licensed and/or bonded if required, to perform the services billed to the department. Out-of-state prosthetic and orthotics providers must meet their state regulatory requirements.

(2) MAA may reimburse qualified providers for DME and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:

- (a) DME providers for DME and related repair services;
- (b) Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this section;
- (c) Licensed prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. This does not apply to medical equipment dealers and pharmacies that do not require licensure to provide selected prosthetics and orthotics;
- (d) Physicians who provide medical equipment and supplies in the physician's office. MAA may pay separately for medical supplies, subject to the provisions in MAA's **resource based relative value scale (RBRVS)** fee schedule; and
- (e) Out-of-state orthotics and prosthetics providers who meet their state regulations.

(3) MAA terminates from Medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0020.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1200, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-1300 Equipment, related supplies, or other nonmedical supplies, and devices that are not covered.** (1) MAA pays only for DME and related supplies, medical supplies and related services that are medically necessary, listed as covered in this chapter, and meet the definition of DME and medical supplies as defined in WAC 388-543-1000 and prescribed per WAC 388-543-1100 and 388-543-1200.

(2) MAA pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, that meet the definition of prosthetic and orthotic as defined in WAC 388-543-1000 and are prescribed per WAC 388-543-1100 and 388-543-1200.

(3) MAA considers all requests for covered DME, related supplies and services, medical supplies, prosthetics, orthotics, and related services and noncovered equipment, related supplies and services, supplies and devices, under the provisions of WAC 388-501-0165. When MAA considers that a request does not meet the requirement for medical necessity, the definition(s) of covered item(s), or is not covered, the client may appeal that decision under the provisions of WAC 388-501-0165.

(4) MAA specifically excludes services and equipment in this chapter from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition

for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

- (a) Included as part of a managed care plan service package;
  - (b) Included in a waived program;
  - (c) Part of one of the Medicare programs for qualified Medicare beneficiaries; or
  - (d) Requested for a child who is eligible for services under the EPSDT program. MAA reviews these requests according to the provisions of chapter 388-534 WAC.
- (5) Excluded services and equipment include, but are not limited to:

(a) Services, procedures, treatment, devices, drugs, or the application of associated services that the department of the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the services are provided;

(b) Any service specifically excluded by statute;

(c) A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by MAA for the client contributes to an increased utility bill (refer to the aging and adult services administration's (AASA) COPES program for potential coverage);

(d) Hairpieces or wigs;

(e) Material or services covered under manufacturers' warranties;

(f) Shoe lifts less than one inch, arch supports for flat feet, and nonorthopedic shoes;

(g) Outpatient office visit supplies, such as tongue depressors and surgical gloves;

(h) Prosthetic devices dispensed solely for cosmetic reasons (refer to WAC 388-531-0150 (1)(d));

(i) Home improvements and structural modifications, including but not limited to the following:

(i) Automatic door openers for the house or garage;

(ii) Saunas;

(iii) Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;

(iv) Swimming pools;

(v) Whirlpool systems, such as jacuzzies, hot tubs, or spas; or

(vi) Electrical rewiring for any reason;

(vii) Elevator systems and elevators; and

(viii) Lifts or ramps for the home; or

(ix) Installation of bathtubs or shower stalls.

(j) Nonmedical equipment, supplies, and related services, including but not limited to, the following:

(i) Back-packs, pouches, bags, baskets, or other carrying containers;

(ii) Bed boards/conversion kits, and blanket lifters (e.g., for feet);

(iii) Car seats for children under five, except for positioning car seats that are prior authorized. Refer to WAC 388-543-1700(13) for car seats;

(iv) Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;

(v) Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;

(vi) Electronic communication equipment, installation services, or service rates, including but not limited to, the following:

(A) Devices intended for amplifying voices (e.g., microphones);

(B) Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to AASA COPEs or outpatient hospital programs for emergency response systems and services);

(C) Two-way radios; and

(D) Rental of related equipment or services;

(vii) Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads;

(viii) Ergonomic equipment;

(ix) Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, trampolines;

(x) Generators;

(xi) Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards);

(xii) Computer utility bills, telephone bills, Internet service, or technical support for computers or electronic notebooks;

(xiii) Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, walkie-talkie, pager, or electronic notebook);

(xiv) Racing strollers/wheelchairs and purely recreational equipment;

(xv) Room fresheners/deodorizers;

(xvi) Bidet or hygiene systems, paraffin bath units, and shampoo rings;

(xvii) Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;

(xviii) Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or

(xix) Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

(k) Personal and **comfort items** that do not meet the DME definition, including but not limited to the following:

(i) Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizer, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;

(ii) Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers and sheets;

(iii) Bedside items, such as bed trays, carafes, and over-the-bed tables;

(iv) Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;

(v) Clothing protectors and other protective cloth furniture coverings;

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(vi) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;

(vii) Diverter valves for bathtub;

(viii) Eating/feeding utensils;

(ix) Emesis basins, enema bags, and diaper wipes;

(x) Health club memberships;

(xi) Hot or cold temperature food and drink containers/holders;

(xii) Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;

(xiii) Impotence devices;

(xiv) Insect repellants;

(xv) Massage equipment;

(xvi) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 388-530 WAC;

(xvii) Medicine cabinet and first aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;

(xviii) Page turners;

(xix) Radio and television;

(xx) Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and

(xxi) Toothettes and toothbrushes, waterpics, and interdental devices whether manual, battery-operated, or electric.

(l) Certain wheelchair features and options are not considered by MAA to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

(i) Attendant controls (remote control devices);

(ii) Canopies, including those for strollers and other equipment;

(iii) Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);

(iv) Identification devices (such as labels, license plates, name plates);

(v) Lighting systems;

(vi) Speed conversion kits; and

(vii) Tie-down restraints, except where medically necessary for client-owned vehicles.

[Statutory Authority: RCW 74.08.090, 74.09.530, 02-16-054, § 388-543-1300, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1300, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-1400 General reimbursement for DME and related services, prosthetics, orthotics, medical supplies and related services.** (1) MAA reimburses a qualified provider who serves a client who is not enrolled in a department-contracted managed care plan only when all of the following apply:

(a) The provider meets all of the conditions in WAC 388-502-0100; and

(b) MAA does not include the item/service for which the provider is requesting reimbursement in other reimbursement rate methodologies. Other methodologies include, but are not limited to, the following:

(i) Hospice providers' per diem reimbursement;

(ii) Hospitals' diagnosis related group (DRG) reimbursement;

(iii) Managed care plans' capitation rate; and

(iv) Nursing facilities' per diem rate.

(2) MAA sets maximum allowable fees for DME and related supplies, prosthetics, orthotics, medical supplies and related services using available published information, such as:

(a) Commercial data bases for price comparisons;

(b) Manufacturers' catalogs;

(c) Medicare fee schedules; and

(d) Wholesale prices.

(3) MAA may adopt policies, procedure codes, and/or rates that are inconsistent with those set by Medicare if MAA determines that such actions are in the best interest of its clients.

(4) MAA updates the maximum allowable fees for DME and supplies and prosthetic/orthotic devices no more than once per year, unless otherwise directed by the legislature. MAA may update the rates for different categories of medical equipment and prosthetic/orthotic devices at different times during the year.

(5) A provider must not bill MAA for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(6) MAA's maximum payment for medical equipment and supplies is the lesser of either of the following:

(a) Providers' **usual and customary charges**; or

(b) Established rates, except as provided in subsection (7)(a) of this section.

(7) If a client is eligible for both Medicare and Medicaid, the following apply:

(a) MAA requires a provider to accept Medicare assignment before any Medicaid reimbursement;

(b) If the service provided is covered by Medicare and Medicaid, MAA pays:

(i) The deductible and coinsurance up to Medicare's allowed amount or MAA's allowed amount, whichever is less; or

(ii) For services that are not covered by Medicare but are covered by MAA, if medically necessary.

(8) MAA may pay for medical services rendered to a client only when MAA is the payor of last resort.

(9) MAA does not cover medical equipment and/or services provided to a client who is enrolled in a MAA-contracted managed care plan, but did not use one of the plan's participating provider.

(10) See WAC 388-543-2100, 388-543-2500, 388-543-2700, and 388-543-2900 for other reimbursement methodologies.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1400, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-1500 When MAA purchases DME and related supplies, prosthetics, and orthotics.** (1) Durable medical equipment (DME) and related supplies, prosthetics, and orthotics purchased by MAA for a client is the client's property.

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(2) MAA's reimbursement for covered DME and related supplies, prosthetics, and orthotics includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the **date of delivery**. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Fitting and set-up; and

(c) Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

(3) MAA requires a provider to furnish to MAA clients only new equipment that includes full manufacturer and dealer warranties.

(4) MAA requires a dispensing provider to include a warranty on equipment for one year after the date MAA considers rented equipment to be purchased, as provided under WAC 388-543-1700(3).

(5) MAA charges the dispensing provider for any costs it incurs to have another provider repair equipment if all of the following apply:

(a) Any DME that MAA considers purchased according to WAC 388-543-1700 requires repair during the applicable warranty period;

(b) The dispensing provider is unwilling or unable to fulfill the warranty; and

(c) The client still needs the equipment.

(6) MAA charges the dispensing provider fifty percent of the total amount MAA paid toward rental and eventual purchase of the first equipment if the rental equipment must be replaced during the warranty period. All of the following must apply:

(a) Any medical equipment that MAA considers purchased according to WAC 388-543-1700 requires replacement during the applicable warranty period;

(b) The dispensing provider is unwilling or unable to fulfill the warranty; and

(c) The client still needs the equipment.

(7) Purchase orders:

(a) MAA rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(i) Dies;

(ii) Loses medical eligibility;

(iii) Becomes covered by a hospice agency; or

(iv) Becomes covered by an MAA managed care plan.

Refer to subsection (7)(c) of this section.

(b) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded per (a) of this subsection, MAA may pay the provider an amount it considers appropriate to help defray these extra costs. MAA requires the provider to submit justification sufficient to support such a claim.

(c) A client may become a managed care plan client before MAA completes the purchase of prescribed medical equipment. If this occurs:

(i) MAA rescinds the purchase order until the managed care primary care provider (PCP) evaluates the client; then

(ii) MAA requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 388-500-0005; then

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(iii) The managed care plan's applicable reimbursement policies apply to the purchase or rental of the equipment.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1500, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-1600 Items and services which require prior authorization.** (1) MAA bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require **prior authorization (PA)** or **expedited prior authorization (EPA)** on utilization criteria. (See WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA.) MAA considers all of the following when establishing utilization criteria:

- (a) High cost;
  - (b) Potential for utilization abuse;
  - (c) Narrow therapeutic indication; and
  - (d) Safety.
- (2) MAA requires providers to obtain prior authorization for certain items and services. This includes, but is not limited to, the following:
- (a) Augmentative communication devices (ACDs);
  - (b) Certain by report (BR) DME and supplies as specified in MAA's published issuances, including billing instructions and numbered memoranda;
  - (c) Blood glucose monitors requiring special features;
  - (d) Certain equipment rentals and certain prosthetic limbs, as specified in MAA's published issuances, including billing instructions and numbered memoranda;
  - (e) Decubitus care products and supplies;
  - (g) Decubitus care mattresses, including flotation or gel mattress, if the provider fails to meet the criteria in WAC 388-543-1900;
  - (g) Equipment parts and labor charges for repairs or modifications and related services;
  - (h) Hospital beds, if the provider fails to meet the requirements in WAC 388-543-1900;
  - (i) Low air loss flotation system, if the provider fails to meet the requirements in WAC 388-543-1900;
  - (j) Orthopedic shoes and selected orthotics;
  - (k) Osteogenic stimulator, noninvasive, if the provider fails to meet the requirements in WAC 388-543-1900;
  - (l) Positioning car seats for children under five years of age;
  - (m) Transcutaneous electrical nerve stimulators, if the provider fails to meet the requirements in WAC 388-543-1900;
  - (n) Wheelchairs, wheelchair accessories, wheelchair modifications, air, foam, and gel cushions, and repairs;
  - (o) Wheelchair-style shower/commode chairs;
  - (p) Other DME not specifically listed in MAA's published issuances, including billing instructions and numbered memoranda, and submitted as a miscellaneous procedure code; and
  - (q) Limitation extensions.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1600, filed 12/13/00, effective 1/13/01.]

(2003 Ed.)

**WAC 388-543-1700 When MAA covers rented DME.** (1) MAA's reimbursement amount for rented durable medical equipment (DME) includes all of the following:

- (a) Delivery to the client;
  - (b) Fitting, set-up, and adjustments;
  - (c) Maintenance, repair and/or replacement of the equipment; and
  - (d) Return pickup by the provider.
- (2) MAA requires a dispensing provider to ensure the DME rented to a MAA client is both of the following:
- (a) In good working order; and
  - (b) Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.
- (3) MAA considers rented equipment to be purchased after twelve months' rental unless one of the following apply:
- (a) The equipment is restricted as rental only; or
  - (b) Other MAA published issuances state otherwise.
  - (4) MAA rents, but does not purchase, certain medically necessary equipment for clients. This includes, but is not limited to, the following:
    - (a) Bilirubin lights for newborns at home with jaundice; and
    - (b) Electric breast pumps.
  - (5) MAA's minimum rental period for covered DME is one day.
  - (6) If a fee-for-service (FFS) client becomes a managed care plan client, both of the following apply:
    - (a) MAA stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan; and
    - (b) The plan determines the client's continuing need for the equipment and is responsible for reimbursing the provider.
  - (7) MAA stops paying for any rented equipment effective the date of a client's death. MAA prorates monthly rentals as appropriate.
  - (8) For a client who is eligible for both Medicaid and Medicare, MAA pays only the client's coinsurance and deductibles. MAA discontinues paying client's coinsurance and deductibles for rental equipment when either of the following applies:
    - (a) The reimbursement amount reaches Medicare's reimbursement cap for the equipment; or
    - (b) Medicare considers the equipment purchased.
  - (9) MAA does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a MAA client.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1700, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-1800 Prior authorization—General policies for DME and related supplies, prosthetics, orthotics, medical supplies and related services.** (1) A provider/vendor may obtain **expedited prior authorization (EPA)** from MAA according to WAC 388-543-1900.

(2) For prior authorization requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate

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charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

(3) When MAA receives an initial request for prior authorization, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

(4) MAA authorizes BR items that require prior authorization and are listed in MAA's published issuances, including billing instructions and numbered memoranda, only if medical necessity is established and the provider furnishes all of the following information to MAA:

- (a) A detailed description of the item or service to be provided;
- (b) The cost or charge for the item;
- (c) A copy of the manufacturer's invoice, price-list or catalog with the product description for the item being provided; and
- (d) A detailed explanation of how the requested item differs from an already existing code description.

(5) MAA requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

- (a) The manufacturer's name;
  - (b) The equipment model and serial number;
  - (c) A detailed description of the item; and
  - (d) Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.
- (6) MAA prior authorizes payment for repair and modification of client-owned equipment only when the criteria in subsection (1) of this section are met. Requests for repairs must include the information listed in subsection (5) of this section.

(7) MAA does not reimburse for purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the requesting provider makes such a request, MAA requires the provider to submit for prior authorization and explain the following:

- (a) Why the existing equipment no longer meets the client's medical needs; or
- (b) Why the existing equipment could not be repaired or modified to meet those medical needs.

(8) MAA informs the provider and the client of a less costly alternative from MAA's manufacturers' literature on file when an MAA denial of a request is based on a less costly, equally effective alternative.

(9) A provider may resubmit a request for prior authorization for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

(10) MAA authorizes rental equipment for a specific period of time. The provider must request authorization from MAA for any extension of the rental period.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1800, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-1900 Expedited prior authorization criteria for DME and related supplies, prosthetics, orthotics, medical supplies, and related services.** (1) The expedited prior authorization process (EPA) is designed to

eliminate the need for written and telephonic requests for prior authorization for selected DME procedure codes. MAA allows payment during a continuous twelve-month period for this process.

(2) MAA requires a provider to create an authorization number for EPA for selected DME procedure codes. The process and criteria used to create the authorization number is explained in MAA published DME-related billing instructions. The authorization number must be used when the provider bills MAA.

(3) The written or telephonic request for prior authorization process must be used when a situation does not meet the criteria for a selected DME code or a requested rental exceeds the limited rental period indicated.

(4) Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA in subsection (2) of this section.

(5) MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1900, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-2000 Wheelchairs.** (1) MAA bases its decisions regarding requests for wheelchairs on medical necessity and on a case-by-case basis.

(2) The following apply when MAA determines that a wheelchair is medically necessary for six months or less:

- (a) If the client lives at home, MAA rents a wheelchair for the client; or
- (b) If the client lives in a nursing facility, the nursing facility must provide a **house wheelchair** as part of the per diem rate paid by AASA.

(3) MAA considers rental or purchase of a **manual wheelchair** for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. MAA determines the type of manual wheelchair based on the following:

- (a) A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities;
- (b) A standard lightweight wheelchair if the client's medical condition is such that the client:
  - (i) Cannot self-propel a standard weight wheelchair; or
  - (ii) Requires custom modifications that cannot be provided on a standard weight wheelchair.
- (c) A high-strength lightweight wheelchair for a client:
  - (i) Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or
  - (ii) Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.

(d) A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

- (i) Support a person weighing up to three hundred pounds; or
- (ii) Accommodate a seat width up to twenty-two inches wide (not to be confused with custom heavy duty wheelchairs).

(e) A custom heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing over three hundred pounds; or

(ii) Accommodate a seat width over twenty-two inches wide.

(f) A rigid wheelchair for a client:

(i) With a medical condition that involves severe upper extremity weakness;

(ii) Who has a high level of activity; and

(iii) Who is unable to self-propel any of the above categories of wheelchair.

(g) A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the above categories of wheelchairs.

(4) MAA considers a **power-drive wheelchair** when the client's medical needs cannot be met by a less costly means of mobility. The prescribing physician must certify that the client can safely and effectively operate a power-drive wheelchair and that the client meets all of the following conditions:

(a) The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category; and

(b) A power-drive wheelchair will provide the client the only means of independent mobility; or

(c) A power-drive wheelchair will enable a child to achieve age-appropriate independence and developmental milestones.

(d) All other circumstances will be considered based on medical necessity and on a case-by-case basis.

(e) The following additional information is required for a three or four-wheeled power-drive scooter/cart:

(i) The prescribing physician certifies that the client's condition is stable; and

(ii) The client is unlikely to require a standard power-drive wheelchair within the next two years.

(5) MAA considers the power-drive wheelchair to be the client's primary chair when the client has both a power-drive wheelchair and a manual wheelchair.

(6) In order to consider purchasing a wheelchair, MAA requires the provider to submit the following information from the prescribing physician, physical therapist, or occupational therapist:

(a) Specific medical justification for the make and model of wheelchair requested;

(b) Define the degree and extent of the client's impairment (such as stage of decubitus, severity of spasticity or flaccidity, degree of kyphosis or scoliosis); and

(c) Documented outcomes of less expensive alternatives (aids to mobility) that have been tried by the client.

(7) In addition to the basic wheelchair, MAA may consider wheelchair accessories or modifications that are specifically identified by the manufacturer as separate line item charges. The provider must submit specific medical justification for each line item, with the modification request.

(8) MAA considers wheelchair modifications to a medically necessary wheelchair when the provider submits all of the following with the modification request:

(a) The make, model, and serial number of the wheelchair to be modified;

(b) The modification requested; and

(c) Specific information regarding the client's medical condition that necessitates the modification.

(9) MAA may consider wheelchair repairs to a medically necessary wheelchair; the provider must submit to MAA the make, model, and serial number of the wheelchair for which the repairs are requested.

(10) MAA may cover two wheelchairs, a manual wheelchair and a power-drive wheelchair, for a noninstitutionalized client in certain situations. One of the following must apply:

(a) The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radii;

(b) The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness;

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities; the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. In these cases, MAA requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home; and

(ii) Cabulance, public buses, or personal transit are neither available, practical, nor possible for financial or other reasons.

(iii) All other circumstances will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2000, filed 12/13/00, effective 1/13/01.]

#### **WAC 388-543-2100 Wheelchairs—Reimbursement methodology.**

(1) MAA reimburses a DME provider for purchased wheelchairs for a home or nursing facility client based on the specific brand and model of wheelchair dispensed. MAA decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:

(a) The client's medical needs;

(b) Product quality;

(c) Cost; and

(d) Available alternatives.

(2) For HCPCS codes for wheelchair rentals and wheelchair accessories (e.g., cushions and backs), MAA uses the Medicare fees that are current on April 1 of each year.

(3) For state-assigned procedure codes, including those listed as BR, for wheelchairs and wheelchair accessories, MAA's maximum allowable reimbursement is based on a percentage of the manufacturer's list price in effect on January 31 of the **base year**, or the invoice for the specific item. This applies to the following:

(a) For basic standard wheelchairs, sixty-five percent;

(b) For add-on accessories and parts, eighty-four percent;

(c) For upcharge modifications and cushions, eighty percent;

(d) For all other manual wheelchairs, eighty percent; and

(e) For all other power-drive wheelchairs, eighty-five percent.

(4) MAA determines rental reimbursement for categories of manual and power-driven wheelchairs based on average market rental rates or Medicare rates.

(5) MAA evaluates and updates the wheelchair fee schedule once per year.

(6) MAA implements wheelchair rate changes on April 1 of the base year, and the rates are effective until the next rate change.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2100, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-2200 Speech generating devices (SGD).** (1) MAA considers all requests for speech generating devices (SGDs) on a case-by-case basis. The SGD requested must be for a severe expressive speech impairment, and the medical condition must warrant the use of a device to replace verbal communication (e.g., to communicate medical information).

(2) In order for MAA to cover an SGD, the SGD must be a speech device intended for use by the individual who has a severe expressive speech impairment, and have one of the following characteristics. For the purposes of this section, MAA uses the Medicare definitions for "digitized speech" and "synthesized speech" that were in effect as of April 1, 2002. The SGD must have:

(a) Digitized speech output, using pre-recorded messages;

(b) Synthesized speech output requiring message formation by spelling and access by physical contact with the device; or

(c) Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access.

(3) MAA requires a provider to submit a prior authorization request for SGDs. The request must be in writing and contain all of the following information:

(a) A detailed description of the client's therapeutic history, including, at a minimum:

(i) The medical diagnosis;

(ii) A physiological description of the underlying disorder;

(iii) A description of the functional limitations; and

(iv) The prognosis for improvement or degeneration.

(b) A written assessment by a licensed speech language pathologist (SLP) that includes all of the following:

(i) If the client has a physical disability, condition, or impairment that requires equipment, such as a wheelchair, or a device to be specially adapted to accommodate an SGD, an assessment by the prescribing physician, licensed occupational therapist or physical therapist;

(ii) Documented evaluations and/or trials of each SGD that the client has tried. This includes less costly types/models, and the effectiveness of each device in promoting the cli-

ent's ability to communicate with health care providers, caregivers, and others;

(iii) The current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;

(iv) An assessment of whether the client's daily communication needs could be met using other natural modes of communication;

(v) A description of the functional communication goals expected to be achieved, and treatment options;

(vi) Documentation that the client's speaking needs cannot be met using natural communication methods; and

(vii) Documentation that other forms of treatment have been ruled out.

(c) The provider has shown or has demonstrated all of the following:

(i) The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;

(ii) The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and

(iii) The client's treatment plan includes a training schedule for the selected device.

(d) A prescription for the SGD from the client's treating physician.

(4) MAA may require trial-use rental. All rental costs for the trial-use will be applied to the purchase price.

(5) MAA covers SGDs only once every two years for a client who meets the criteria in subsection (3) of this section. MAA does not approve a new or updated component, modification, or replacement model for a client whose SGD can be repaired or modified. MAA may make exceptions to the criteria in this subsection based strictly on a finding of unforeseeable and significant changes to the client's medical condition. The prescribing physician is responsible for justifying why the changes in the client's medical condition were unforeseeable.

(6) Clients who are eligible for both Medicare and Medicaid must apply first to Medicare for an SGD. If Medicare denies the request and the client requests an SGD from MAA, MAA evaluates the request based on medical necessity and the requirements in this section. The request for an SGD must meet the authorization requirements in this section.

[Statutory Authority: RCW 74.08.090, 74.09.530. 02-16-054, § 388-543-2200, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-2200, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-2300 Bathroom/shower equipment.**

(1) MAA considers a caster-style shower commode chair as the primary option for clients.

(2) MAA considers a wheelchair-style shower commode chair only if the client meets both of the following:

(a) Is able to propel the equipment; and

(b) Has special positioning needs that cannot be met by a caster-style chair.

(3) All other circumstances will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2300, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-2400 Hospital beds.** (1) Beds covered by MAA are limited to hospital beds for rental or purchase. MAA bases the decision to rent or purchase a manual, semi-electric, or full electric hospital bed on the length of time the client needs the bed, as follows:

(a) MAA initially authorizes a maximum of two months rental for a short-term need. Upon request, MAA may allow limitation extensions as medically necessary;

(b) MAA determines rental on a month-to-month basis if a client's prognosis is poor;

(c) MAA considers a purchase if the need is for more than six months;

(d) If the client continues to have a medical need for a hospital bed after six months, MAA may approve rental for up to an additional six months. MAA considers the equipment to be purchased after a total of twelve months' rental.

(2) MAA considers a manual hospital bed the primary option when the client has full-time caregivers.

(3) MAA considers a full electric hospital bed only if the client meets all of the following criteria:

(a) The client's medical need requires the client to be positioned in a way that is not possible in a regular bed;

(b) The position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);

(c) The client's medical condition requires immediate position changes;

(d) The client is able to operate the controls independently; and

(e) The client needs to be in the **Trendelenburg position**.

(4) All other circumstances for hospital beds will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2400, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-2500 Reimbursement methodology for other durable medical equipment.** (1) For the purposes of this section, MAA uses the following terms:

(a) **"Other durable medical equipment (other DME)"** means all durable medical equipment, excluding wheelchairs and related items.

(b) **"Pricing cluster"** means a group of discounted manufacturers' list prices and/or dealer's costs for brands/models of other DME that MAA uses to calculate the reimbursement rate for a procedure code that does not have a fee established by Medicare. MAA uses the discounted manufacturer list price for a brand/model unless that price is not available.

(2) MAA establishes reimbursement rates for purchased other DME.

(a) For HCPCS procedure codes that have a Medicare rate established for a new purchase, MAA uses the rate that is in effect on January first of the year in which MAA sets the reimbursement.

(b) For all other procedure codes, MAA uses a pricing cluster to establish the rate.

(3) Establishing a pricing cluster and reimbursement rates.

(2003 Ed.)

(a) In order to make up a pricing cluster for a procedure code, MAA determines which brands/models of other DME its clients most frequently use. MAA obtains prices for these brands/models from manufacturer catalogs or commercial data bases. MAA may change or otherwise limit the number of brands/models included in the pricing cluster, based on the following:

(i) Client medical needs;

(ii) Product quality;

(iii) Introduction of new brands/models;

(iv) A manufacturer discontinuing or substituting a brand/model; and/or

(v) Cost.

(b) If a manufacturer list price is not available for any of the brands/models used in the pricing cluster, MAA calculates the reimbursement rate at the manufacturer's published cost to providers plus a thirty-five percent mark-up.

(c) For each brand used in the pricing cluster, MAA discounts the manufacturer's list price by twenty percent.

(i) If six or more brands/models are used in the pricing cluster, MAA calculates the reimbursement rate at the seventieth percentile of the pricing cluster.

(ii) If five brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the fourth highest discounted list price, as described in (b) of this subsection.

(iii) If four brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in (b) of this subsection.

(iv) If three brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in (b) of this subsection.

(v) If two or fewer brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the highest discounted list price, as described in (b) of this subsection.

(4) Rental reimbursement rates for other DME.

(a) MAA sets monthly rental rates at one-tenth of the purchase reimbursement rate as it would be calculated as described in subsections (2) and (3) of this section.

(b) MAA sets daily rental rates at one-three hundredth of the purchase reimbursement rate as it would be calculated as described in subsections (2) and (3) of this section.

(5) MAA annually evaluates and updates reimbursement rates for other DME.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2500, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-2600 Prosthetics and orthotics.** (1) MAA reimburses for prosthetics and orthotics to licensed prosthetic and orthotic providers only. This does not apply to:

(a) Selected prosthetics and orthotics that do not require specialized skills to provide; and

(b) Out-of-state providers, who must meet the licensure requirements of that state.

(2) MAA does not cover prosthetics dispensed for purely cosmetic reasons.

(3) MAA covers a replacement prosthesis only when the purchase of a replacement prosthesis is less costly than repairing or modifying a client's current prosthesis.

(4) MAA requires the client to take responsibility for routine maintenance of a prosthetic or orthotic. If the client

does not have the physical or mental ability to perform the task, MAA requires the client's caregiver to be responsible. MAA authorizes extensive maintenance that the manufacturer recommends be performed by an authorized dealer.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2600, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-2700 Prosthetics and orthotics—Reimbursement.** (1) MAA determines reimbursement for prosthetics and orthotics according to a set fee schedule. MAA considers Medicare's current fee schedule when determining maximum allowable fees. For BR codes, MAA reimburses eighty-five percent of the agreed upon fee.

(2) MAA's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds.

(3) MAA's hospital reimbursement rate includes any prosthetics and/or orthotics required for surgery and/or placed during the hospital stay.

(4) MAA evaluates and updates the maximum allowable fees for prosthetics and orthotics at least once per year, independent of scheduled legislatively authorized vendor rate increases. Rates remain effective until the next rate change.

(5) Reimbursement for prosthetics and orthotics is limited to HCPCS/National Codes with the same level of coverage as Medicare.

(6) Reimbursement for gender dyphoria surgery includes payment for all related prosthetics and supplies.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2700, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-2800 Reusable and disposable medical supplies.** (1) MAA requires that a physician prescribe reusable and disposable medical supplies. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being 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.]

**WAC 388-543-2900 Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology.** (1) MAA determines rates for each category of medical supplies and non-DME (MSE) using either the:

- (a) Medicare fee schedule; or
- (b) Manufacturers' catalogs and commercial data bases for price comparisons.

(2) MAA evaluates and updates the maximum allowable fees for MSE as follows:

(a) For HCPCS MSE codes, MAA considers the current Medicare fee schedule;

(b) For all MSE with state-assigned procedure codes, when the legislature mandates a vendor rate increase or decrease.

(c) MAA sets the maximum allowable fees for new MSE using one of the following:

- (i) Medicare's fee schedule; or
- (ii) For those items without a Medicare fee, commercial data bases to obtain all brands to make up MAA's pricing cluster. MAA establishes the fee for products in the pricing cluster by using the lesser of either:

(A) Eighty-five percent of the average manufacturer's list price; or

(B) One hundred twenty-five percent of the average dealer cost.

(d) All the brands for which MAA obtains pricing information make up MAA's pricing cluster. However, MAA may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients. MAA considers all of the following:

- (i) A client's medical needs;
- (ii) Product quality;
- (iii) Cost; and
- (iv) Available alternatives.

(3) MAA's nursing facility per diem rate includes any reusable and disposable medical supplies that may be required for a nursing facility client. MAA may reimburse the following medical supplies separately for a client in a nursing facility:

(a) Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to the following:

- (i) Colostomy and other ostomy bags and necessary supplies; and
- (ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies;



(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony; and

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks after surgery.

(4) MAA considers decubitus care products to be included in the nursing facility per diem rate and does not reimburse for these separately.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2900, filed 12/13/00, effective 1/13/01.]

**WAC 388-543-3000 DME and supplies provided in physician's office.** MAA does not pay a DME provider for medical supplies used in conjunction with a physician office visit. MAA pays the office physician for these supplies, as stated in the RBRVS, when it is appropriate.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-3000, filed 12/13/00, effective 1/13/01.]

**Chapter 388-544 WAC**

**VISION AND HEARING AID SERVICES**

**WAC**

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**VISION CARE**

**WAC 388-544-0050 Definitions for vision care services.** The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter. Defined words and phrases are bolded the first time they are used in the text. Unless otherwise defined in this chapter, medical terms are used as commonly defined within the scope of professional medical practice in the state of Washington.

"**Stable visual condition**" means that a client's eye condition has no acute disease or injury; or the client has reached a point after any acute disease or injury where the variation in need for refractive correction has diminished or steadied. The client's vision condition has stabilized to the extent that eyeglasses or contact lenses are appropriate and that any pre-

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scription for refractive correction is likely to be sufficient for one year or more.

"**Visual field exams or testing**" means a process to determine defects in the field of vision and tests the function of the retina, optic nerve and optic pathways. The process may include simple confrontation to increasingly complex studies with sophisticated equipment.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520, 01-01-010, § 388-544-0050, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0100 Client eligibility for vision care services.** (1) The **medical assistance administration (MAA)** covers vision care services for clients eligible for the following "scope-of-care" designations (see WAC 388-529-0100):

(a) **Categorically needy** (e.g., CNP, CHIP, children's health);

(b) **Medically needy (MNP)**; and

(c) **Medical care services (MCS or GAU/ADATSA).**

(2) MAA does not cover vision care services for clients with the following program designations:

(a) **Medically indigent (MIP)** unless the qualifying emergency medical condition is related to the eye(s);

(b) Family planning only;

(c) Any program designated "emergency medical only"; or

(d) Any other program that does not meet the conditions of subsection (1) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520, 01-01-010, § 388-544-0100, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0150 Requirements for vision care providers.** (1) The following providers are eligible to enroll/contract with MAA to provide and bill for vision care services furnished to eligible clients:

(a) Ophthalmologists/MD or DO.

(b) Optometrists; and

(c) Opticians.

(2) Enrolled/contracted eye care providers must:

(a) Meet the requirements in chapter 388-502 WAC;

(b) Provide only those services that are within the scope of the provider's license; and

(c) Obtain all hardware and contact lenses from MAA's contract suppliers.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520, 01-01-010, § 388-544-0150, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0200 Vision care services MAA covers without MAA's prior authorization.** (1) MAA covers **medically necessary** eye examinations, refractions, eyeglasses (frames and/or lenses), and fitting fees as follows:

(a) For clients who are asymptomatic and are twenty-one years of age or older, once every twenty-four months;

(b) For clients who are asymptomatic and are twenty years of age or younger, once every twelve months;

(c) For adults or children who are identified on the medical assistance identification card (MAID) as being developmentally disabled, once every twelve months;

(d) For clients on medication that affects vision, as often as is medically necessary as documented by the provider;

(e) For clients for whom the provider is diagnosing or treating a medical condition that has symptoms of vision problems or disease, as often as medically necessary. The provider must document the diagnosis and/or treatment in the client's record to justify the frequency of examinations and other services.

(2) MAA covers medically necessary **visual field exams** for the diagnosis and treatment of abnormal signs, symptoms or injuries. MAA does not reimburse visual field exams that are done by simple confrontation. Documentation in the record must show all of the following:

(a) The extent of the testing;

(b) Why the testing was reasonable and necessary for the client; and

(c) The medical basis for the frequency of testing.

(3) MAA covers medically necessary eyeglasses (frames and/or lenses as needed) according to the following:

(a) When the client's condition in both eyes is **stable** as defined in WAC 388-544-0050, Stable visual condition, and when the minimum correction need is documented and meets one of the following:

(i) Sphere power equal to or greater than plus or minus 0.50 diopters;

(ii) Astigmatism power equal to or greater than plus or minus 0.50 diopters; or

(iii) A combination of spherical power and astigmatic power that is equal to or greater than a spherical equivalent of plus or minus 0.75 diopters (the spherical equivalent means one half cylinder added algebraically to the sphere correction).

(b) MAA covers one pair of back-up eyeglasses when contact lenses are medically necessary and they are the client's primary visual correction aid as described in WAC 388-544-0400. MAA limits back-up eye glasses as follows (also see WAC 388-544-0250 (1)(e)):

(i) For clients twenty years of age or younger, once every two years;

(ii) For clients twenty-one years of age and older, once every six years; or

(iii) When MAA agrees in advance to the medical necessity and the service is provided consistent with the limitations included in MAA's authorization.

(4) MAA covers medically necessary gas permeable or daily-wear-soft contact lenses per WAC 388-544-0400.

(5) MAA covers medically necessary therapeutic contact bandage lenses per WAC 388-544-0450.

(6) MAA covers all hyperopic prescriptions for clients who are twenty years of age or younger and who have a diagnosis of "accommodative esotropia" or any strabismus correction. These clients are not subject to the requirements in subsection (3)(a) of this section (stable eye condition and minimum correction need).

(7) MAA covers medically necessary ocular orthotics/prosthetics per WAC 388-544-0500.

(8) MAA covers the following surgeries:

(a) Strabismus surgery for clients seventeen years of age and younger; and

(b) Cataract surgery per WAC 388-544-0550.

(9) MAA considers all requests for vision care services not listed as covered in this section or where requested services exceed stated limitations. MAA considers such requests under WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0200, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0250 Vision care services MAA does not cover without MAA's prior authorization.** (1) MAA evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0165.

(2) MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165 which relate to medical necessity.

(3) MAA evaluates a request for a covered service that is subject to limitation(s) or other restriction(s), and approves such a service beyond those specific limitations or restrictions when the service is medically necessary, under the standards for covered services in WAC 388-501-0165.

(4) The vision care services that MAA does not cover without MAA's prior authorization include, but are not limited to:

(a) Any of the following types of contact lenses:

(i) Disposable lenses;

(ii) Extended wear soft lenses; or

(iii) Extended wear soft toric lenses.

(b) Any eye service or hardware that MAA considers not to be medically necessary;

(c) Any eyeglasses (frames and/or lenses) or contact lenses upgraded at private expense to avoid MAA's contract limitations (e.g., frames that are not available through MAA's contract or noncontract frames or lenses for which the client or other person pays the difference between MAA's payment and the total cost) (see WAC 388-544-0300(7) and 388-544-0350(3));

(d) Bifocal additions to eyeglasses with bifocal correction of less than 1.0 diopter;

(e) Both eyeglasses and contact lenses in a two-year period for any client (see WAC 388-544-0200 (3)(b) for backup eyeglass exceptions);

(f) Eyeglasses or contact lenses when the prescribed need does not meet the minimum corrections described in this chapter;

(g) Eyeglasses or contact lenses when the prescription is over two years old;

(h) Group vision screening for eyeglasses;

(i) Lens replacements for a refractive change when the client does not have a stable visual condition as defined in WAC 388-544-0050 (see WAC 388-544-0350(1));

(j) Other vision services or hardware for persons enrolled in MAA's managed care program (Healthy Options) when the requirements of that program have not been met;

(k) Orthoptics and visual training therapy;

(l) Plano lenses (no refractive correction) for both eyes, except as provided in WAC 388-544-0350 (12)(a));

(m) Progressive additions lenses, including blended bifocals;

(n) Refractive surgery of any type (e.g., Radial Keratotomy or laser resurfacing);

(o) Separate charges for eye exams conducted in combination with emergency or operating room procedures;

(p) Strabismus surgery for a client eighteen years of age or older, unless the client meets MAA's established prior authorization criteria for correctable double vision;

(q) Sunglasses or colored/tinted lenses requested for cosmetic or other nonmedical reasons;

(r) Two pairs of eyeglasses (e.g., instead of one pair of multifocals); and

(s) Other services or hardware that do not meet the requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0250, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0300 Eyeglass frames and service.** (1) The medical assistance administration (MAA) covers pre-approved eyeglass frames through MAA's contracted supplier.

(2) MAA covers eyeglass frames, with specific time limits, for eligible clients who:

(a) Are twenty-one years of age and older, once every twenty-four months;

(b) Are twenty years of age and younger, once every twelve months;

(c) Are identified on the MAID card as being developmentally disabled (adults or children), once every twelve months;

(d) Have been unable to adjust to contact lenses after thirty days. The provider must document the client's inability to adjust and the client must return the contact lenses to the provider.

(3) MAA covers preapproved special frames called "durable and flexible frames" through MAA's contracted supplier when a client:

(a) Is diagnosed with a seizure disorder that results in frequent falls; or

(b) Has a medical condition that has resulted in two or more broken eyeglass frames in a twelve-month period (e.g., Tourette's syndrome).

(4) MAA covers replacement eyeglass frames that have been lost, broken, or stolen:

(a) For adults, only with MAA's prior authorization (see WAC 388-501-0165); and

(b) Without MAA's prior authorization for clients who are either:

(i) Twenty years of age or younger; or

(ii) Identified on the MAID care as being developmentally disabled, regardless of the client's age.

(5) MAA covers incidental repairs to a client's eyeglass frames when both of the following apply:

(a) The repair or adjustment is not typically provided to the public at no cost; and

(b) The cost of the repair does not exceed MAA's cost for replacement frames. MAA's reimbursement for repairs does not exceed its payment level for replacement frames.

(6) If the client has a medically diagnosed allergy to the materials in the available eyeglass frames, MAA covers the

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cost of coating the contact eyeglass frames to make the frames nonallergenic.

(7) MAA does not allow clients to upgrade eyeglass frames and pay only the upgrade costs in order to avoid MAA's contract limitations (see WAC 388-544-0250 (1)(c) and 388-544-0350(3)).

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0300, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0350 Eyeglass lenses and service.** (1) The medical assistance administration (MAA) covers medically necessary eyeglass lenses to correct a client's vision if both of the following apply:

(a) The condition requiring correction is a stable visual condition as defined in WAC 388-544-0050; and

(b) The prescription is less than two years old.

(2) MAA covers the following types of medically necessary eyeglass lenses:

(a) Single vision lenses;

(b) Round or flat top D-style bifocals;

(c) Trifocals that are twenty-five or twenty-eight millimeters;

(d) Slab-off and prism lenses (including Fresnel lenses); and

(e) Glass lenses fifty-four millimeters and smaller.

(3) For clients who own their own serviceable eyeglass frames and request lenses only, MAA covers these requests if the lenses are medically necessary and the size and style of the required lens(es) meet MAA's contract requirements.

(4) MAA covers medically necessary lens replacements without regard to time limits when (a), (b), and (c) of this subsection apply:

(a) One of the following caused the vision change:

(i) Eye surgery;

(ii) The effect(s) of prescribed medication; or

(iii) One or more diseases;

(b) Both the eye condition and the treatment have stabilized as defined in WAC 388-544-0050, Stable visual condition; and

(c) The lens correction has at least one diopter difference between the old and new prescriptions.

(5) MAA covers lens replacement for lost or broken lenses according to the same standards as frames in WAC 388-544-0300 (2) and (4).

(6) MAA allows bifocal lenses to be replaced with single vision lenses or trifocal lenses to be replaced with bifocals or single vision lenses when all of the following apply:

(a) A client has attempted to adjust to the bifocals or trifocals for at least sixty days;

(b) The client is unable to make the adjustment; and

(c) The bifocal or trifocal lenses being replaced are returned to the provider.

(7) MAA covers plastic executive bifocals or trifocals only for clients who are diagnosed with:

(a) Accommodative esotropia; or

(b) Strabismus.

(8) MAA covers high index lenses when the client requires a refractive correction of plus or minus eight diopters or greater.

(9) MAA covers the tinting of plastic lenses when:

(a) The client's medical need is diagnosed and documented as a chronic eye condition causing photophobia; and

(b) The tinting is done by MAA's contracted lens supplier.

(10) MAA covers glass photochromatic lenses when the client's medical need is diagnosed and documented as related to either (a) or (b) of this subsection:

(a) Ocular albinism; or

(b) Blindness, defined as:

(i) Visual acuity for distance vision of twenty/two hundred or worse in the better eye with best correction; or

(ii) A limitation of the client's visual field (widest diameter) subtending an angle of less than twenty degrees from central.

(11) MAA covers treating plastic lenses for scratch resistance only when the client is either:

(a) Twenty years or age or younger; or

(b) Identified on the MAID card as being developmentally disabled.

(12) MAA covers polycarbonate lenses when a client is any of the following:

(a) Blind in one eye as defined in subsection (10) of this section and the client needs protection for the other eye, regardless of whether a vision correction is required;

(b) Twenty years of age or younger and diagnosed with strabismus or amblyopia; or

(c) Identified on the MAID card as being developmentally disabled.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0350, filed 12/6/00, effective 1/6/01.]

#### **WAC 388-544-0400 Contact lenses and services.** (1)

The medical assistance administration (MAA) covers gas permeable or daily wear soft contact lenses as the client's primary refractive correction method if a client has a vision correction of plus or minus 6.0 diopters or greater.

(2) MAA does not cover contact lenses if the client's ocular condition makes it medically inadvisable (contraindicated) for the client to use contact lenses.

(3) MAA covers contact lens replacements:

(a) Once every twelve months for normal replacement; or

(b) When the contact lenses are lost or damaged, with the following limitations:

(i) The prescription must not be over seventeen months old; and

(ii) The date of dispensing for the lost or damaged lenses must not be within the past eleven months.

(4) MAA does not cover contact lenses for a patient who has received MAA-covered eyeglasses within the past two years unless the provider:

(a) Documents the medical necessity to MAA's satisfaction; and

(b) Receives prior authorization from MAA.

(5) MAA covers soft toric contact lenses (daily wear) for clients with astigmatism requiring a correction equal to or greater than one diopter (plus or minus).

(6) MAA covers lenticular, aspheric and myodisc contact lenses when the client has one or more of the following:

(a) Multiple cataract surgeries on the same eye;

(b) Aphakia;

(c) Keratoconus with refractive error of plus or minus ten diopters; or

(d) Corneal softening (e.g., bullous keratopathy).

(7) MAA covers contact lenses when:

(a) The client has high anisometropia (the eyes have refractive errors that differ, left to right, by plus or minus three diopters or greater); and

(b) Eyeglasses cannot reasonably correct the refractive errors.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0400, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0450 Therapeutic contact bandage lenses.** The medical assistance administration (MAA) covers therapeutic contact bandage lenses only when needed immediately after:

(1) Eye injury; or

(2) Eye surgery.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0450, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0500 Ocular prosthetics.** The medical assistance administration (MAA) covers ocular prosthetics which are medically necessary and provided by any of the following:

(1) An ophthalmologist;

(2) An ocularist; or

(3) An optometrist who specializes in orthotics.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0500, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0550 Cataract surgery.** (1) MAA covers cataract surgery when:

(a) It is included in the scope of care for the client's medical program;

(b) It is medically necessary; and

(c) The provider clearly documents the need in the client's record.

(2) MAA considers the surgery medically necessary when the client has:

(a) Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or

(b) One or more of the following conditions:

(i) Dislocated or subluxated lens;

(ii) Intraocular foreign body;

(iii) Ocular trauma;

(iv) Phacogenic glaucoma;

(v) Phacogenic uveitis; or

(vi) Phacoanaphylactic endophthalmitis.

(3) MAA covers cataract surgery as a nonemergent procedure under any of its medical coverage programs, unless the client is diagnosed as being statutorily blind as defined in WAC 388-544-0350 (10)(b). If the client is blind, the need for cataract surgery is emergent and the cataract surgery is covered by MAA, even if the client is eligible only for medically indigent coverage (MIP).

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0550, filed 12/6/00, effective 1/6/01.]

**WAC 388-544-0600 Payment methodology.** (1) The medical assistance administration (MAA) covers one hundred percent of the MAA contract price for eyeglass frames, lenses, and contact lenses when these items are obtained through MAA's approved contract(s).

(2) See WAC 388-531-1850 for professional fee payment methodology.

[Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0600, filed 12/6/00, effective 1/6/01.]

## HEARING AID SERVICES

**WAC 388-544-1010 Definitions. "Expedited prior authorization"** (EPA) means a process designed by MAA to eliminate the need for written prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies these criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

**"FM systems"** means a hearing device that uses a frequency modulated radio signal. FM systems are sometimes referred to as radio frequency (RF) aids.

**"Limitation extension"** (LE) means prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in MAA billing instructions.

**"Maximum allowable fee"** means the maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

**"Prior authorization"** means MAA and/or department of health approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1010, filed 11/15/00, effective 12/16/00.]

### WAC 388-544-1100 Hearing aid services—General.

(1) MAA covers only the hearing aid services listed in this chapter, subject to the exceptions, restrictions, and limitations listed in this chapter.

(2) MAA evaluates requests for services listed as non-covered or subject to limitations or restrictions according to the provisions in WAC 388-501-0165.

(3) MAA reimburses providers at the maximum allowable rates established by MAA.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1100, filed 11/15/00, effective 12/16/00.]

**WAC 388-544-1200 Hearing aid services—For adults.** This section applies to medical assistance clients eighteen years of age or older:

(1) MAA covers the purchase of one new, nonrefurbished hearing aid for an adult client every five years if all of the following conditions are met:

- (a) The client must be:
  - (i) Eighteen years of age or older; and

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(ii) Eligible for the categorically needy program or the medical care services program.

(b) The client must either:

(i) Have an average hearing of fifty decibel hearing level (dBHL) in the better ear based on auditory screening by a certified audiologist or licensed hearing instrument fitter/dispenser at one thousand, two thousand, three thousand, and four thousand Hertz (Hz) with effective masking as indicated; or

(ii) Be referred by a screening provider under the Healthy Kids/early and periodic screening, diagnosis, and treatment (EPSDT) program (only for clients eighteen to twenty years old).

(c) The client's current hearing aid, if the client has one, is not sufficient for the hearing loss in the better ear.

(d) The hearing aid must be:

(i) Medically necessary as defined in WAC 388-500-0005; and

(ii) Warranted for one year.

(2) Reimbursement for hearing aids includes:

(a) A prefitting evaluation;

(b) An ear mold; and

(c) A minimum of three post-fitting consultations.

(3) MAA covers the repair of a hearing aid when the:

(a) Initial one-year warranty has expired;

(b) Client continues to meet the criteria in subsection (1) of this section;

(c) Cost of repair is less than fifty percent of the cost of a new hearing aid;

(d) Provider has documented the repair and replacement costs; and

(e) Repair is warranted for ninety days.

(4) MAA covers the cost of renting a hearing aid for up to two months while the client's own hearing aid is being repaired.

(5) MAA covers one replacement hearing aid in a five year period when the:

(a) Hearing aid is lost or broken beyond repair;

(b) Client continues to meet the criteria in subsection (1) of this section; and

(c) Provider has documented the necessity for the replacement.

(6) MAA covers replacement of ear molds as follows:

(a) Once a year for soft ear molds; and

(b) Once every three years for hard ear molds.

(7) Prior MAA authorization is required for the following services for adults:

(a) Bone conduction hearing aids; and

(b) Binaural hearing aids.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1200, filed 11/15/00, effective 12/16/00.]

**WAC 388-544-1300 Hearing aid services—For children.** This section applies to medical assistance clients seventeen years of age or younger:

(1) MAA covers the purchase of new, nonrefurbished hearing aids for children if all of the following conditions in subsections (1)(a) and (1)(b) are met:

(a) The child must:

(i) Be seventeen years of age or under;

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(ii) Be eligible for any MAA medical program, except medically indigent program (MIP) and family planning only program; and

(iii) Have prior authorization from the child's local department of health's (DOH) children with special health care needs (CSHCN) coordinator to receive a hearing aid.

(b) The hearing aid must be:

(i) Medically necessary as defined in WAC 388-500-0005; and

(ii) Warranted for one year.

(2) Reimbursement for hearing aids includes:

(a) A prefitting evaluation;

(b) An ear mold for in-the-ear (ITE) hearing aids; and

(c) A minimum of three post-fitting consultations.

(3) MAA covers the repair of a hearing aid when the:

(a) Client's local CSHCN coordinator authorizes the repair;

(b) Initial one-year warranty has expired;

(c) Client continues to meet the criteria in subsection (1) of this section;

(d) Cost of repair is less than fifty percent of the cost of a new hearing aid;

(e) Provider has documented the repair and replacement costs; and

(f) Repair is warranted for ninety days.

(4) MAA covers the cost of renting a hearing aid while the client's own hearing aid is being repaired when the rental is authorized for ninety days.

(5) MAA covers replacement of a hearing aid when the:

(a) Client's local CSHCN coordinator authorizes the replacement;

(b) Client continues to meet the criteria in subsection (1) of this section;

(c) Hearing aid is lost or broken beyond repair; and

(d) Provider has documented the necessity for the replacement.

(6) MAA covers replacement of hard and soft ear molds when the replacement is authorized by the client's local CSHCN coordinator.

(7) All hearing aid equipment and services for children require prior authorization from the client's local CSHCN coordinator, except FM systems which require prior authorization from MAA.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1300, filed 11/15/00, effective 12/16/00.]

**WAC 388-544-1400 Hearing aid services—Noncovered services.** (1) MAA does not cover any of the following:

(a) The purchase of batteries, ear trumpets, or tinnitus maskers;

(b) Group screenings for hearing loss, except as provided under the Healthy Kids/EPSTDT program under WAC 388-534-0100;

(c) Computer-aided hearing devices used in school;

(d) Hearing aid charges reimbursed by insurance or other payer source;

(e) Digital hearing aids; or

(f) FM systems or programmable hearing aids for:

(i) Adults;

(ii) Children when the device is used in school; or

(iii) Children whose hearing loss is adequately improved with hearing aids.

(2) MAA evaluates a request for any service listed in this section according to the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1400, filed 11/15/00, effective 12/16/00.]

## Chapter 388-545 WAC

### THERAPIES

#### WAC

388-545-300	Occupational therapy.
388-545-500	Physical therapy.
388-545-700	Speech/audiology services.
388-545-900	Neurodevelopmental centers.

**WAC 388-545-300 Occupational therapy.** (1) The following providers are eligible to enroll with medical assistance administration (MAA) to provide occupational therapy services:

(a) A licensed occupational therapist;

(b) A licensed occupational therapy assistant supervised by a licensed occupational therapist; and

(c) An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

(2) Clients in the following MAA programs are eligible to receive occupational therapy services described in this chapter:

(a) Categorically needy;

(b) Children's health;

(c) General assistance unemployable (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program for emergency hospital-based services only; or

(f) Medically needy program only when the client is either:

(i) Twenty years of age or younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program (healthy kids program) as described in chapter 388-534 WAC; or

(ii) Receiving home health care services as described in chapter 388-551 WAC, subchapter II.

(3) Occupational therapy services received by MAA eligible clients must be provided:

(a) As part of an outpatient treatment program for adults and children;

(b) By a home health agency as described under chapter 388-551 WAC, subchapter II;

(c) As part of the physical medicine and rehabilitation (PM&R) program as described in WAC 388-550-2551;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education program or individualized family service plan as described in WAC 388-537-0100; or

(f) When prescribed by a provider for clients age twenty-one or older. The therapy must:

(i) Prevent the need for hospitalization or nursing home care;



(ii) Assist a client in becoming employable;  
 (iii) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(iv) Be a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(4) MAA pays only for covered occupational therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary, when prescribed by a provider; and

(c) Begun within thirty days of the date prescribed.

(5) MAA covers the following occupational therapy services per client, per calendar year:

(a) Unlimited occupational therapy program visits for clients twenty years of age or younger;

(b) One occupational therapy evaluation. The evaluation is in addition to the twelve program visits allowed per year;

(c) Two durable medical equipment needs assessments. The assessments are in addition to the twelve program visits allowed per year;

(d) Twelve occupational therapy program visits;

(e) Twenty-four additional outpatient occupational therapy program visits when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement;

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(f) Twenty-four additional occupational therapy program visits following a completed and approved inpatient PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of function due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quads only;

(ix) Bilateral limb loss; or

(x) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(g) Additional medically necessary occupational therapy services, regardless of the diagnosis, must be approved by MAA.

(6) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS), per client, per lifetime.

(7) MAA does not cover occupational therapy services that are included as part of the reimbursement for other treat-

ment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-545-300, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-16-068, § 388-545-300, filed 8/2/99, effective 9/2/99.]

**WAC 388-545-500 Physical therapy.** (1) The following providers are eligible to provide physical therapy services:

(a) A licensed physical therapist or physiatrist; or

(b) A physical therapist assistant supervised by a licensed physical therapist.

(2) Clients in the following MAA programs are eligible to receive physical therapy services described in this chapter:

(a) Categorically needy (CN);

(b) Children's health;

(c) General assistance-unemployable (GA-U) (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program (MIP) for emergency hospital-based services only; or

(f) Medically needy program (MNP) only when the client is either:

(i) Twenty years of age or younger and referred under the early and periodic screening, diagnosis and treatment program (EPSDT/healthy kids program) as described in WAC 388-86-027; or

(ii) Receiving home health care services as described in chapter 388-551 WAC.

(3) Physical therapy services that MAA eligible clients receive must be provided as part of an outpatient treatment program:

(a) In an office, home, or outpatient hospital setting;

(b) By a home health agency as described in chapter 388-551 WAC;

(c) As part of the acute physical medicine and rehabilitation (acute PM&R) program as described in the acute PM&R subchapter under chapter 388-550 WAC;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-537-0100; or

(f) For disabled children, age two and younger, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(4) MAA pays only for covered physical therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary and ordered by a physician, physician's assistant (PA), or an advanced registered nurse practitioner (ARNP);

(c) Begun within thirty days of the date ordered;

(d) For conditions which are the result of injuries and/or medically recognized diseases and defects; and

(e) Within accepted physical therapy standards.

(5) Providers must document in a client's medical file that physical therapy services provided to clients age twenty-one and older are medically necessary. Such documentation may include justification that physical therapy services:

(a) Prevent the need for hospitalization or nursing home care;

(b) Assist a client in becoming employable;

(c) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(d) Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(6) MAA determines physical therapy program units as follows:

(a) Each fifteen minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(7) MAA does not limit coverage for physical therapy services listed in subsections (8) through (10) of this section if the client is twenty years of age or younger.

(8) MAA covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year, for clients twenty-one years of age and older:

(a) One physical therapy evaluation. The evaluation is in addition to the forty-eight program units allowed per year;

(b) Forty-eight physical therapy program units;

(c) Ninety-six additional outpatient physical therapy program units when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement.

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(vi) Meningocele;

(vii) Down's syndrome;

(viii) Cerebral palsy; or

(ix) Symptoms involving nervous and musculoskeletal systems and lack of coordination;

(d) Two durable medical equipment (DME) needs assessments. The assessments are in addition to the forty-eight physical therapy program units allowed per year. Two program units are allowed per DME needs assessment; and

(e) One wheelchair needs assessment in addition to the two durable medical needs assessments. The assessment is in addition to the forty-eight physical therapy program units allowed per year. Four program units are allowed per wheelchair needs assessment.

(f) The following services are allowed, per day, in addition to the forty-eight physical therapy program units allowed per year:

(i) Two program units for orthotics fitting and training of upper and/or lower extremities.

(ii) Two program units for checkout for orthotic/prosthetic use.

(iii) One muscle testing procedure. Muscle testing procedures cannot be billed in combination with each other.

(g) Ninety-six additional physical therapy program units are allowed following a completed and approved inpatient acute PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient physical therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of functions due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quadriplegics only;

(ix) Bilateral limb loss;

(x) Open wound of lower limb; or

(xi) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(9) For clients age twenty-one and older, MAA covers physical therapy services which exceed the limitations established in subsection (8) of this section if the provider requests prior authorization and MAA approves the request.

(10) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS) per client, per lifetime.

(11) Duplicate services for occupational therapy and physical therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).

(12) MAA does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(13) MAA does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be billed by the hospital.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-545-500, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520, 00-04-019, § 388-545-500, filed 1/24/00, effective 2/24/00.]

#### **WAC 388-545-700 Speech/audiology services. (1)**

The following providers are eligible to enroll with medical assistance administration (MAA) to provide, and be reimbursed for, speech/audiology services:

(a) A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association;

(b) A speech-language pathologist who has completed the equivalent educational and work experience necessary for such a certificate;

(c) An audiologist who is appropriately licensed or registered to perform audiology services within their state of residence; and

(d) School districts or educational service districts. Services must be noted in the client's individual educational pro-

gram or individualized family service plan as described under WAC 388-537-0100.

(2) Clients in the following MAA programs are eligible to receive speech/audiology services described in this chapter:

(a) Categorically needy, children's health, general assistance unemployable, and Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) programs within Washington state or border areas only; or

(b) Medically needy program only when the client is either:

(i) Twenty years of age or under; or

(ii) Receiving home health care services as described under chapter 388-551 WAC, subchapter II;

(c) Medically indigent program only for emergency hospital-based services.

(3) MAA pays only for covered speech/audiology services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) For conditions which are the result of medically recognized diseases and defects; and

(c) Medically necessary, as determined by a health professional.

(4) The following speech/audiology services are covered per client, per calendar year, per provider:

(a) Unlimited speech/audiology program visits for clients twenty years of age and younger;

(b) One medical diagnostic evaluation for clients twenty-one years of age and older. The medical diagnostic evaluation is in addition to the twelve program visits allowed per year;

(c) One second medical diagnostic evaluation at the time of discharge for any of the following:

(i) Anoxic brain damage;

(ii) Acute, ill-defined, cerebrovascular disease;

(iii) Subarachnoid, subdural, and extradural hemorrhage following injury; or

(iv) Intracranial injury of other and unspecified nature;

(d) Twelve speech/audiology program visits for clients twenty-one years of age and older;

(e) Twenty-four additional speech/audiology visits if the speech/audiology service is for any of the following:

(i) Medically necessary conditions for developmentally delayed clients;

(ii) Neurofibromatosis;

(iii) Severe oral or motor dyspraxia;

(iv) Amyotrophic lateral sclerosis (ALS);

(v) Multiple sclerosis;

(vi) Cerebral palsy;

(vii) Quadriplegia;

(viii) Acute, infective polyneuritis (Guillain-Barre' syndrome);

(ix) Acute, but ill-defined, cerebrovascular disease;

(x) Meningomyelocele;

(xi) Cleft palate and cleft lip;

(xii) Down's syndrome;

(xiii) Lack of coordination;

(xiv) Severe aphasia;

(xv) Severe dysphagia;

(xvi) Fracture of the:

(A) Vault or base of the skull;

(B) Multiple fracture involving skull or face with other bones;

(C) Cervical column;

(D) Larynx and trachea; or

(E) Other and unqualified skull fractures;

(xvii) Head injuries as follows:

(A) Cerebral laceration and contusion;

(B) Subarachnoid, subdural, and extradural hemorrhage following injury;

(C) Other and unspecified intracranial hemorrhage following injury;

(D) Injury to blood vessels of the head and neck; or

(E) Intracranial injury of other second unspecified nature;

(xviii) Burns of:

(A) The face, head, and neck, when severe;

(B) Multiple, specified sites; or

(C) Internal organs;

(xix) Cervical spinal cord injury without evidence of spinal bone injury; or

(xx) Other speech disturbances (e.g., severe dysarthria).

(f) Additional medically necessary speech/audiology program visits beyond the initial twelve visits and additional twenty-four visits for clients twenty-one years of age and older if approved by MAA.

(5) MAA limits:

(a) Caloric vestibular testing to four units for each ear, and

(b) Sinusoidal vertical axis rotational testing to three units for each direction.

(6) MAA does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-545-700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-16-071, § 388-545-700, filed 8/2/99, effective 9/2/99.]

#### **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

388-546-0001	Definitions.
388-546-0100	The MAA transportation program.
388-546-0150	Client eligibility for ground and air ambulance transportation.
388-546-0200	Scope of coverage for ground and air ambulance.
388-546-0250	Ambulance services that MAA does not cover.
388-546-0300	General requirements for air and ground ambulance providers.
388-546-0400	General limitations to payment for ground and air ambulance services.
388-546-0450	Ground ambulance levels of service and other reimbursement.
388-546-0500	Special circumstances and payment limits for ground ambulance services.
388-546-0600	Procedure code modifiers.
388-546-0700	Specific payment limitations for air ambulance services.
388-546-0800	Payment for ground and air ambulance services outside the state of Washington.
388-546-1000	Nonemergency ground ambulance transportation.
388-546-5000	Nonemergency transportation program definitions.
388-546-5100	Nonemergency transportation program scope of coverage.
388-546-5200	Nonemergency transportation program broker and provider requirements.
388-546-5300	Nonemergency transportation program client requirements.
388-546-5400	Nonemergency transportation program general reimbursement limitations.
388-546-5500	Modifications of privately owned vehicles.

**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 medi-

cal 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.]

(2003 Ed.)

**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 transport

[Title 388 WAC—p. 926]

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

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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 non-emergency 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 requirements 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 non-emergency ground ambulance transportation as medical services.

(2) Licensed ambulance providers, who contract with MAA's transportation brokers, may be reimbursed for non-emergency 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 nonemergency 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 neces-

sary, 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

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

388-550-2300 Payment—PM&R. [Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2300, filed 12/18/97, effective 1/18/98.] Repealed by 99-17-111, filed 8/18/99, effective 9/18/99. Statutory Authority: RCW 74.08.090 and 74.09.520.  
 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 388-550-1000 Applicability.** The department shall pay for hospital services provided to eligible clients when:

- (1) The eligible client is a patient in a general hospital and the hospital meets the definition in RCW 70.41.020;
- (2) The services are medically necessary as defined under WAC 388-500-0005; and
- (3) The conditions, exceptions and limitations in this chapter are met.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1000, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1050 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.

(2003 Ed.)

**"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 med-

ical 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 services. The amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the state plan); and

(4) The denominator D is the hospital's total charge for inpatient hospital services in the same period as the numerator.

**"Major diagnostic category (MDC)"** means one of the twenty-five mutually exclusive groupings of principal diagnosis areas in the DRG system. The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

**"Market basket index"** - See **"hospital market basket index."**

**"Medicaid"** 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.

**"Spendedown"** 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 (spendedown) 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 (HCFA) 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 non-participating 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 388-550-1200 Limitations on hospital coverage.** Hospital coverage under the medical assistance fee for service program is limited for certain eligible clients. This coverage includes, but is not limited to the following:

(1) Medical care clients enrolled with the department's healthy options carriers are subject to the respective carrier's policies and procedures for coverage of hospital services;

(2) Medical care clients covered by primary care case management are subject to the clients' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for clients described in subsection (2) and (3) of this section, see WAC 388-538-100.

(4) Coverage for medically indigent (MI) clients is limited to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter:

(a) Out-of-state care, hospital or other medical, is not covered for clients under the MI program; and

(b) Border areas are considered in-state.

(5) Out-of-state medical care is not covered for clients under the medical care services program.

(6) See WAC 388-550-1100(3) for chemical-dependent pregnant clients.

(7) Only Medicaid categorically needy and medically needy clients under twenty-one years of age, or sixty-five years of age or older may receive care in a state mental institution or approved psychiatric facility.

(8)(a) For clients eligible for both Medicare and Medicaid hospitalization, MAA pays deductibles and coinsurance, unless the client has exhausted his or her Medicare Part A benefits.

(i) MAA payment is limited in amount so that when added to the Medicare payment, the total amount is no more than what the department pays for the same service when provided to a Medicaid eligible, non-Medicare client.

(ii) Providers must accept the total Medicare/Medicaid amount as payment in full.

(iii) Beneficiaries are not liable for any additional charges billed by providers or by a managed care entity.

(iv) Providers or managed care entities that charge beneficiaries excess amounts are subject to sanctions.

(b) If such benefits are exhausted, the department pays for hospitalization for such clients subject to MAA rules.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-1200, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1300 Revenue code categories and subcategories.** (1) For reimbursement and audit purposes, hospitals shall report and bill all services provided to a medical care client under the appropriate cost centers or revenue codes, except the following services which are subject to current procedural terminology codes and rates when provided in an outpatient setting:

(a) Laboratory/pathology;

(b) Radiology, diagnostic and therapeutic;

(c) Nuclear medicine;

(d) Computerized tomography scans, magnetic resonance imaging, and other imaging services;

(e) Physical therapy;

(f) Occupational therapy;

(g) Speech/language therapy; and

(h) Other hospital services as identified and published by the department.

(2) Revenue code categories in this chapter shall be as listed in the state of Washington's UB-92 procedure manual, implemented October 1, 1993, which was patterned after the national uniform billing data element specifications adopted by the national uniform billing committee.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1300, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1400 Covered revenue codes for hospital services.** (1) The department shall cover the following revenue code categories for both inpatient and outpatient hospitalizations:

(a) "Pharmacy," except that:

(i) Subcategories "take-home drugs," "experimental drugs," and "other pharmacy" are not covered; and

(ii) Subcategory "nonprescription" is covered for inpatients only;

(b) "Intravenous (IV) therapy," except subcategory "other IV therapy";

(c) "Medical/surgical supplies and devices," except for the following subcategories:

(i) "Take home supplies";

(ii) "Prosthetic devices";

(iii) "Oxygen - take home"; and

(iv) "Other supplies/devices."

(d) "Oncology," except subcategory "other oncology";

(e) "Respiratory services," except subcategory "other respiratory services";

(f) Subcategories "general classification" and "minor surgery" under the "operating room services" category;

(g) "Anesthesia," except subcategories "acupuncture" and "other anesthesia";

(h) "Blood storage and processing," except subcategory "other blood storage and processing";

(i) "Other imaging services," except subcategory "other image services";

(j) "Emergency room," except subcategory "other emergency room";

(k) "Pulmonary function," except subcategory "other pulmonary function";

(l) "Cardiology," except subcategory "other cardiology";

(m) "Magnetic resonance imaging (MRI)," except subcategory "other MRI";

(n) "Cast room," except subcategory "other cast room";

(o) "Recovery room," except subcategory "other recovery room";

(p) "Labor room/delivery," except for subcategories "circumcision" and "other labor room/delivery";

(q) "EKG/ECG (electrocardiogram)," except subcategory "other EKG/ECG";

(r) "EEG (electroencephalogram)," except subcategory "other EEG";

(s) "Gastrointestinal services," except subcategory "other gastroenteritis";

(t) "Treatment or observation room," except subcategory "other treatment room";

(u) "Lithotripsy," except subcategory "other lithotripsy";

and  
(v) "Organ acquisition," except for subcategories "unknown donor" and "other organ."

(2) Except for certain services, such as inpatient hospice services covered by MAA pursuant to other rules, the department shall cover the following revenue code categories and/or subcategories for inpatient hospitalizations only:

(a) "Room and board - private, medical, or general," except subcategory "hospice";

(b) "Semi-private room and board" (two to four beds), except subcategory "hospice";

(c) "Nursery for newborns and premature babies";

(d) "Intensive care," except subcategory "post-ICU";

(e) "Coronary care," except subcategory "post-CCU";

(f) "Laboratory," except subcategory "renal patient (home)";

(g) "Laboratory pathological";

(h) "Radiology," both "diagnostic" and "therapeutic";

(i) "Nuclear medicine";

(j) "Physical therapy," "occupational therapy," and "speech-language therapy";

(k) "CT (computed tomographic) scans";

(l) "Operating room services," subcategories "organ transplant other than kidney" and "kidney transplant only";

(m) "Clinic," subcategory "chronic pain center" only;

(n) "Ambulance," subcategory "neonatal ambulance services (support crews)" only;

(o) "Other donor bank" category, except that subcategories "peripheral blood stem cell harvesting" and "reinfusion" are limited only to facilities approved by the medical assistance administration (MAA).

In addition to specifically excluded subcategories, the subcategory "other" in each category shall not be covered.

(3) Except for certain services, such as inpatient hospice services covered by MAA pursuant to other rules, the department shall cover the following revenue code categories for outpatient hospital services only:

(a) "Ambulatory surgical care";

(b) "Outpatient services";

(c) Subcategories "general classification" and "dental clinic," under "clinic";

(d) Subcategory "rural health clinic," under "free-standing clinic";

(e) "Drugs requiring specific identification," except covered only for certified kidney centers;

(f) "Hospice services";

(g) "Respite care";

(h) "Inpatient renal dialysis";

(i) "Hemodialysis - outpatient or home";

(j) "Peritoneal dialysis - outpatient or home";

(k) "Continuous ambulatory peritoneal dialysis - outpatient or home";

(l) "Continuous cycling peritoneal dialysis - outpatient or home";

(m) "Miscellaneous dialysis";

(n) Subcategories "education/training" and "weight loss," under the "other therapeutic services" category, except limited to facilities approved by MAA.

In addition to specifically excluded subcategories, the subcategory "other" in each category shall not be covered.

(4) The department shall cover the following revenue code categories and/or subcategories subject to the following specific limitations:

(a) The "private (deluxe)" and "room and board - ward" categories shall be reimbursed at the semi-private hospital room rates.

(b) All inpatient psychiatric services shall be subject to the policies and procedures of the mental health division, and reimbursed only to department-approved psychiatric facilities. See chapter 246-318 WAC. Inpatient psychiatric revenue codes include, but are not limited to:

(i) The subcategory "psychiatric" under all "room and board" categories;

(ii) The subcategory "psychiatric" under the "intensive care" category;

(iii) The "psychiatric/psychological treatments" category; and

(iv) The "psychiatric/psychological services" category.

(c) The department shall reimburse the subcategory "detoxification" under all room and board categories only to detoxification facilities approved by the division of alcohol and substance abuse.

(d) The subcategory "rehabilitation" under all "room and board" categories shall be reimbursed only to MAA-approved rehabilitation facilities.

(e) Only the subcategories "chemical-using pregnant women" and "administrative days" shall be covered in the "other room and board" category.

(f) Subcategory "nonprescription drugs" under the category "pharmacy" shall be covered for inpatient hospitalizations only. See WAC 388-550-1400 (1)(a)(ii). Certain exemptions apply for pregnant women as described in WAC

388-530-1150 (1)(d)(ii). For coverage of nonprescription drugs, see WAC 388-530-110 and 388-530-1150.

(g) The subcategories "renal patient (home)" and "non-routine dialysis" under category "laboratory" shall be reimbursed in the outpatient setting only to Medicare-certified kidney centers.

(h) Subcategory "chronic pain center" under the "clinic" category shall be reimbursed only to MAA-approved chronic pain treatment facilities.

(i) Only the subcategory "neonatal ambulance services (support crews)" under the "ambulance" category shall be covered, and only for inpatient hospitalizations.

(j) The category "drugs requiring specific identification" shall be reimbursed only for outpatients and only to Medicare-approved kidney centers.

(k) Subcategories "education/training" and "weight loss," under the "other therapeutic service" category, shall be reimbursed only to MAA-approved facilities.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-1400, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1400, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1500 Noncovered revenue codes.** (1) Revenue code subcategories titled "other" shall not be covered by the medical assistance administration (MAA), unless otherwise specified.

(2) The department shall not cover the following revenue code categories in either an inpatient or outpatient setting:

- (a) "All-inclusive rate";
- (b) "Other room and board," except as indicated in WAC 388-550-1400 (4)(e);
- (c) "Leave of absence";
- (d) "Not assigned" (all such categories);
- (e) "Special charges";
- (f) "Incremental nursing charge rate";
- (g) "All-inclusive ancillary";
- (h) "Pharmacy" subcategories for "take home" and "experimental drugs";
- (i) "Durable medical equipment (other than renal)";
- (j) "Blood" (and blood products);
- (k) "Audiology";
- (l) "Clinic," except as specified in WAC 388-550-1400 (3)(c);
- (m) "Free-standing clinic," except as specified in WAC 388-550-1400 (3)(d);
- (n) "Osteopathic services";
- (o) "Ambulance," except as specified in WAC 388-550-1400 (4)(i);
- (p) "Skilled nursing";
- (q) "Medical social services";
- (r) "Home health aide (home health)" and "other visits (home health)";
- (s) "Units of service (home health)";
- (t) "Oxygen (home health)";
- (u) "Medicare/surgical supplies";
- (v) "Home IV therapy services";
- (w) "Preventive care services";
- (x) "Other diagnostic services";
- (y) "Professional fees" (all such categories); and

(z) "Patient convenience items."

(3) The department shall not cover the following subcategories in the "other therapeutic service" category:

- (a) "General classification";
- (b) "Recreational therapy";
- (c) "Cardiac rehabilitation";

(d) "Drug rehabilitation," except under the chemically-using pregnant (CUP) women program;

(e) "Alcohol rehabilitation," except under the CUP program; and

(f) "Air fluidized support beds."

(4) The department shall not cover the following subcategories under the "free-standing clinic" category:

- (a) "General classification";
- (b) "Rural health - home";
- (c) "Family practice"; and
- (d) "Other clinic."

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1500, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1600 Specific items/services not covered.** The department shall not cover certain hospital items/services for any hospital stay including, but not limited to, the following:

- (1) Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up;
- (2) Telephone/telegraph services or television/radio rentals;
- (3) Medical photographic or audio/videotape records;
- (4) Crisis counseling;
- (5) Psychiatric day care;
- (6) Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit;
- (7) Standby personnel and travel time;
- (8) Routine hospital medical supplies and equipment such as bed scales;
- (9) Handling fees and portable X-ray charges;
- (10) Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client;
- (11) Cafeteria charges;
- (12) Services and supplies provided to nonpatients, such as meals and "father packs"; and
- (13) Standing orders. The department shall cover routine tests and procedures only if the department determines such services are medically necessary, according to the following criteria. The procedure or test:
  - (a) Is specifically ordered by the admitting physician or, in the absence of the admitting physician, the hospital staff having responsibility for the client (e.g., physician, advanced registered nurse practitioner, or physician assistant);
  - (b) Is for the diagnosis or treatment of the individual's condition; and
  - (c) Does not unnecessarily duplicate a test available or made known to the hospital which is performed on an outpatient basis prior to admission; or
  - (d) Is performed in connection with a recent admission.



[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1600, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1700 Hospital services—Prior approval.** (1) Providers of hospital-related services to clients not enrolled with the department's managed care carriers shall obtain prior approval from the medical assistance administration (MAA) for hospital services requiring prior approval. For inpatient psychiatric admissions and inpatient treatment for alcohol and other substance abuse, see chapter 246-318 and 246-326 WAC respectively.

(2) The department shall require that for medical care clients not enrolled with the department's managed care carriers, providers receive prior approval from the department for the following hospital-related services:

(a) All nonemergent admissions to or planned inpatient hospital surgeries in nonparticipating hospitals in selective contracting areas;

(b) Inpatient detoxification, medical stabilization, and drug treatment for a pregnant Medicaid client as described under WAC 388-550-1100(3);

(c) Cataract surgery that does not meet requirements in WAC 388-544-0550;

(d) The following surgical procedures, regardless of the diagnosis or place of service:

(i) Hysterectomies for clients forty-four years and younger;

(ii) Reduction mammoplasty; and

(iii) Surgical bladder repair.

(e) All physical medicine and rehabilitation (PM&R) inpatient hospital stays, even when provided by MAA-approved PM&R contract facilities (see WAC 388-550-2300);

(f) All outpatient magnetic resonance imaging and magnetic resonance angiography procedures;

(g) All nonemergent inpatient hospital transfers (see WAC 388-550-3600);

(h) All out-of-state non-emergent hospital stays;

(i) Hospital-related services as described in WAC 388-550-1800 when not provided in an MAA-approved facility; and

(j) Services in excess of the department's established limits.

(3) The department shall inform providers which diagnosis codes from the International Classification of Diseases, 9th Revision, Clinical Modification and procedure codes from physicians' current procedural terminology require prior authorization for nonemergent hospital admissions.

(4) When a client's hospitalization exceeds the number of days allowed by WAC 388-550-4300(2):

(a) The hospital shall, within sixty days after discharge, submit to MAA a request for authorization of the extra days with adequate medical justification, to include at a minimum the following:

(i) History and physical examination;

(ii) Social history;

(iii) Progress notes and doctor's orders for the entire length of stay;

(iv) Treatment plan/critical pathway; and

(v) Discharge summary.

(b) The department shall approve or deny a length of stay extension request within fifteen working days of receiving the request.

(5) The department shall require prior approval for out-of-state hospital admissions of clients not enrolled with department's managed care carriers, except for emergent hospitalizations. The department shall inform providers which codes from the current revision of ICD-9CM are designated as emergent diagnosis codes. The nature of the client's emergent medical condition must be fully documented in the client's hospital's records.

(6) The department shall not reimburse ambulance providers for ambulance transports in cases involving hospital transfers without prior authorization by the department.

(7) The department shall require that providers receive prior approval from the department for medical transportation to out-of-state treatment programs or services authorized by the department for clients not enrolled with the department's managed care carriers.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-550-1700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1700, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1750 Services requiring approval.** (1) The department shall require that for medical services clients not enrolled with the department's managed care carriers, providers receive approval from the department for the following:

(a) Hospital length-of-stay extensions, in order for the provider to receive payment for the additional hospital days;

(b) All hospital readmissions within seven days of discharge; and

(c) All hospitalizations billed under "miscellaneous diagnosis-related group (DRG)," four hundred sixty-eight.

(2) Providers shall obtain approval for:

(a) Length-of-stay extensions, during or immediately after the extension;

(b) Readmissions, immediately after the readmission; and

(c) Hospitalizations under "miscellaneous DRG," four hundred sixty-eight, immediately after the hospitalization.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1750, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1800 Services—Contract facilities.** The department shall reimburse certain services without requiring prior authorization when such services are provided in medical assistance administration (MAA)-approved contract facilities. These services include, but are not limited to, the following:

(1) All transplant procedures specified in WAC 388-550-1900(2);

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400;

(3) Polysomnograms and multiple sleep latency tests for clients one year of age and older (allowed only in outpatient hospital settings), as described under WAC 388-550-6350;

(4) Diabetes education (allowed only in outpatient hospital setting), as described under WAC 388-550-6400; and

(5) Weight loss program (allowed only in outpatient hospital setting), as described under WAC 388-550-6450.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1800, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-1900 Transplant coverage.** (1) The department shall pay for transplant procedures only for eligible clients who:

- (a) Meet the criteria in WAC 388-550-2000; and
- (b) Are not otherwise subject to a managed care plan.

(2) The department shall cover the following transplant procedures:

- (a) Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas;
- (b) Bone marrow and peripheral stem cell (PSC);
- (c) Skin grafts; and
- (d) Corneal transplants.

(3) For procedures covered under subsections (2)(a) and (b) of this section, the department shall pay facility charges only to those medical centers that meet the standards and conditions:

- (a) Established by the department; and
- (b) Specified in WAC 388-550-2100 and 388-550-2200.

(4) The department shall pay facility charges for skin grafts and corneal transplants to any qualified medical facility, subject to the limitations in this chapter.

(5) The department shall deem organ procurement fees included in the reimbursement to the transplant facility. The department may make an exception to this policy and reimburse these fees separately to a transplant facility when an eligible medical care client is covered by a third-party payer which will pay for the organ transplant procedure itself but not for the organ procurement.

(6) The department shall, without requiring prior authorization, pay for up to fifteen matched donor searches per client approved for a bone marrow transplant. The department shall require prior authorization for matched donor searches in excess of fifteen per bone marrow transplant client.

(7) The department shall not pay for experimental transplant procedures. In addition, the department shall consider experimental those services including, but not limited to, the following:

- (a) Transplants of three or more different organs during the same hospital stay;
- (b) Solid organ and bone marrow transplants from animals to humans; and
- (c) Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

(8) The department shall pay for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the

original hospital stay. The department shall cover bone marrow, PSC, skin grafts and corneal transplants whenever medically necessary.

(9) In reviewing coverage for transplant services, the department shall consider cost benefit analyses on a case-by-case basis.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1900, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-2000 Medical criteria—Transplant services.** (1) The department shall pay for transplant surgery in accordance with the provisions of this chapter for an eligible client who has:

(a) End-stage organ disease, except end-stage renal disease and diseases treatable with bone marrow or peripheral stem cell (PSC) transplants;

(b) A critical medical need for a transplant and a poor prognosis for survival without one, except for kidney, skin graft, or corneal transplants;

(c) Tried all other appropriate medical and surgical therapies that customarily yield both short and long term survival comparable to that of a transplant;

(d) Been identified by the transplant facility as a candidate for whom the transplant, as a therapy, has a high probability of a successful clinical outcome, defined as a better than sixty percent survival rate after one year; and

(e) Agreed to long-term adherence to a disciplined medical regimen.

(2) Medical care clients enrolled with the department's managed care carriers shall be subject to their respective carriers' criteria and policies.

(3) The department shall not cover transplant procedures for clients with the following medical conditions:

(a) An irreversible terminal state in which the client has had multi-organ system failure, is moribund, or on life support, defined as mechanical systems such as ventilators or heart-lung respirators which are used to supplement or support the normal autonomic functions of a person;

(b) Current active and incurable or metastatic malignancy within other organ systems;

(c) An active infection that will interfere with the client's recovery;

(d) Irreversible renal or hepatic disease that substantially affects longevity. MAA shall exempt from this criterion clients requesting a kidney, liver, bone marrow, PSC, skin graft or corneal transplant;

(e) Significant atherosclerotic vascular disease or atherosclerotic coronary disease that substantially affects longevity. MAA shall not apply this criterion to clients requesting a heart, bone marrow, PSC, skin graft or corneal transplant;

(f) Any other major irreversible disease likely to substantially limit life expectancy to three years or less;

(g) Inability to follow a drug regimen or maintain necessary therapies and/or other prescribed health care regimens;

(h) Ventilator dependence, except when used in short-term, acute situations. The department shall not consider ventilator dependence for transplants involving bone marrow, PSC, skin or cornea;

(i) Current use or history within the past year of alcohol or substance abuse and/or smoking, or failure to have abstained for long enough to indicate low likelihood of recidivism; and

(j) A history of behavior pattern or psychiatric illness that has not been assessed, treated or considered stable, that would likely lead to nonconformance or interference with a disciplined medical regimen.

(4) The department may deny coverage for corneal transplants for clients with an associated disease severe enough to prevent visual improvement, such as macular degeneration or diabetic retinopathy.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2000, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-2100 Requirements—Transplant facilities.** (1) The department shall require a transplant facility to meet the following requirements in order to be reimbursed for transplant services provided to medical care clients. The facility shall have:

(a) An approved certificate of need (CON) from the state department of health (DOH) for the type(s) of transplant procedure(s) to be performed, except that MAA shall not require CON approval for peripheral stem cell (PSC), skin graft and corneal transplant facilities;

(b) Approval from the United Network of Organ Sharing (UNOS) to perform transplants, except that MAA shall not require UNOS approval for PSC, skin graft and corneal transplant facilities; and

(c) Been approved by the department as a center of excellence transplant center for the specific organ(s) or procedure(s) the facility proposes to perform. An out-of-state transplant center shall be a Medicare-certified facility participating in that state's Medicaid program.

(2) The department shall consider a facility for approval as a transplant center of excellence when the facility submits to the department a copy of its DOH-approved CON for transplant services, or documentation that it has, at a minimum:

(a) Organ-specific transplant physicians for each organ or transplant team. The transplant surgeon and other responsible team members shall be experienced and board-certified or board-eligible practitioners in their respective disciplines, including, but not limited to, the fields of cardiology, cardiovascular surgery, anesthesiology, hemodynamics and pulmonary function, hepatology, hematology, immunology, oncology, and infectious diseases. The department shall consider this requirement met when the facility submits to the department a copy of its DOH-approved CON for transplant services;

(b) Component teams which are integrated into a comprehensive transplant team with clearly defined leadership and responsibility. Transplant teams shall include, but not be limited to:

(i) A team-specific transplant coordinator for each type of organ;

(ii) An anesthesia team available at all times;

(iii) A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients;

(iv) Pathology resources for studying and reporting the pathological responses of transplantation;

(v) Infectious disease services with both the professional skills and the laboratory resources needed to discover, identify, and manage a whole range of organisms; and

(vi) Social services resources.

(c) An organ procurement coordinator;

(d) A method ensuring that transplant team members are familiar with transplantation laws and regulations;

(e) An interdisciplinary body and procedures in place to evaluate and select candidates for transplantation;

(f) An interdisciplinary body and procedures in place to ensure distribution of donated organs in a fair and equitable manner conducive to an optimal or successful patient outcome;

(g) Extensive blood bank support;

(h) Patient management plans and protocols;

(i) Written policies safeguarding the rights and privacy of patients; and

(j) Satisfied the annual volume and survival rates criteria for the particular transplant procedures performed at the facility, as specified in WAC 388-550-2200(2).

(3) In addition to the requirements of subsection (2) of this section, a facility being considered for approval as a transplant center of excellence shall submit a copy of its approval from the United Network for Organ Sharing (UNOS), or documentation showing that the facility:

(a) Participates in the national donor procurement program and network; and

(b) Systematically collects and shares data on its transplant program(s) with the network.

(4) The department shall apply the following specific requirements to PSC transplant facilities:

(a) A PSC transplant facility may receive approval from the department to do PSC:

(i) Harvesting, if it has its own apheresis equipment which meets federal or American Association of Blood Banks (AABB) requirements;

(ii) Processing, if it meets AABB quality of care requirements for human tissue/tissue banking; and/or

(iii) Reinfusion, if it meets the criteria established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

(b) A hospital may purchase PSC processing and harvesting services from other department-approved processing providers.

(c) The department shall not reimburse a PSC transplant facility for AABB inspection and certification fees related to PSC transplant services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2100, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-2200 Transplant requirements—COE.** (1) The department shall measure the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the

department, the department shall apply these criteria to a facility during both initial and periodic evaluations for designation as a transplant COE. The COE performance criteria shall include, but not be limited to:

(a) Meeting annual volume requirements for the specific transplant procedures for which approved;

(b) Patient survival rates; and

(c) Relative cost per case.

(2) A transplant COE shall meet or exceed annually the following applicable volume criteria for the particular transplant procedures performed at the facility, except for cornea transplants which do not have established minimum volume requirements. Annual volume requirements for transplant centers of excellence include:

(a) Twelve or more heart transplants;

(b) Ten or more lung transplants;

(c) Ten or more heart-lung transplants;

(d) Twelve or more liver transplants;

(e) Twenty-five or more kidney transplants;

(f) Eighteen or more pancreas transplants;

(g) Eighteen or more kidney-pancreas transplants;

(h) Ten or more bone marrow transplants; and

(i) Ten or more peripheral stem cell (PSC) transplants.

Dual-organ procedures may be counted once under each organ and the combined procedure.

(3) A transplant facility within the state that fails to meet the volume requirements in subsection (1) of this section may submit a written request to the department for conditional approval as a transplant center of excellence. The department shall consider the minimum volume requirement met when the requestor submits an approved certificate of need for transplant services from the state department of health.

(4) An in-state facility granted conditional approval by the department as a transplant center of excellence shall meet the department's criteria, as established in this chapter, within one year of the conditional approval. The department shall automatically revoke such conditional approval for any facility which fails to meet the department's published criteria within the allotted one year period, unless:

(a) The facility submits a written request for extension of the conditional approval thirty calendar days prior to the expiration date; and

(b) Such request is granted by the department.

(5) A transplant center of excellence shall meet Medicare's survival rate requirements for the transplant procedure(s) performed at the facility.

(6) A transplant center of excellence shall submit to the department annually, at the same time the hospital submits a copy of its Medicare Cost Report (HCFA 2552 report) documentation showing:

(a) The numbers of transplants performed at the facility during its preceding fiscal year, by type of procedure; and

(b) Survival rates data for procedures performed over the preceding three years as reported on the United Network of Organ Sharing report form.

(7)(a) Transplant facilities shall submit to the department, within sixty days of the date of the facility's approval as a center of excellence, a complete set of the comprehensive patient selection criteria and treatment protocols used by the

facility for each transplant procedure it has been approved to perform.

(b) The facility shall submit to the department updates to said documents annually thereafter, or whenever the facility makes a change to the criteria and/or protocols.

(c) If no changes occurred during a reporting period the facility shall so notify the department to this effect.

(8) The department shall evaluate compliance with the provisions of WAC 388-550-2100 (2)(d) and (e) based on the protocols and criteria submitted to the department by transplant centers of excellence in accordance with subsection (7) of this section. The department shall terminate a facility's designation as a transplant center of excellence if a review or audit finds that facility in noncompliance with:

(a) Its protocols and criteria in evaluating and selecting candidates for transplantation; and

(b) Distributing donated organs in a fair and equitable manner that promotes an optimal or successful patient outcome.

(9)(a) The department shall provide transplant centers of excellence it finds in noncompliance with subsection (8) of this section sixty days within which such centers may submit a plan to correct a breach of compliance;

(b) The department shall not allow the sixty-day option as stated in (a) of this subsection for a breach that constitutes a danger to the health and safety of clients as stated in WAC 388-502-0030;

(c) Within six months of submitting a plan to correct a breach of compliance, a center shall report to the department showing:

(i) The breach of compliance has been corrected; or

(ii) Measurable and significant improvement toward correcting such breach of compliance.

(10) The department shall periodically review the list of approved transplant centers of excellence. The department may limit the number of facilities it designates as transplant centers of excellence or contracts with to provide services to medical care clients if, in the department's opinion, doing so would promote better client outcomes and cost efficiencies.

(11) The department shall reimburse department-approved centers of excellence for covered transplant procedures using any of the methods identified in chapter 388-550 WAC.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-2200, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2200, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-2400 Chronic pain management program.** (1)(a) The department shall cover inpatient chronic pain management training to assist eligible clients to manage chronic pain.

(b) The department shall pay for only one inpatient hospital stay, up to a maximum of twenty-one days, for chronic pain management training per eligible client's lifetime.

(c) Refer to WAC 388-550-1700 (2)(i) and 388-550-1800 for prior authorization.

(2) The department shall reimburse approved chronic pain management facilities an all-inclusive per diem facility fee under the revenue code published in the department's

chronic pain management fee schedule. MAA shall reimburse professional fees for chronic pain management services to performing providers in accordance with the department's fee schedule.

(3) The department shall not reimburse a contract facility for unrelated services provided during the client's inpatient stay for chronic pain management, unless the facility requested and received prior approval from the department for those services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2400, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-2431 Hospice services—Inpatient payments.** See chapter 388-551 WAC, Alternatives to hospital services, subchapter I—Hospice services.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2431, filed 2/26/99, effective 3/29/99.]

**WAC 388-550-2500 Inpatient hospice services.** (1) The department shall reimburse hospice agencies participating in the medical assistance program for general inpatient and inpatient respite services provided to clients in hospice care, when:

(a) The hospice agency coordinates the provision of such inpatient services; and

(b) Such services are related to the medical condition for which the client sought hospice care.

(2) Hospice agencies shall bill the department for their services using revenue codes. The department shall reimburse hospice providers a set per diem fee according to the type of care provided to the client on a daily basis.

(3) The department shall reimburse hospital providers directly pursuant to this chapter for inpatient care provided to clients in the hospice program for medical conditions not related to their terminal illness.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2500, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-2501 Acute physical medicine and rehabilitation (acute PM&R) program—General.** **Acute physical medicine and rehabilitation (acute PM&R)** is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services during the acute phase of rehabilitation. It requires prior authorization by medical assistance administration (MAA).

(1) A multidisciplinary team coordinates individualized client **acute PM&R** services at an MAA-approved rehabilitation facility to achieve the following for the client:

(a) Improved health and welfare; and

(b) Maximum physical, social, psychological and vocational potential.

(2) MAA determines the length of stay based on individual cases and community standards of care for **acute PM&R** services.

(3) When MAA's authorized acute period of rehabilitation ends, the provider transfers the client to a more appropriate level of care. Therapies may continue to help the client

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achieve maximum potential through other covered programs such as:

(a) Home health services (see subchapter II of chapter 388-551 WAC);

(b) Nursing facilities (see chapter 388-97 WAC); or

(c) Outpatient hospital services (see chapter 388-550 WAC).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2501, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-2511 Acute PM&R definitions.** The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to this subchapter. Defined words and phrases are bolded in the text. In case of any conflicts, this section prevails for this subchapter.

**"Accredit" (or "Accreditation")** is a term used by nationally recognized health organizations, such as CARF, to state a facility meets community standards of medical care.

**"Acute"** means an intense medical episode, not longer than two months.

**"Acute physical medicine and rehabilitation (acute PM&R)"** means a comprehensive inpatient rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for a diagnostic category for which the client shows significant potential functional improvement.

**"CARF."** The official name for 'The Rehabilitation Accreditation Commission' of Tucson, Arizona. **CARF** is a national private agency that develops and maintains current, "field-driven" (community) standards through surveys and **accreditations** of rehabilitation facilities.

**"Level A services"** mean hospital-based **acute** rehabilitation services for medically stable clients with conditions that require complex nursing, medical and therapy needs as listed in WAC 388-550-2551(2). Such conditions include, but are not limited to, traumatic brain injuries, spinal cord injuries, and complicated bilateral amputations.

**"Level B services"** mean hospital- or nursing facility-based **acute** rehabilitation services for medically stable clients with new or exacerbated multiple sclerosis, mild head injuries, spinal cord injuries following the removal of the thoracic lumbar sacral orthosis (TLSO), and other medical conditions that require less complex nursing, medical and therapy needs as listed in WAC 388-550-2551(3).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2511, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-2521 Client eligibility requirements for acute PM&R services.** (1) Clients in any of the following medical programs are eligible to receive acute PM&R Level A and Level B services:

(a) Children's health (V);

(b) Categorically needy program (CNP);

(c) Categorically needy program - qualified Medicare beneficiary (CNP-QMB);

(d) General assistance - determination pending for disability (GAX);

[Title 388 WAC—p. 949]

(e) Limited casualty program - medically needy program (LCP-MNP); and

(f) Medically needy program - qualified Medicare beneficiary (MNP-QMB).

(2) Clients in any of the following programs may receive only **Level A** hospital-based services:

(a) Medically indigent program (MIP) - emergency hospital-based and emergency transportation services. These clients may only receive services when:

(i) They are transferred directly from an **acute** hospital stay; and

(ii) The client's **acute PM&R** needs are directly related to the emergency medical need for the hospital stay;

(b) General assistance unemployable (GAU - No out-of-state care);

(c) CNP - emergency medical only;

(d) LCP-MNP - emergency medical only; and

(e) Alcoholism and drug addiction treatment and support act (ADATSA) (GAW).

(3) Clients in programs not listed in this section are not covered for **acute PM&R** services. See WAC 388-529-0100 and 388-529-0200 for scope of medical coverage.

(4) If a client is enrolled in an MAA Healthy Options managed care plan at the time of acute care admission, that plan pays for and coordinates **acute PM&R** services as appropriate.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2521, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-2531 Requirements for becoming an MAA Level A or B acute PM&R provider.** (1) To provide **acute PM&R** services to medical assistance clients, a provider obtains MAA approval for the faculty. To obtain MAA approval for the facility, the provider must:

(a) Submit a letter of request;

(b) Include evidence that confirms the requirements listed in subsection (2) and (3) of this section are met; and

(c) Send the letter and documentation to:

Acute PM&R Program Manager

Division of Health Services Quality Support

Medical Assistance Administration

PO Box 45506

Olympia WA 98504-5506

(2) In order to be approved by MAA as a **Level A** provider, a hospital must be:

(a) Medicare certified;

(b) **Accredited** by the joint commission on **accreditation** of hospital organizations (JCAHO);

(c) Licensed by department of health (DOH) as an acute care hospital (as defined by DOH in WAC 246-310-010, Definitions);

(d) **CARF accredited** for comprehensive integrated inpatient rehabilitation programs; and

(e) Operating per the standards set by DOH, excluding the certified rehabilitation registered nurse (CRRN) requirement, in either:

(i) WAC 246-976-830, Level I trauma rehabilitation designation; or

(ii) WAC 246-976-840, Level II trauma rehabilitation designation.

(3) In order to be approved by and contracted with MAA as a **Level B** provider, a facility must be:

(a) Medicare certified;

(b) Licensed by DOH as an acute care hospital (as defined by DOH in WAC 246-310-010, Definitions) or nursing facility;

(c) **CARF accredited** for comprehensive integrated inpatient rehabilitation programs;

(d) Contracted under MAA's selective contracting program, if in a selective contracting area, unless exempted from the requirement by MAA; and

(e) Operating per the standards set by DOH in WAC 246-976-840, Level II trauma rehabilitation designation, excluding the CRRN requirement.

(4) To obtain conditional contract approval, the applying facility must meet the criteria in subsections (1), (2) and/or (3) of this section, excluding the **CARF accreditation** requirement listed in section (2)(c) and (3)(c) of this section. The facility must:

(a) Actively operate under **CARF** standards; and

(b) Have begun the process of obtaining full **CARF accreditation**.

(5) MAA will revoke a conditional contract approval if the facility does not obtain full **CARF accreditation** within twelve months of the conditional approval date by MAA.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2531, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-2541 Quality of care for acute PM&R clients through audits and reviews.** (1) To ensure quality of care, MAA may conduct an on-site review of any MAA-approved **acute PM&R** facility. See WAC 388-501-0130, Administrative controls, for additional information on audits conducted by department staff.

(2) In addition, MAA-approved **Level B** nursing facilities are subject to regular on-site surveys conducted by the department's aging and adult services administration (AASA).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2541, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-2551 How MAA determines client placement in Level A or B acute PM&R.** (1) At the time of authorization, MAA determines the most appropriate client placement on a case-by-case basis:

(a) In the level of care (level A or B);

(b) In the least restrictive environment; and

(c) At the lowest cost to MAA.

(2) Examples of client conditions suitable for **Level A** placement include:

(a) Cognitive and/or motor deficits;

(b) Brain damage from infectious brain diseases;

(c) Quadriplegia or paraplegia;

(d) Skin flap grafts for decubitus ulcers that need close observation by a surgeon, when the client is ready to mobilize or be upright in a chair;



(e) Extensive burns requiring complex medical care and debridement;

(f) Bilateral limb loss requiring close observation when the client has complex medical needs;

(g) Multiple trauma with complicated orthopedic conditions and neurological deficits; or

(h) Stroke with resulting hemiplegia or severe cognitive deficits, including speech and swallowing deficits requiring close observation with radiological examination.

(3) Examples of client conditions suitable for **Level B** placement include:

(a) New strokes when medically stable;

(b) Newly diagnosed or recently exacerbated multiple sclerosis with new loss of function;

(c) New mild head injury when medically stable; or

(d) Spinal cord injuries following the removal of a thoracic lumbar sacral orthosis after the client's first phase of acute rehabilitation.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2551, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-2561 MAA's requirements for authorizing acute PM&R services.** (1) The patient care coordinator or the attending physician must call the MAA clinical consultation team before admitting an MAA client.

(2) The patient care coordinator or attending physician must provide to MAA objective information showing that:

(a) **Acute PM&R** treatment would effectively enable the client to obtain a greater degree of self-care, independence, or both;

(b) The client's medical condition requires that intensive twenty-four-hour inpatient comprehensive **acute PM&R** services be provided in an MAA-approved **acute PM&R** facility; and

(c) The client suffers from severe disabilities including, but not limited to, motor and/or cognitive deficits.

(3) Clients must be medically stable and show evidence that they are physically and cognitively ready to participate in the rehabilitation program. They must be willing and capable to participate at least three hours per day, seven days per week, in **acute PM&R** activities.

(4) For extension of authorization, the facility's rehabilitation staff must provide adequate medical justification, including significant observable improvement in the client's condition, to MAA prior to the expiration of the initial approved stay. If MAA denies the extension, the client must be transferred to an appropriate lower level of care as defined in WAC 388-550-2501(3).

(5) MAA may authorize administrative day reimbursement for clients who do not meet requirements described in this section, or who stay in the facility longer than the community standard's length of stay. The administrative day rate is the statewide Medicaid average daily nursing facility rate as determined by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2561, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-2565 The long term acute care (LTAC) program—General.** The long term acute care

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(LTAC) program is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in a medical assistance administration (MAA)-approved LTAC facility during the acute phase of a client's care. MAA requires prior authorization for LTAC stays. See WAC 388-550-2590 for prior authorization requirements.

(1) A facility's multidisciplinary team coordinates individualized LTAC services at an MAA-approved LTAC facility.

(2) MAA determines the authorized length of stay for LTAC services based on the client's need as documented in the client's medical records and the criteria described in WAC 388-550-2590.

(3) When the MAA-authorized length of stay ends, the provider transfers the client to a more appropriate level of care or, if appropriate, discharges the client to the client's residence.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2565, filed 7/3/02, effective 8/3/02.]

**WAC 388-550-2570 LTAC program definitions.** The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to the LTAC program.

"Level 1 services" means long term acute care (LTAC) services provided to clients who require more than eight hours of direct skilled nursing care per day. Level 1 services include one or both of the following:

(1) Active ventilator weaning care and any specialized therapy services, such as physical, occupational, and speech therapies; or

(2) Complex medical care that may include: Care for complex draining wounds, care for central lines, multiple medications, frequent assessments and close monitoring, third degree burns that may involve grafts and/or frequent transfusions, and specialized therapy services, such as physical, occupational, and speech therapies.

"Level 2 services" means long term acute care (LTAC) services provided to clients who require four to eight hours of direct skilled nursing care per day. Level 2 services include at least two of the following:

(1) Ventilator care for clients who are stable, dependent on a ventilator, and have complex medical needs;

(2) Care for clients who have tracheostomies, complex airway management and medical needs, and the potential for decannulation; and

(3) Specialized therapy services, such as physical, occupational, and speech therapies.

"Long term acute care" means inpatient intensive long term care services provided in MAA-approved LTAC facilities to eligible medical assistance clients who require Level 1 or Level 2 services.

"Survey" or "review" means an inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with LTAC program requirements.

"Transportation company" means either an MAA-approved transportation broker or a transportation company doing business with MAA.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2570, filed 7/3/02, effective 8/3/02.]

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**WAC 388-550-2575 Client eligibility requirements for LTAC services.** Only a client who is eligible for one of the following programs may receive LTAC services, subject to the restrictions and limitations in WAC 388-550-2565, 388-550-2570, 388-550-2580, 388-550-2585, 388-550-2590, 388-550-2595, 388-550-2596, and other published rules:

- (1) Categorically needy program (CNP);
- (2) CNP - Children's health insurance program (CNP-CHIP);
- (3) Limited casualty program - medically needy program (LCP-MNP);
- (4) CNP - Emergency medical only; or
- (5) LCP-MNP - Emergency medical only.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2575, filed 7/3/02, effective 8/3/02.]

**WAC 388-550-2580 Requirements for becoming an LTAC facility.** (1) To apply to become an MAA-approved LTAC facility, MAA requires a hospital provider to:

- (a) Submit a letter of request to:  
LTAC Program Manager  
Division of Medical Management  
Medical Assistance Administration  
PO Box 45506  
Olympia WA 98504-5506; and
- (b) Include documentation that confirms the facility is:
  - (i) Medicare certified for LTAC;
  - (ii) Accredited by the joint commission on accreditation of hospital organizations (JCAHO);
  - (iii) Licensed by the department of health (DOH) as an acute care hospital as defined under WAC 246-310-010; and
  - (iv) Contracted under MAA's selective contracting program, if in a selective contracting area, unless exempted from the requirements by MAA.
- (2) The hospital facility qualifies as an MAA-approved LTAC facility when:
  - (a) The facility meets all the requirements in this section;
  - (b) MAA's clinical staff has conducted a facility site visit; and
  - (c) MAA provides written notification that the facility qualifies to be reimbursed for providing LTAC services to eligible medical assistance clients.
- (3) MAA-approved LTAC facilities must meet the general requirements in chapter 388-502 WAC, Administration of medical programs providers.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2580, filed 7/3/02, effective 8/3/02.]

**WAC 388-550-2585 LTAC facilities—Quality of care.** (1) To ensure quality of care, MAA may conduct post-pay or on-site reviews of any MAA-approved LTAC facility. See WAC 388-502-0240, Audits and the audit appeal process for contractors/providers, for additional information on audits conducted by department staff.

(2) A provider of LTAC services must act on any reports of substandard care or violations of the facility's medical staff bylaws. The provider must have and follow written procedures that provide a resolution to either a complaint or grievance or both.

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(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

- (a) The department of health (DOH);
- (b) The Joint Commission on Accreditation of Hospital Organizations (JCAHO);
- (c) MAA; or
- (d) Other agencies with review authority for MAA programs.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2585, filed 7/3/02, effective 8/3/02.]

**WAC 388-550-2590 MAA's prior authorization requirements for Level 1 and Level 2 services.** (1) MAA requires prior authorization for Level 1 and Level 2 LTAC inpatient stays. The prior authorization process includes all of the following:

- (a) For an initial thirty-day stay:
  - (i) The client must:
    - (A) Be eligible under one of the programs listed in WAC 388-550-2575;
    - (B) Meet the high cost outlier status at the transferring hospital as described in WAC 388-550-3700; and
    - (C) Require Level 1 or Level 2 services as defined in WAC 388-550-2570.
  - (ii) The LTAC provider of services must:
    - (A) Before admitting the client to the LTAC facility, submit a request for prior authorization to the MAA clinical consultation team by fax, electronic mail, or telephone, as published in MAA's LTAC billing instructions; and
    - (B) Include sufficient medical information to justify the requested initial stay.
- (b) For extensions of stay:
  - (i) The client must:
    - (A) Be eligible under one of the programs listed in WAC 388-550-2575; and
    - (B) Require Level 1 or Level 2 services as defined in WAC 388-550-2570.
  - (ii) The LTAC provider of services must:
    - (A) Before the client's current authorized period of stay expires, submit a request for the extension of stay to the MAA clinical consultation team by fax, electronic mail, or telephone; and
    - (B) Include sufficient medical information to justify the requested extension of stay.

(2) The MAA clinical consultation team authorizes, in writing, Level 1 or Level 2 services for initial stays or extensions of stay based on the client's circumstances and the medical justification received. A client who does not agree with a decision regarding a length of stay 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 and the facility, or both. After MAA reviews the available information, the result may be:

- (a) A reversal of the initial MAA decision;
  - (b) Resolution of the client's issue(s); or
  - (c) A fair hearing conducted per chapter 388-02 WAC.
- (3) MAA may authorize administrative day rate reimbursement for a client who:

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(a) Does not meet the requirements described in this section;

(b) Is waiting for placement in another facility; or

(c) If appropriate, is waiting to be discharged to the client's residence.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2590, filed 7/3/02, effective 8/3/02.]

**WAC 388-550-2595 Identification of and payment methodology for services and equipment included in the LTAC fixed per diem rate.** (1) In addition to room and board, the LTAC fixed per diem rate includes, but is not limited to, the following (see MAA's LTAC billing instructions for applicable revenue codes):

(a) Room and board - Rehabilitation;

(b) Room and board - Intensive care;

(c) Pharmacy - Up to and including two hundred dollars per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy;

(d) Medical/surgical supplies and devices;

(e) Laboratory - General;

(f) Laboratory - Chemistry;

(g) Laboratory - Immunology;

(h) Laboratory - Hematology;

(i) Laboratory - Bacteriology and microbiology;

(j) Laboratory - Urology;

(k) Laboratory - Other laboratory services;

(l) Respiratory services;

(m) Physical therapy;

(n) Occupational therapy; and

(o) Speech-language therapy.

(2) MAA pays the LTAC facility the LTAC fixed per diem rate in effect at the time the LTAC services are provided, minus the sum of:

(a) Client liability, whether or not collected by the provider; and

(b) Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from:

(i) Insurers and indemnitors;

(ii) Other federal or state medical care programs;

(iii) Payments made to the provider on behalf of the client by individuals or organizations not liable for the client's financial obligations; and

(iv) Any other contractual or legal entitlement of the client, including, but not limited to:

(A) Crime victims' compensation;

(B) Workers' compensation;

(C) Individual or group insurance;

(D) Court-ordered dependent support arrangements; and

(E) The tort liability of any third party.

(3) MAA may make annual rate increases to the LTAC fixed per diem rate by using the same inflation factor and date of rate increase that MAA uses for acute care hospital diagnostic-related group (DRG) rates. This DRG rate adjustment method is described in WAC 388-550-3450(5).

(2003 Ed.)

[Statutory Authority: RCW 74.08.090. 03-02-056, § 388-550-2595, filed 12/26/02, effective 1/26/03; 02-14-162, § 388-550-2595, filed 7/3/02, effective 8/3/02.]

**WAC 388-550-2596 Services and equipment covered by MAA but not included in the LTAC fixed per diem rate.** (1) MAA uses the ratio of costs-to-charges (RCC) payment method to reimburse an LTAC facility for the following that are not included in the LTAC fixed per diem rate:

(a) Pharmacy - After the first two hundred dollars per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy;

(b) Radiology services;

(c) Nuclear medicine services;

(d) Computerized tomographic (CT) scan;

(e) Operating room services;

(f) Anesthesia services;

(g) Blood storage and processing;

(h) Blood administration;

(i) Other imaging services - Ultrasound;

(j) Pulmonary function services;

(k) Cardiology services;

(l) Recovery room services;

(m) EKG/ECG services;

(n) Gastro-intestinal services;

(o) Inpatient hemodialysis; and

(p) Peripheral vascular laboratory services.

(2) MAA uses the appropriate inpatient or outpatient payment method described in other published WAC to reimburse providers other than LTAC facilities for services and equipment that are covered by MAA but not included in the LTAC fixed per diem rate. The provider must bill MAA directly and MAA reimburses the provider directly.

(3) Transportation services that are related to transporting a client to and from another facility for the provision of outpatient medical services while the client is still an inpatient at the LTAC facility, or related to transporting a client to another facility after discharge from the LTAC facility:

(a) Are not covered or reimbursed through the LTAC fixed per diem rate;

(b) Are not reimbursable directly to the LTAC facility;

(c) Are subject to the provisions in chapter 388-546 WAC; and

(d) Must be billed directly to the:

(i) Department by the transportation company to be reimbursed if the client required ambulance transportation; or

(ii) Department's contracted transportation broker, subject to the prior authorization requirements and provisions described in chapter 388-546 WAC, if the client:

(A) Required nonemergent transportation; or

(B) Did not have a medical condition that required transportation in a prone or supine position.

(4) MAA evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standards of WAC 388-501-0165.

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[Statutory Authority: RCW 74.08.090, 03-02-056, § 388-550-2596, filed 12/26/02, effective 1/26/03; 02-14-162, § 388-550-2596, filed 7/3/02, effective 8/3/02.]

**WAC 388-550-2598 Critical access hospital (CAH) program.** (1) The critical access hospital (CAH) program provides cost-based reimbursement to a critical access hospital (CAH) through a retrospective cost reimbursement system. Reimbursement is based on a CAH's actual cost of providing hospital services to eligible medical assistance clients during the hospital fiscal year (HFY) of the CAH, subject to the conditions and limitations in this section and other published WACs. CAH program requirements and how the medical assistance administration (MAA) calculates a CAH cost settlement adjustment are described in this section.

(2) The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to the CAH program:

(a) "CAH," see "critical access hospital."

(b) "CAH fee-for-service (FFS) cost settlement adjustment" means the department's annual reimbursement or recoupment adjustment to a CAH's fee-for-service interim payment.

(c) "CAH Healthy Options (HO) cost settlement payment" means the department's annual reimbursement adjustment related to a CAH's HO utilization.

(d) "CAH HFY" see "CAH hospital fiscal year."

(e) "CAH hospital fiscal year" means each individual hospital's fiscal year.

(f) "Cost settlement" means a reconciliation of the interim CAH payments with a CAH's actual costs determined after the end of the CAH's HFY.

(g) "Critical access hospital (CAH)" means an MAA-approved hospital that is Medicare-certified by the Centers for Medicare and Medicaid Services (CMS) to operate as a CAH.

(h) "IDWCC rate" see "inpatient departmental weighted cost-to-charge (IDWCC) rate."

(i) "Inpatient departmental weighted cost-to-charge (IDWCC) rate" means a rate MAA uses to determine a fee-for-service interim inpatient CAH payment.

(j) "Interim CAH payment" means the actual payment the department makes, per claim, to a CAH during its HFY, using the appropriate IDWCC or ODWCC rate, as determined by MAA.

(k) "ODWCC rate" see "outpatient departmental weighted cost-to-charge (ODWCC) rate."

(l) "Outpatient departmental weighted cost-to-charge (ODWCC) rate" means a rate MAA uses to determine a fee-for-service interim outpatient CAH payment.

(m) "Per service" means services provided during a healthy options (HO) equivalent admission. (For an example of how to calculate a HO equivalent admission, see subsection (12), step 2.)

(3) An MAA-approved CAH must be Medicare-certified as a CAH. A CAH must provide proof of certification to MAA upon request.

(4) An MAA-approved CAH must also meet the general applicable requirements in chapter 388-502 WAC, Adminis-

tration of medical programs—Providers. For information on audits conducted by department staff, see WAC 388-502-0240.

(5) MAA may conduct a postpay or on-site review of any CAH to ensure quality of care.

(6) To ensure a client receives necessary care:

(a) A CAH is responsible to investigate any reports of substandard care or violations of the facility's medical staff bylaws;

(b) A CAH provider must have and follow written procedures that provide a resolution to complaints and grievances; and

(c) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(i) Department of health (DOH); or

(ii) Other agencies with review authority for MAA programs.

(7) Subject to the restrictions and limitations in this section and other published WAC, the MAA CAH fee-for-service reimbursement method uses the:

(a) IDWCC rate; and

(b) ODWCC rate.

(8) This section describes the parallel steps MAA uses to calculate both the fee-for-service IDWCC rate and fee-for-service ODWCC rate for each CAH. Consideration will be given to recalculation of the interim payment rates if a CAH submits changes to the initially submitted Medicare HCFA-2552 Cost Report. MAA:

(a) Obtains the following information for each CAH from the Medicare HCFA-2552 Cost Report the CAH initially submits for the period to be cost settled:

(i) Cost-to-charge ratio of each respective ancillary service cost center; and

(ii) Total costs and number of patient days of each respective accommodation cost center.

(b) Obtains from the Medicaid Management Information System (MMIS) the following summary claims data submitted by each CAH for the HFY to be cost settled:

(i) Medical assistance program codes;

(ii) Inpatient and outpatient claim types;

(iii) Procedure codes, revenue codes or diagnosis-related group (DRG) codes;

(iv) Allowed charges and third party liability/client and MAA paid amounts;

(v) Number of claims; and

(vi) Units of service.

(c) Separates the inpatient claims data and outpatient claims data.

(d) Obtains the cost center allowed charges by classifying inpatient allowed charges billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's Medicare HCFA-2552 cost report the CAH initially submits to MAA.

(e) Determines the MAA departmental-weighted costs for each cost center by multiplying the cost center's allowed charges for the appropriate inpatient or outpatient claim type by the related ancillary service cost center ratio or accommodation cost center per diem.

(f) Obtains totals from the cost centers used for cost settlement and interim rates from (e) of this subsection by:

- (i) Summing all allowed charges; and
- (ii) Summing all MAA departmental-weighted costs.

(g) Determines a CAH's fee-for-service IDWCC rate and fee-for-service ODWCC rate by dividing the total MAA departmental-weighted costs from (f)(ii) of this subsection by the total allowed charges from (f)(i) of this subsection. Neither the IDWCC rate nor the ODWCC rate may exceed one hundred percent.

(9) MAA makes interim CAH payments to a CAH during the CAH's HFY using the IDWCC rate for inpatient services provided, and the ODWCC rate for outpatient services provided, as determined in the CAH's most recent cost settlement.

(10) MAA performs a cost settlement for a CAH after the end of the CAH's HFY. MAA calculates the cost settlement using:

- (a) MAA claims data; and

(b) The following information submitted by the CAH to MAA at the close of the CAH's HFY:

- (i) The Medicare HCFA-2552 Cost Report (see requirements in WAC 388-550-5700); and
- (ii) Total HO inpatient and outpatient allowed charges for the CAH's HFY dates of services.

(11) MAA rebases and implements a CAH's new IDWCC rate and ODWCC rate at cost settlement. The rebased IDWCC and ODWCC rates:

- (a) Are used to determine a CAH's adjustment for services in the cost-settled HFY; and
- (b) Become the current interim payment rates.

(12) See the example in this subsection for how MAA calculates a fee-for-service and managed care CAH cost settlement adjustment. A cost settlement payment for services provided through a Healthy Options managed care plan is limited to no more than the additional amounts per service paid under the CAH program for other medical assistance programs.

Example of the payment calculation for a fee-for-service (FFS) and Healthy Options (HO) Critical Access Hospital (CAH) cost settlement adjustment using charges from claims and the hospital's inpatient departmental weighted cost-to-charge (IDWCC) and outpatient departmental weighted cost-to-charge (ODWCC)			
STEP 1 CAH FFS Cost Settlement Adjustment for Hospital XYZ			
CAH's Hospital Fiscal Year (HFY)			
		Programs	
		Inpatient Medical Assistance Programs	Outpatient Medical + Assistance Programs
		Total Cost Settlement = Adjustment	
CAH HFY Total allowed charges		\$96,735	\$130,000
IDWCC and ODWCC used for CAH cost settlement	x	84.3%	
CAH actual FFS cost	=	\$81,548	\$105,000
FFS interim CAH payment	-	\$80,833	\$100,000
* CAH FFS cost settlement adjustment	=	\$ 715	\$ 5,000

\*If the CAH FFS cost settlement adjustment total is zero or less, a HO cost settlement is not performed. (Go directly to step 3.) If the CAH FFS cost settlement adjustment total is greater than zero, proceed to step 2.

STEP 2 Calculate Total CAH HO Cost Settlement Payment	
\$130,000	Total allowed CAH HFY charges
+ 10	FFS inpatient admissions during CAH HFY
= \$ 13,000	Average charge per FFS inpatient admission used for HO equivalent admissions
\$5,000	CAH FFS cost settlement adjustment (from Step 1)
+ 10	FFS admissions during CAH HFY
= \$ 500	CAH settlement for each FFS admission
\$ 78,000	Total allowed HO charges (includes inpatient and outpatient charges)
+ \$ 13,000	Average charge per FFS admission used for HO equivalent admissions
6	HO equivalent admissions
\$ 500	CAH settlement for each FFS admission
x 6	HO equivalent admissions
= \$ 3,000	CAH HO cost settlement payment due the CAH

STEP 3 Calculate Total Additional CAH Cost Settlement Adjustment	
\$ 5,000	CAH FFS cost settlement adjustment (from Step 1)
+ \$ 3,000	CAH HO cost settlement payment (from Step 2)
= \$ 8,000	Total additional CAH cost settlement adjustment due from the department

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.5225, and HB 1162, 2001 2nd sp.s. c 2. 02-13-099, § 388-550-2598, filed 6/18/02, effective 7/19/02.]

**WAC 388-550-2600 Inpatient psychiatric services.**  
For psychiatric hospitalizations, including involuntary admissions, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2600, filed 12/18/97, effective 1/18/98.]

(2003 Ed.)

**WAC 388-550-2750 Hospital discharge planning services.** For discharge planning service requirements, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2750, filed 12/18/97, effective 1/18/98.]

[Title 388 WAC—p. 955]

**WAC 388-550-2800 Inpatient payment methods and limits.** (1) The department reimburses hospitals for Medicaid inpatient hospital services using the rate setting methods identified in the department's approved state plan that includes:

Method	Used for
Diagnoses related group (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 facilities and long-term acute care (LTAC) hospitals
Cost settlement	MAA-approved critical access hospitals (CAHS)

(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) Under WAC 246-976-935, MAA may:

(a) Enhance payments for trauma care provided to a client under a Title XIX Medicaid program when the trauma:

(i) Qualifies under the trauma program; and

(ii) Care is provided in a nongovernmental hospital designated by the department of health (DOH) as a trauma services center.

(b) Provide an annual grant for trauma services to:

(i) A governmental hospital certified by DOH as a trauma services center; and

(ii) An MAA-approved critical access hospital (CAH).

(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, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-2800, filed 10/8/02, effective 11/8/02. 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 388-550-3000 DRG payment system.** (1) Except where otherwise specified, MAA uses the diagnosis-related group (DRG) system, which categorizes patients into clinically coherent and homogenous groups with respect to resource use, as the reimbursement method for inpatient hospital services.

(2) MAA periodically evaluates which all-patient group (AP-DRG) version to use.

(3)(a) MAA calculates the DRG payment for a particular hospital by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, for that admission by the hospital's cost-based conversion factor, as determined in WAC 388-550-3450.

(b) If the hospital is participating in the selective contracting program, the department multiplies the DRG relative weight for the admission by the hospital's negotiated conversion factor, as specified in WAC 388-550-4600(4).

(4)(a) MAA pays for a hospital readmission within seven days of discharge for the same client when department review concludes the readmission did not occur as a result of premature hospital discharge.

(b) When a client is readmitted to the same hospital within seven days of discharge, and MAA review concludes the readmission resulted from premature hospital discharge, MAA treats the previous and subsequent admissions as one hospital stay and pay a single DRG for the combined stay.

(5) If two different DRG assignments are involved in a readmission as described in subsection (4) of this section, MAA reviews the hospital's records to determine the appropriate reimbursement.

(6) MAA recognizes Medicaid's DRG payment for a Medicare-Medicaid dually eligible client to be payment in full.

(a) MAA pays the Medicare deductible and co-insurance related to the inpatient hospital services provided to clients eligible for Medicare and Medicaid subject to the Medicaid maximum allowable limit set in WAC 388-550-1200(6).

(b) MAA ensures total Medicare and Medicaid payments to a provider for such client does not exceed Medicaid's maximum allowable charges.

(c) MAA pays for those allowed charges beyond the threshold using the outlier policy described in WAC 388-550-3700 in cases where:

- (i) Such client's Medicare Part A benefits including lifetime reserve days are exhausted; and
- (ii) The Medicaid outlier threshold status is reached.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-3100 Calculating DRG relative weights.** (1) MAA sets Washington Medicaid-specific DRG relative weights, as follows:

- (a) Uses the all-patient grouper (AP-DRG) to classify Washington Medicaid hospital admissions data.
- (b) Statistically tests each DRG for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.
- (c) Establishes relative weights from Washington Medicaid hospital admissions data. These relative weights may be stable or unstable.
- (d) Tests the stability of Washington Medicaid relative weights from subsection (1)(c) of this section using a reasonable statistical test to determine if the weights are stable. MAA accepts as stable and adopts those Washington Medicaid relative weights that pass the reasonable statistical test.
- (e) Pays admissions for DRGs having unstable Washington Medicaid relative weights using the RCC method.

(2) When using ratios with a Washington Medicaid relative weight as base, MAA adjusts all stable Medicaid relative weights so that the average weight of the case mix population equals 1.0.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3100, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-3150 Base period costs and claims data.** (1) The department shall set a hospital's cost-based conversion factor using base period cost data from its Medicare cost report (Form HCFA 2552) for its fiscal year corresponding with the base period.

(2) The department shall use in rate-setting only base period cost data that have been desk reviewed and/or field audited by the Medicare intermediary.

(3) The department shall, to the extent feasible, factor out of a hospital's base period cost data nonallowable hospital charges associated with the items/services listed in WAC 388-550-1600(1) before calculating the hospital's conversion factor.

(4) The department shall use the figures for total costs, capital costs, and direct medical education costs from a hospital's HCFA 2552 report in calculating that hospital's allowable costs for each of the thirty-eight categories of cost/revenue centers, listed in subsections (5) and (6) below, used to categorize Medicaid claims.

(5) The department shall use nine categories to assign a hospital's accommodation costs and days of care. These accommodation categories are:

- (a) Routine;
- (b) Intensive care;

- (c) Intensive care-psychiatric;
- (d) Coronary care;
- (e) Nursery;
- (f) Neonatal intensive care unit;
- (g) Alcohol/substance abuse;
- (h) Psychiatric; and
- (i) Oncology.

(6) The department shall use twenty-nine categories to assign ancillary costs and charges. These ancillary categories are:

- (a) Operating room;
- (b) Recovery room;
- (c) Delivery/labor room;
- (d) Anesthesiology;
- (e) Radiology-diagnostic;
- (f) Radiology-therapeutic;
- (g) Radioisotope;
- (h) Laboratory;
- (i) Blood storage;
- (j) Intravenous therapy;
- (k) Respiratory therapy;
- (l) Physical therapy;
- (m) Occupational therapy;
- (n) Speech pathology;
- (o) Electrocardiography;
- (p) Electroencephalography;
- (q) Medical supplies;
- (r) Drugs;
- (s) Renal dialysis;
- (t) Ancillary oncology;
- (u) Cardiology;
- (v) Ambulatory surgery;
- (w) Computerized tomography scan/magnetic resonance imaging;

- (x) Clinic;
- (y) Emergency;
- (z) Ultrasound;
- (aa) Neonatal intensive care unit transportation;
- (bb) Gastrointestinal laboratory; and
- (cc) Miscellaneous.

(7) The department shall:

(a) Extract from the Medicaid Management Information System all Medicaid paid claims data for each hospital's base year;

(b) Assign line item charges from the paid hospital claims to the appropriate accommodation and ancillary cost center categories; and

(c) Use the cost center categories to apportion Medicaid costs.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3150, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-3200 Medicaid cost proxies.** (1) For cases in which a hospital has Medicaid charges (claims) for certain accommodation or ancillary cost centers which are not separately reported on its Medicare cost report, the department shall establish cost proxies to estimate such costs in order to ensure recognition of Medicaid related costs.

(2) The department shall develop per diem proxies for accommodation cost centers using the median value of the hospital's per diem cost data within the affected hospital peer group.

(3) The department shall develop ratio of cost-to-charge (RCC) proxies for ancillary cost centers using the median value of the hospital's RCC data within the affected hospital peer group.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3200, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-3250 Indirect medical education costs.** (1) For a hospital with a graduate medical education program, the department shall remove indirect medical education-related costs from the aggregate operating and capital costs of each hospital in the peer group before calculating a peer group's cost cap.

(2) To arrive at indirect medical education costs for each component, the department shall:

(a) Multiply Medicare's indirect cost factor of 0.579 by the ratio of the number of interns and residents in the hospital's approved teaching programs to the number of hospital beds; and

(b) Multiply the product obtained in subsection (2)(a) of this section by the hospital's operating and capital components.

(3) After the peer group's cost cap has been calculated, the department shall add back to the hospital's aggregate costs its indirect medical education costs. See WAC 388-550-3450(6).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3250, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-3300 Hospital peer groups and cost caps.** (1) For rate-setting purposes the department 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 388-550-3350 Outlier costs.** (1)(a) The department shall remove the cost of low- and high-cost outlier cases from individual hospitals' aggregate costs before calculating the peer group cost cap.

(b) After this initial step, all subsequent calculations involving outliers in subsections (2) through (5) of this section pertain only to high-cost outliers.

(c) For a definition of outliers see WAC 388-550-1050, Definitions.

(2) After an individual hospital's base period costs and its peer group cost cap are determined, the department shall add the individual hospital's indirect medical education costs and an outlier cost adjustment back to:

(a) The lesser of the hospital's calculated aggregate cost; or

(b) The peer group's seventieth percentile cost cap.

(3) The outlier cost adjustment is determined as follows to reduce the original high-cost outlier amount in proportion to the reduction in the hospital's base period costs as a result of the capping process:

(a) If the individual hospital's aggregate operating, capital, and direct medical education costs for the base period are less than the seventieth percentile costs for the peer group, the entire high-cost outlier amount is added back.

(b) A reduced high-cost outlier amount is added back if:

(i) The individual hospital's aggregate base period costs are higher than the seventieth percentile for the peer group; and

(ii) The hospital is capped at the seventieth percentile.

(iii) The amount of the outlier added back is determined by multiplying the original high-cost outlier amount by the percentage obtained when the hospital's final cost cap, which is the peer group's seventieth percentile cost, is divided by its uncapped base period costs, as determined in WAC 388-550-3300(4).

(4) The department shall pay high-cost outlier claims from the outlier set-aside pool. The department shall calculate an individual hospital's high-cost outlier set-aside as follows:

(a) For each hospital, the department extracts utilization and paid claims data from the Medicaid Management Information System (MMIS) for the most recent twelve-month period for which the department estimates the MMIS has complete payment information.

(b) Using the data in (a) of this subsection, the department determines the projected annual amount above the high-cost DRG outlier threshold that the department paid to each hospital.

(c) The department's projected high-cost outlier payment to the hospital determined in (b) of this subsection is divided by the department's total projected annual DRG payments to the hospital to arrive at a hospital-specific high-cost outlier percentage. This percentage becomes the hospital's outlier set-aside factor.

(5) The department shall use the individual hospital's outlier set-aside factor to reduce the hospital's CBCF by an amount that goes into a set-aside pool to pay for all high-cost outlier cases during the year. The department shall fund the outlier set-aside pool on hospitals' prior high-cost outlier experience. No cost settlements shall be made to hospitals for outlier cases.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3350, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-3381 How MAA pays acute PM&R facilities for Level A services.** (1) A Level A rehabilitation facility is paid by MAA according to:

(a) The individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500, Payment method—RCC; and

(b) MAA's fee schedule as described in WAC 388-550-6000, Payment—Outpatient hospital services.

(2) **Level A inpatient acute PM&R room and board** includes, but is not limited to:

- (a) Facility use;
- (b) Medical social services;
- (c) Bed and standard room furnishings; and
- (d) Nursing services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3381, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-3400 Case-mix index.** (1)(a) The department shall adjust hospital costs for case mix under the diagnosis-related group (DRG) payment systems.

(b) The department shall calculate a case-mix index (CMI) for each individual hospital to measure the relative cost for treating Medicaid cases in a given hospital.

(2) The department shall calculate the CMI for each hospital using Medicaid admissions data from the individual hospital's base period cost report, as described in WAC 388-550-3150. The hospital-specific CMI is calculated as follows:

(a) The department shall multiply the number of Medicaid admissions to the hospital for a specific DRG by the relative weight for that DRG. The department shall repeat this process for each DRG billed by the hospital.

(b) The department shall add together the products in (a) of this subsection for all of the Medicaid admissions to the hospital in the base year.

(c) The department shall divide the sum obtained in (b) of this subsection by the corresponding number of Medicaid hospital admissions.

(d) Example: If the average case mix index for a group of hospitals is 1.0, a CMI of 1.0 or greater for a hospital in that group means that the hospital has treated a mix of patients in the more costly DRGs. A CMI of less than 1.0 indicates a mix of patients in the less costly DRGs.

(3) The department shall recalculate each hospital's case mix index periodically, but no less frequently than each time rebasing is done.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3400, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-3401 How MAA pays acute PM&R facilities for Level B services.** (1) MAA pays a contracted Level B facility for acute PM&R services at a fixed daily rate established by MAA.

(2) MAA may make cost inflation adjustments to the maximum daily rate by using the same inflation factor and schedule that MAA uses to pay independent hospitals. This diagnosis-related group (DRG) reimbursement method is described in WAC 388-550-3450 (5)(a).

(3) MAA pays the rate in effect at the time of a client's admission to a facility.

(4) Equipment and services identified in the Level B contract as excluded from the fixed daily rate are paid to the MAA provider that directly provides the equipment or services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3401, filed 8/18/99, effective 9/18/99.]

**WAC 388-550-3450 Payment method for calculating CBCF rates.** (1) For Medicaid accommodation costs, MAA:

(a) Uses each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the nine accommodation categories described in WAC 388-550-3150(5); then

(b) Divides those costs per category by total hospital days per category to arrive at a per day accommodation cost; then

(c) Multiplies the per day accommodation cost for each category by the total Medicaid days to arrive at total Medic-

aid accommodation costs per category for the three components.

(2) For ancillary costs MAA:

(a) Uses the base period cost data to calculate total operating, capital, and direct medical education costs for each of the hospital's twenty-nine ancillary categories; then

(b) Divides these costs by total charges per category to arrive at a ratio of costs-to-charges (RCC) per ancillary category; then

(c) Multiplies these RCCs by Medicaid charges per category, as tracked by the Medicaid Management Information System (MMIS), to arrive at total Medicaid ancillary costs per category for the three components (operating, capital, and medical education).

(3) MAA:

(a) Combines Medicaid accommodation and ancillary costs to derive the hospital's total costs for operating, capital, and direct medical education components for the base year; then

(b) Divides the hospital's combined total cost by the number of Medicaid cases during the base year to arrive at an average Medicaid cost per DRG admission; then

(c) Adjusts, for hospitals with a fiscal year ending different than the common fiscal year end, the Medicaid average cost by a factor determined by MAA to standardize hospital costs to the common fiscal year end. MAA adjust the hospital's Medicaid average cost by the hospital's specific case mix index.

(4) MAA caps the Medicaid average cost per case for peer groups B and C at seventy percent of the peer group average. In calculation of the peer group cap, MAA removes the indirect medical education and outlier costs from the Medicaid average cost per admission.

(a) For hospitals in MAA peer groups B or C, MAA determines aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap; then

(b) To whichever is less, the hospital-specific aggregate cost or the peer group cost cap determined in subsection (4) of this section, MAA adds:

(i) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(ii) An outlier cost adjustment in accordance with WAC 388-550-3350(2).

(5) For an inflation adjustment MAA may:

(a) Multiply the sum obtained in subsection (4) of this section by an inflation factor as determined by the legislature for the period January 1 of the year after the base year through October 31 of the rebase year; then

(b) Reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted CBCF; then

(c) Multiply the hospital's adjusted CBCF by the applicable DRG relative weight to calculate the DRG payment for each admission.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3450, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.]

(2003 Ed.)

**WAC 388-550-3500 Hospital inflation adjustment determinations.** Effective on November 1 of each year, MAA may adjust all cost-based conversion factors (CBCF) by an inflation factor, as determined by the legislature and as addressed in subsequent budget notes. MAA does not automatically give an inflation increase to negotiated conversion factors for contracted hospitals participating in the hospital selective contracting program.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3500, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-3600 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.]

[Title 388 WAC—p. 961]

**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	The greater amount of 3x app. DRG pymt (\$15,000) or \$33,000
\$ 500	
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 388-550-3900 Payment method—Border area hospitals.** (1) Under the diagnosis-related group (DRG) payment method:

(a) MAA calculates the cost-based conversion factor (CBCF) of a border area hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(b) For a border area hospital with no HCFA 2552 for the rebasing year, MAA assigns the MAA peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(2) MAA calculates:

(a) The ratio of costs-to-charges (RCC) in accordance with WAC 388-550-4500.

(b) For a border area hospital with no HCFA 2552 Medicare cost report, its RCC on the Washington in-state average RCC ratios.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3900, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-4000 Out-of-state hospitals payment method.** The department shall pay out-of-state hospitals the lesser of billed charges or the amount calculated using the weighted average of ratio of cost-to-charge ratios for in-state Washington hospitals multiplied by the allowed charges for medically necessary services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4000, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-4100 Payment method—New hospitals.** (1) For rate-setting purposes, MAA considers as new:

(a) A hospital which began services after the most recent rebased cost-based conversion factors (CBCFs), or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) MAA determines a new hospital's CBCF as the average of the CBCF of all hospitals within the same MAA peer group.

(3) MAA determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC rate for all current Washington in-state hospitals.

(4) MAA considers that a change in hospital ownership does not constitute a new hospital.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-4100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4100, filed 12/18/97, effective 1/18/98.]

#### **WAC 388-550-4200 Change in hospital ownership.**

(1) For purposes of this section, a change in hospital ownership may involve one or more, but is not limited to, the following events:

(a) A change in the composition of the partnership;

(b) A sale of an unincorporated sole proprietorship;

(c) The statutory merger or consolidation of two or more corporations;

(d) The leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;

(e) The transfer of a government-owned institution to a governmental entity or to a governmental corporation;

(f) Donation of all or part of a provider's facility to another entity if the donation affects licensure or certification of the provider entity;

(g) Disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity; or

(h) A change in the provider's federal identification tax number.

(2) A hospital shall notify the department in writing ninety days prior to the date of an expected change in the hospital's ownership, but in no case later than thirty days after the change in ownership takes place.

(3) When a change in a hospital's ownership occurs, the department shall set the new provider's cost-based conversion factor (CBCF) at the same level as the prior owner's, except as provided in subsection (4) below.

(4) The department shall set for a hospital formed as a result of a merger:

(a) A blended CBCF based on the old hospitals' rates, proportionately weighted by admissions for the old hospitals; and

(b) An RCC rate determined by combining the old hospitals' cost reports and following the process described in WAC 388-550-4500.

(5) The department shall recapture depreciation and acquisition costs as required by section 1861 (V)(1)(0) of the Social Security Act.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4200, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-4300 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 diag-

nosis 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.]

(2003 Ed.)

**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.

[Title 388 WAC—p. 965]

(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 388-550-4600 Hospital selective contracting program.** (1) The department shall designate selective contracting areas (SCA) in which hospitals participate in competitive bidding to provide hospital services to medical care clients. Selective contracting areas are based on historical patterns of hospital use by Medicaid clients.

(2) The department shall require medical care clients in a selective contracting area obtain their elective (nonemergent) inpatient hospital services from participating or exempt hospitals in the SCA. Elective (nonemergent) inpatient hospital services provided by nonparticipating hospitals in an SCA shall not be reimbursed by the department, except as provided in WAC 388-550-4700.

(3) The department shall exempt from the selective contracting program those hospitals that are:

(a) In an SCA but designated by the department as remote. The department shall designate as remote hospitals meeting the following criteria:

(i) Located more than ten miles from the nearest hospital in the SCA;

(ii) Having fewer than seventy-five beds; and

(iii) Having fewer than five hundred Medicaid admissions in a two-year period.

(b) Owned by health maintenance organizations (HMOs) and providing inpatient services to HMO enrollees only;

(c) Children's hospitals;

(d) State psychiatric hospitals or separate (freestanding) psychiatric facilities; and

(e) Out-of-state hospitals in nonborder areas, and out-of-state hospitals in border areas not designated as selective contracting areas.

(4)(a) The department shall negotiate with selectively contracted hospitals a negotiated conversion factor (NCF) for inpatient hospital services.

(b) The department shall calculate its maximum financial obligation for a client under the hospital selective contract in the same manner as DRG payments using cost-based conversion factors (CBCFs).

(c) The department shall apply NCFs to Medicaid clients only. The department shall use CBCFs in calculating payments for MI/medical care services clients.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4600, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-4700 Payment—Non-SCA participating hospitals.** (1) In a selective contracting area (SCA), MAA pays any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) MAA pays any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the department to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest contracting hospital exceeds the client's county travel distance standard, as follows:

<u>County</u>	<u>Community Travel Distance Standard</u>
Adams	25 miles
Asotin	15 miles
Benton	15 miles
Chelan	15 miles
Clallam	20 miles
Clark	15 miles
Columbia	19 miles
Cowlitz	15 miles
Douglas	20 miles
Ferry	27 miles
Franklin	15 miles
Garfield	30 miles
Grant	24 miles
Grays Harbor	23 miles
Island	15 miles
Jefferson	15 miles
King	15 miles
Kitsap	15 miles
Kittitas	18 miles
Klickitat	15 miles
Lewis	15 miles
Lincoln	31 miles
Mason	15 miles
Okanogan	29 miles
Pacific	21 miles
Pend Oreille	25 miles
Pierce	15 miles

<u>County</u>	<u>Community Travel Distance Standard</u>
San Juan	34 miles
Skagit	15 miles
Skamania	40 miles
Snohomish	15 miles
Spokane	15 miles
Stevens	22 miles
Thurston	15 miles
Wahkiakum	32 miles
Walla Walla	15 miles
Whatcom	15 miles
Whitman	20 miles
Yakima	15 miles

(b) If a client must travel outside his/her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client may obtain such services from a contracting hospital appropriate to the client's condition.

(3) MAA requires prior authorization for all nonemer-gent admissions to nonparticipating hospitals in an SCA. See WAC 388-550-1700 (2)(a).

(4) MAA pays a licensed hospital all applicable Medi-care deductible and coinsurance amounts for inpatient ser-vices provided to Medicaid clients who are also beneficiaries of Medicare Part A subject to the Medicaid maximum allow-able as established in WAC 388-550-1200 (8)(a).

(5) The department pays any licensed hospital DRG-exempt services as listed in WAC 388-550-4400.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4700, filed 2/26/99, effec-tive 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-4800 Hospital payment methods—**  
**State administered programs.** (1) Except as provided in subsection (2) of this section, the medical assistance adminis-tration (MAA) uses the ratio of costs-to-charges (RCC) and diagnosis-related group (DRG) payment methods described in this section to reimburse hospitals at reduced rates for covered services provided to clients eligible under the following state-administered programs:

- (a) Medically indigent (MI) program;
- (b) General assistance unemployable (GAU) program;
- (c) Alcoholism and Drug Addiction Treatment and Sup-port Act (ADATSA) program; and
- (d) Involuntary Treatment Act (ITA)-Q program. (The ITA-Q program covers ITA services for non-Medicaid eligi-ble clients.)

(2) MAA exempts the following services from the state-administered programs' payment methods and reduced rates:

(a) Detoxification services when the services are pro-vided under an MAA-assigned provider number starting with "thirty-six." (MAA reimburses these services using the Title XIX Medicaid RCC payment method.)

(b) Program services provided by MAA-approved criti-cal access hospitals (CAHs) to clients eligible under state-administered programs. (MAA reimburses these services through cost settlement as described in WAC 388-550-2598.)

(3) MAA determines:

(a) A state-administered program RCC payment by reducing a hospital's Title XIX Medicaid RCC rate using the hospital's ratable.

(b) A state-administered program DRG payment by reducing a hospital's Title XIX Medicaid DRG cost based conversion factor (CBCF) using the hospital's ratable and equivalency factor (EF).

(4) MAA determines:

(a) The RCC rate for the state-administered programs mathematically as follows:

State-administered programs' RCC rate= current Title XIX Medicaid RCC rate x (one minus the current hospital ratable)

(b) The DRG conversion factor (CF) for the state-admin-istered programs mathematically as follows:

State-administered programs' DRG CF= current Title XIX Medicaid DRG CBCF x (one minus the current hospital ratable) x EF

(5) MAA determines payments to hospitals for covered services provided to clients eligible under the state-adminis-tered programs mathematically as follows:

(a) Under the RCC payment method:

State-administered programs' RCC payment=state-administered programs' RCC Rate x allowed charges

(b) Under the DRG payment method:

State-administered programs' DRG payment=state-administered programs' DRG CF x all patient DRG relative weight (to include any necessary high-cost outlier payment)

(6) To calculate a hospital's ratable that is applied to both the Title XIX Medicaid RCC rate and the Title XIX Medicaid DRG CBCF used to determine the respective state-adminis-tered program's reduced rates, MAA:

(a) Adds the hospital's Medicaid revenue (Medicaid rev-ue as reported by department of health (DOH) includes all Medicaid revenue and all other medical assistance revenue) and Medicare revenue to the value of the hospital's charity care and bad debts, all of which is taken from the most recent complete calendar year data available from DOH at the time of the ratable calculation; then

(b) Deducts the hospital's low-income disproportionate share hospital (LIDSH) revenue from the amount derived in (a) of this subsection to arrive at the hospital's community care dollars; then

(c) Subtracts the hospital-based physicians revenue that is reported in the hospital's most recent HCFA-2552 Medi-care cost report received by MAA at the time of the ratable calculation, from the total hospital revenue reported by DOH from the same source as discussed in (a) of this subsection, to arrive at the net hospital revenue; then

(d) Divides the amount derived in (b) of this subsection by the amount derived in (c) of this subsection to obtain the ratio of community care dollars to net hospital revenue (also called the preliminary ratable factor); then

(e) Subtracts the amount derived in (d) of this subsection from 1.0 to obtain the hospital's preliminary ratable; then

(f) Determines a neutrality factor by:

(i) Multiplying hospital-specific Medicaid revenue that is reported by DOH from the same source as discussed in (a) of this subsection by the preliminary ratable factor; then

(ii) Multiplying that same hospital-specific Medicaid revenue by the prior year's final ratable factor; then

(iii) Summing all hospital Medicaid revenue from the hospital-specific calculations that used the preliminary ratable factor discussed in (f)(i) of this subsection; then

(iv) Summing all hospital revenue from the hospital-specific calculations that used the prior year's final ratable factor discussed in (f)(ii) of this subsection; then

(v) Comparing the two totals; and

(vi) Setting the neutrality factor at 1.0 if the total using the preliminary ratable factor is less than the total using the prior year's final ratable factor; or

(vii) Establishing a neutrality factor that is less than 1.0 that will reduce the total using the preliminary ratable factor to the level of the total using the prior year's final ratable factor, if the total using the preliminary ratable factor is greater than the total using the prior year's ratable factor; then

(g) Multiplies, for each specific hospital, the preliminary ratable by the neutrality factor to establish hospital-specific final ratables for the year; then

(h) Subtracts each hospital-specific final ratable from 1.0 to determine hospital-specific final ratable factors for the year; then

(i) Calculates an in-state-average ratable and an in-state-average ratable factor used for new hospitals with no prior year history.

(7) MAA updates each hospital's ratable annually on August 1.

(8) MAA:

(a) Uses the equivalency factor (EF) to hold the hospital specific state-administered programs' DRG CF at the same level prior to rebasing, adjusted for inflation; and

(b) Calculates a hospital's EF as follows:

EF = State-administered programs' prior DRG CF divided by current Title XIX Medicaid DRG CBCF x (one minus the prior ratable)

(9) Effective December 1, 1991, for hospital admissions of clients eligible under the state-administered MI program, MAA:

(a) Further reduces RCC and DRG payments to a hospital for covered services provided to clients eligible under the MI program by multiplying the respective payment referred to in subsection (5) of this section by ninety-seven percent; and

(b) Applies this payment reduction to the medically indigent disproportionate share hospital (MIDSH) payment methodology in accordance with section 3(b) of the "Medicaid Voluntary Contributions and Provider-Specific Tax Amendment of 1991."

(10) Under WAC 246-976-935, MAA may:

(a) Enhance payments for trauma care provided to a client eligible under the MI program or GAU program when the trauma:

(i) Qualifies under the trauma program; and

(ii) Care is provided in a nongovernmental hospital designated by DOH as a trauma services center.

(b) Provide an annual grant for trauma services to:

(i) A governmental hospital certified by DOH as a trauma services center; and

(ii) An MAA-approved critical access hospital (CAH).

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290.02-21-019, § 388-550-4800, filed 10/8/02, effective 11/8/02. 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.]

**WAC 388-550-4900 Disproportionate share payments.** (1) As required by section 1902 (a)(13)(A) of the Social Security Act, the medical assistance administration (MAA) gives consideration to hospitals which serve a disproportionate number of low-income clients with special needs by making a payment adjustment to eligible hospitals. MAA considers this adjustment a disproportionate share payment.

(2) MAA considers a hospital a disproportionate share hospital if both the following apply:

(a) The hospital's Medicaid inpatient utilization rate (MIPUR) is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or its low-income utilization rate (LIUR) exceeds twenty-five percent; and

(b) The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals, This requirement does not apply to a hospital:

(i) The inpatients of which are predominantly individuals under eighteen years of age; or

(ii) Which did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(3) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(4) MAA may consider a hospital a disproportionate share hospital if both of the following apply:

(a) The hospital has a MIPUR of not less than one percent; and

(b) The hospital meets the requirement of subsection (2)(b) of this section.

(5) MAA administers the low-income disproportionate share (LIDSH) program and may administer any of the:

(a) Medically indigent disproportionate share (MIDSH);

(b) General assistance-unemployable disproportionate share (GAUDSH);

(c) Small rural hospital assistance program disproportionate share (SRHAPDSH);

(d) Teaching hospital assistance program disproportionate share (THAPDSH);

(e) State teaching hospital financing program disproportionate share (STHFPDSH);

(f) County teaching hospital financing program disproportionate share (CTHFPDSH); and

(g) Public hospital district disproportionate share (PHDDSH).

(6) MAA allows a hospital to receive any one or all of the disproportionate share hospital (DSH) payment adjust-



ments discussed in subsection (5) of this section when the hospital:

- (a) Applies to MAA; and
- (b) Meets the eligibility requirements for the particular DSH payment program, as discussed in WAC 388-550-5000 through 388-550-5400.
- (7) MAA ensures each hospital's total DSH payments do not exceed the individual hospital's DSH limit, defined as:
  - (a) The cost to the hospital of providing services to Medicaid clients, including clients served under Medicaid managed care programs;
  - (b) Less the amount paid by the state under the non-DSH payment provision of the state plan;
  - (c) Plus the cost to the hospital of providing services to uninsured patients; and
  - (d) Less any cash payments made by uninsured clients.
- (8) MAA's total annual DSH payments must not exceed the state's DSH allotment for the federal fiscal year.

If the DSH statewide allotment is exceeded, MAA recoups overpayments from hospitals in the following program order:

- (a) PHDDSH;
- (b) THAPDSH;
- (c) CTHFPDSH;
- (d) STHFPDSH;
- (e) SRHAPDSH;
- (f) MIDSH;
- (g) GAUDSH; and
- (h) LIDSH.

[Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5000 Payment method—LIDSH.** (1) A hospital serving the department's clients is eligible for a low-income disproportionate share hospital (LIDSH) payment adjustment if the hospital meets the requirements of WAC 388-550-4900(2).

(2) MAA pays hospitals considered eligible under the criteria in subsection (1) of this section. The total LIDSH payment amounts equal the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(3) MAA distributes LIDSH payments to individual hospitals as follows by:

(a) For each LIDSH-eligible hospital, determining the standardized Medicaid inpatient utilization rate (MIPUR). The MIPUR is standardized by dividing the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(b) Multiplies the hospital's standardized MIPUR by the hospital's most recent case mix index, and then by the hospital's most recent fiscal year Title XIX admissions, and lastly by the hospital's profitability factor. MAA then multiplies the product by an initial random base amount; then

(c) Compares the sum of all annual LIDSH payments to the appropriated amount. If the amounts differ, MAA progressively selects a new base amount by trial and error until

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the sum of the LIDSH payments to hospitals equals the appropriated amount.

[Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. 99-14-040, § 388-550-5000, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5100 Payment method—MIDSH.** (1) MAA considers a hospital eligible for the medically indigent disproportionate share hospital (MIDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is an in-state or border area hospital;
- (c) Provides services to clients under the medically indigent program; and
- (d) Has a low-income utilization rate of one percent or more.

(2) MAA determines the MIDSH payment for each eligible hospital in accordance with WAC 388-550-4800.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5100, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5150 Payment method—GAUDSH.** (1) MAA considers a hospital eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is an in-state or border area hospital;
- (c) Provides services to clients under the medical care services program; and
- (d) Has a low-income utilization rate (LIUR) of one percent or more.

(2) MAA determines the GAUDSH payment for each eligible hospital in accordance with WAC 388-550-4800, except that the payment is not reduced by the additional three percent specified in WAC 388-550-4800(4).

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5150, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5200 Payment method—SRHAPDSH.** (1) MAA considers a hospital eligible for the small rural hospital assistance program disproportionate share hospital (SRHAPDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is an in-state hospital;
- (c) Is a small, rural hospital, defined as a hospital with fewer than seventy-five licensed beds and located in a city or town with a nonstudent population of thirteen thousand or less; and
- (d) Provides at least one percent of its services to low-income patients in rural areas of the state.

(2) MAA determines the SRHAPDSH payment for each eligible hospital in accordance with WAC 388-550-4800, except that the payment is not reduced by the additional three percent specified in WAC 388-550-4800(4).

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(2)(a) MAA pays hospitals qualifying for SRHAPDSH payments from a legislatively appropriated pool.

(b) MAA determines each individual hospital's SRHAPDSH payment as follows: The total dollars in the pool will be multiplied by the percentage derived from dividing the Medicaid payments to the individual hospital during the fiscal year that is two years previous to the state fiscal year immediately preceded by the total Medicaid payments to all SRHAPDSH hospitals during the same hospital fiscal year.

(3) MAA's SRHAPDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured indigent patients. MAA reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5200, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

#### **WAC 388-550-5250 Payment method—THAPDSH.**

(1) MAA considers a hospital eligible for the teaching hospital assistance program disproportionate share hospital (THAPDSH) program if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is a Washington State University hospital; and

(c) Has a Medicaid inpatient utilization rate (MIPUR) of twenty percent or more.

(2) MAA funds THAPDSH payments with legislatively appropriated monies. MAA divides the legislatively appropriated THAPDSH amount equally between qualifying hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5250, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5250, filed 12/18/97, effective 1/18/98.]

#### **WAC 388-550-5300 Payment method—STHFPDSH.**

(1) The medical assistance administration (MAA) considers a hospital eligible for the state teaching hospital financing program disproportionate share hospital (STHFPDSH) program if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is a state-owned university or public corporation hospital (border area hospitals are excluded);

(c) Provides a major medical teaching program, defined as a program in a hospital with more than one hundred residents and/or interns; and

(d) Has a Medicaid inpatient utilization rate (MIPUR) of at least twenty percent.

(2) MAA, using a prospective payment method:

(a) Pays hospitals meeting the criteria in subsection (1) of this section a STHFPDSH payment from the legislatively appropriated pool specifically designated for disproportionate share hospital (DSH) payments to state and county teaching hospitals.

(b) Limits STHFPDSH payments to eligible hospitals to an annually determined amount of the legislatively appropriated pool for DSH payments to state and county teaching hos-

pitals. MAA establishes the annual amount by identifying the amount of available DSH funding the hospital has within its individual hospital DSH cap as determined through hospital data used for the prospective payment method.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-5300, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5300, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5300, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5350 Payment method—CTHFPDSH.** (1) The medical assistance administration (MAA) considers a hospital eligible for the county teaching hospital financing program disproportionate share hospital (CTHFPDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is a county hospital in Washington state (border area hospitals are excluded), so designated by the county in which located;

(c) Provides a major medical teaching program, defined as a program in a hospital with more than one hundred residents and/or interns; and

(d) Has a low-income utilization rate (LIUR) of at least twenty-five percent.

(2) MAA, using a prospective payment method:

(a) Pays hospitals meeting the criteria in subsection (1) of this section a CTHFPDSH payment from the legislatively appropriated pool specifically designated for disproportionate share hospital (DSH) payments to state and county teaching hospitals.

(b) Limits CTHFPDSH payments to eligible hospitals to an annually determined amount of the legislatively appropriated pool for DSH payments to state and county teaching hospitals. MAA establishes the annual amount by identifying the amount of available DSH funding the hospital has within its individual hospital DSH cap as determined through historical data used for the prospective payment method.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-5350, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5350, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5350, filed 12/18/97, effective 1/18/98.]

#### **WAC 388-550-5400 Payment method—PHDDSH.**

(1) MAA considers a hospital eligible for the public hospital district disproportionate share hospital (PHDDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is a public district hospital in Washington state or a border area hospital owned by a public corporation; and

(c) Provides at least one percent of its services to low-income patients.

(2) MAA pays hospitals considered eligible under the criteria in subsection (1) of this section a PHDDSH payment amount from the legislatively appropriated PHDDSH pool.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5400, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5500 Payment—Hospital-based RHCs.** (1) The department shall reimburse hospital-based rural health clinics under the prospective payment methods effective July 1, 1994. Under the prospective payment method, the department shall not make reconciliation payments to a hospital-based rural health clinic to cover its costs for a preceding period.

(2) The department shall pay an amount equal to the hospital-based rural health clinic's charge multiplied by the hospital's specific ratio of costs to charges (RCC), not to exceed one hundred percent of the charges.

(3) The department shall determine the hospital-based rural health clinic's RCC from the hospital's annual Medicare cost report, pursuant to WAC 388-550-4500(1).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5500, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5550 Public notice for changes in Medicaid payment rates for hospital services.** (1) The purpose and intent of this section is to describe the manner in which the department, pertaining to Medicaid hospital rates, will comply with section 4711(a) of the federal Balanced Budget Act of 1997, Public Law 105-33, as codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For purposes of this section, the term:

(a) "Stakeholders" means providers, beneficiaries, representatives of beneficiaries, and other concerned state residents.

(b) "Rate" means the Medicaid payment amount to a provider for a particular hospital service, except for disproportionate share payments not mandated by federal law.

(c) "Methodology" underlying the establishment of a Medicaid hospital rate means (unless otherwise noted) the principles, procedures, limitations, and formulas detailed in WAC 388-550-2800 through 388-550-5500.

(d) "Justification" means an explanation of why the department is proposing or implementing a Medicaid rate change based on a change in Medicaid rate-setting methodology.

(e) "Reasonable opportunity to review and provide written comments" means a period of fourteen calendar days in which stakeholders may provide written comments to the department.

(f) "Hospital services" means those services that are performed in a hospital facility for an inpatient client and which are payable only to the hospital entity, not to individual performing providers.

(g) "Web site" means the department's internet home page on the worldwide web: <http://www.wa.gov/dshs/maa> is the internet address.

(3) The department will notify stakeholders of proposed and final changes in individual Medicaid hospital rates for hospital services, as follows:

(a) Publish the proposed Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates;

(b) Give stakeholders a reasonable opportunity to review and provide written comments on the proposed Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates; and

(c) Publish the final Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates.

(4)(a) Except as otherwise provided in this section, the department will determine the manner of publication of proposed or final Medicaid hospital rates.

(b) Publication of proposed Medicaid hospital rates will occur as follows:

(i) The department will mail each provider's proposed rate to the affected provider via first-class mail at least fifteen calendar days before the proposed date for implementing the rates; and

(ii) For other stakeholders, the department will post proposed rates on the department's web site.

(c) Publication of final Medicaid hospital rates will occur as follows:

(i) The department will mail each provider's final rate to the affected provider via first-class mail at least one calendar day before implementing the rate; and

(ii) For other stakeholders, the department will post final rates on the department's web site.

(d) The publications required by subsections (4)(b) and (c) of this section will refer to the appropriate sections of chapter 388-550 WAC for information on the methodologies underlying the proposed and final rates.

(5) The department, whenever it proposes amendments to the methodologies underlying the establishment of Medicaid hospital rates as described in WAC 388-550-2800 through 388-550-5500, will adhere to the notice and comment provisions of the Administrative Procedure Act (chapter 34.05 RCW).

(6) Stakeholders who wish to receive notice of either proposed and final Medicaid hospital rates or proposed and final amendments to WAC 388-550-2800 through 388-550-5500 must notify the department in writing. The department will send notice of all such actions to such stakeholders post-age prepaid by regular mail.

(7)(a) The notice and publication provisions of section 4711(a) of the Balanced Budget Act of 1997 do not apply when a rate change is:

(i) Necessary to conform to Medicare rules, methods, or levels of reimbursement for clients who are eligible for both Medicare and Medicaid;

(ii) Required by Congress, the legislature, or court order, and no further rulemaking is necessary to implement the change; or

(iii) Part of a non-Medicaid program.

(b) Although notice and publication are not required for Medicaid rate changes described in subsection (7)(a) of this section, the department will attempt to timely notify stakeholders of these rate changes.

(8) The following rules apply when the department and an individual hospital negotiate or contractually agree to Medicaid rates for hospital services:

(a) Receipt by the hospital of the contract or contract amendment form for signature constitutes notice to the hospital of proposed Medicaid rates.

(b) Receipt by the hospital of the contract or contract amendment form signed by both parties constitutes notice to the hospital of final Medicaid rates.

(c) Notwithstanding subsection (4)(c) of this section, final Medicaid contract rates are effective on the date contractually agreed to by the department and the individual hospital.

(d) Prior to the execution of the contract, the department will not publish negotiated contract prices that are agreed to between the department and an individual provider to anyone other than the individual provider. Within fifteen calendar days after the execution of any such contract, the department will publish the negotiated contract prices on its web site.

(9) The following rules apply when a hospital provider or other stakeholder wishes to challenge the adequacy of the public notification process followed by the department in proposing or implementing a change to Medicaid hospital rates, the methodologies underlying the establishment of such rates, or the justification for such rates:

(a) If any such challenge is limited solely to the adequacy of the public notification process, then the challenge will:

(i) Not be pursued in any administrative appeal or dispute resolution procedure established in rule by the department; and

(ii) Be pursued only in a court of proper jurisdiction as may be provided by law.

(b) If a hospital provider brings any such challenge in conjunction with an appeal of its Medicaid rate, then the hospital provider may pursue the challenge in an administrative appeal or dispute resolution procedure established in rule by the department under which hospital providers may appeal their Medicaid rates.

[Statutory Authority: RCW 74.09.500 and 42 USC 1396a (a)(13)(A). 98-23-036, § 388-550-5550, filed 11/10/98, effective 12/11/98.]

**WAC 388-550-5600 Administrative appeal for hospital rate reimbursement.** The hospital appeals and dispute process follows the procedures as stated in WAC 388-502-0220, Administrative appeal for contractor/provider rate reimbursement.

[Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-550-5600, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5600, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5700 Hospital reports and audits.** (1) In-state and border area hospitals shall complete and submit a copy of their annual Medicare cost reports (HCFA 2552) to the department. These hospital providers shall:

(a) Maintain adequate records for audit and review purposes, and assure the accuracy of their cost reports;

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(b) Complete their annual Medicare HCFA 2552 cost report according to the applicable Medicare statutes, regulations, and instructions; and

(c) Submit a copy to the department:

(i) Within one hundred fifty days from the end of the hospital's fiscal year; or

(ii) If the hospital provider's contract is terminated, within one hundred fifty days of effective termination date; or

(d) Request up to a thirty day extension of the time for submitting the cost report in writing at least ten days prior to the due date of the report. Hospital providers shall include in the extension request the completion date of the report, and the circumstances prohibiting compliance with the report due date;

(2) If a hospital provider improperly completes a cost report or the cost report is received after the due date or approved extension date, the department may withhold all or part of the payments due the hospital until the department receives the properly completed or late report.

(3) Hospitals shall submit other financial information required by the department to establish rates.

(4) The department shall periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5700, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5800 Outpatient and emergency hospital services.** The department shall cover outpatient services, emergent outpatient surgical care, and other emergency care performed on an outpatient basis in a hospital for categorically needy or limited casualty program-medically needy clients. The department shall limit clients eligible for the medically indigent program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5800, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-5900 Prior authorization—Outpatient services.** The department shall require providers to obtain prior authorization for the following selected outpatient hospital services:

(1) Magnetic resonance imaging;

(2) Magnetic resonance angiography;

(3) Sleep studies/polysomnograms for clients over one year old, unless provided in a medical assistance administration (MAA)-approved facility;

(4) Peripheral stem cell transplants, unless provided in an MAA-approved facility;

(5) Positron emission tomography scans, except that the department shall not require prior authorization for brain PET scans;

(6) Evaluation, management and treatment of chronic pain, unless provided in an MAA-approved facility; and

(7) Weight loss program costs, unless provided in a department-approved outpatient weight-loss facility.

(8) See WAC 388-550-1700 for hospital services requiring prior approval and WAC 388-550-1800 for certain prior approval exemptions.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5900, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6000 Payment—Outpatient hospital services.** (1) Excluding nonallowable revenue codes and the services specified in subsection (2) of this section, MAA determines payment and reimburses for outpatient hospital services by multiplying a hospital's outpatient rate by the allowed charges on the hospital's outpatient claim. MAA's rate-setting method for a hospital outpatient rate is described in WAC 388-550-4500.

(2) MAA excludes the following outpatient services from the outpatient rate reimbursement method described in subsection (1) of this section and reimburses for these services the lesser of the hospital billed charges or MAA's maximum allowable fees:

- (a) Laboratory/pathology;
- (b) Radiology, diagnostic and therapeutic;
- (c) Nuclear medicine;
- (d) Computerized tomography scans, magnetic resonance imaging, and other imaging services;
- (e) Physical therapy;
- (f) Occupational therapy;
- (g) Speech/language therapy;
- (h) Sleep studies;
- (i) Synaxis; and
- (j) Other hospital services as identified and listed in MAA's published fee schedule.

(3) For outpatient observation room, the department reimburses the lesser of the:

- (a) Allowed charges multiplied by the hospital outpatient rate; or
- (b) Administrative day rate described in WAC 388-550-4500 (8)(a).

(4) The department considers hospital stays of twenty-four hours or less outpatient short stays and uses the outpatient payment method to reimburse a hospital for these stays. However, when an outpatient short stay involves one of the following situations, the department uses inpatient payment methods to reimburse a hospital for covered services:

- (a) Death of a client;
  - (b) Obstetrical delivery;
  - (c) Initial care of a newborn; or
  - (d) Transfer of a client to another acute care hospital.
- (5) Under WAC 246-976-935, MAA may:
- (a) Enhance payments for trauma care provided to a client eligible under the medically indigent (MI) program or a Title XIX Medicaid program when the trauma:
    - (i) Qualifies under the trauma program; and
    - (ii) Care is provided in a nongovernmental hospital designated by the department of health (DOH) as a trauma services center.
  - (b) Provide an annual grant for trauma services to:

(i) A governmental hospital certified by DOH as a trauma services center; and

(ii) An MAA-approved critical access hospital (CAH).

(6) The department uses the outpatient payment method to reimburse covered inpatient hospital services provided within twenty-four hours of a client's inpatient admission that are not related to the admission. Inpatient hospital services are provided within twenty-four hours of a client's inpatient admission that are related to the admission are paid according to WAC 388-550-2900(12).

(7) For a client enrolled in an MAA-contracted Healthy Options managed care plan, the plan is responsible to reimburse a hospital provider for hospital services that the plan covers. MAA reimburses for a service not covered by the managed care plan only when:

- (a) The service is included in the scope of coverage under the client's medical assistance program;
- (b) The service is medically necessary as defined in WAC 388-550-1050; and

(c) The provider has a current core provider agreement with MAA and meets applicable MAA program requirements in other published WACs.

(8) The department does not reimburse for:

- (a) Room and ancillary services charges beyond the twenty-four hour period for outpatient short stays; or
- (b) Emergency room, labor room, observation room, and other room charges in combination when billing periods for these charges overlap.

(9) In order to be reimbursed for covered outpatient hospital services, hospitals must bill MAA according to the conditions of payment under WAC 388-502-0100, time limits under WAC 388-502-0150, and other applicable published issuances. In addition, MAA requires hospitals to bill outpatient claims using the line item date of service and the appropriate revenue codes, CPT codes, and modifiers listed in MAA's published fee schedule. A hospital's bill to the department must show the admitting, principal, and secondary diagnoses and include the attending physician's name and MAA-assigned provider number.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-6000, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v), 42 C.F.R. 447.271 and 42 C.F.R. 11303. 99-14-028, § 388-550-6000, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-6000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6100 Outpatient hospital physical therapy.** (1) The department shall pay for physical therapy as an outpatient hospital service when:

- (a) The attending physician prescribes physical therapy;
- (b) A licensed physical therapist or physiatrist or a physical therapist assistant supervised by a licensed physical therapist provides the treatment; and
- (c) The therapy assists the client:
  - (i) In avoiding hospitalization or nursing facility care; or
  - (ii) In becoming employable; or
  - (iii) Who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(iv) As part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(2) The hospital shall bill outpatient hospital physical therapy services to the department using the appropriate current procedural terminology or department-assigned codes. The department shall not pay outpatient hospitals a facility fee for such services.

(3) The department shall pay for outpatient hospital physical therapy for clients eligible under the:

(a) Categorically needy, general assistance unemployable and ADATSA programs;

(b) Medically needy program only when the client is:

(i) Twenty years of age and under and referred by a screening provider under the early and periodic screening, diagnosis, and treatment program; or

(ii) Receiving home health care services.

(4) The department shall not pay for physical therapy programs for clients under the limited casualty program-medically indigent program.

(5)(a) For clients who are twenty years of age or under, the department shall not require prior authorization or limit the number of physical therapy sessions payable per client per calendar year, subject to the provision of subsection (8) below, provided the services are medically necessary.

(b) Providers shall fully document in the client's medical record the medical justification for continued therapy.

(6)(a) Except as provided in subsection (7) below, the department shall pay for categorically needy, medically needy and medical care services clients who are twenty-one years of age or older a total of eighteen hours of physical therapy in a calendar year, in any combination of modalities and procedures, for:

(i) Acute conditions; or

(ii) Following joint surgery.

(b) The department shall set time unit equivalents for each physical therapy procedure or modality, and publish such schedules periodically.

(7) For a client twenty-one years of age or older who has a medical diagnosis specified in the outpatient hospital billing instructions as normally requiring more intensive physical therapy treatment, the department shall cover up to twenty-four hours of physical therapy in a calendar year, in any combination of modalities and procedures.

(8)(a) Notwithstanding the hours per calendar year limit, the department shall reimburse a maximum of one hour of physical therapy session per day, except that a maximum of two hours shall be allowed when a client assessment/evaluation is performed on the same date.

(b) The physical therapy provider shall document in each client's record the amount of time spent on services to the client.

(9)(a) The department shall require that physical therapy begin within thirty days of the date the therapy was prescribed.

(b) The department may deny payment for therapy started more than thirty days after the date of the prescription, unless medical justification for the delay is presented to the department.

(c) The hospital shall include the prescription for physical therapy services in the client's medical record.

(10) The department shall not pay for physical therapy services under fee-for-service when physical therapy is already included in other reimbursement methodologies applied to the case, including but not limited to DRG payment for inpatient hospital services and nursing facility per diem.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6100, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6150 Outpatient hospital occupational therapy.** (1) The department shall pay for occupational therapy as an outpatient hospital service when:

(a) The service is provided by a licensed occupational therapist or a licensed occupational therapy assistant supervised by a licensed occupational therapist;

(b) The provider obtains approval from the department before services are performed, for services requiring prior approval as designated in the department's billing instructions; and

(c) The occupational therapy is provided:

(i) As part of an outpatient program when identified in the early and periodic screening, diagnosis, and treatment program of a recipient twenty years of age and younger; or

(ii) As part of the physical medicine and rehabilitation program.

(2)(a) The hospital shall bill outpatient hospital occupational therapy services to the department using the appropriate current procedural terminology or department-assigned codes.

(b) The department shall not pay outpatient hospitals a facility fee for these services.

(3) The department shall pay for occupational therapy provided to clients eligible under the:

(a) Categorically needy, general assistance unemployable and ADATSA programs;

(b) Medically needy program only when the client is:

(i) Twenty years of age and younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program; or

(ii) Receiving home health care services.

(4) The department shall reimburse for occupational therapy as part of an outpatient program when identified in the early and periodic screening, diagnosis, and treatment program of an eligible client.

(5) The department shall cover one assessment, two durable medical equipment needs assessments, and twelve sessions of outpatient hospital occupational therapy per year.

(6) The department shall pay for up to twenty-four additional therapy visits for clients under the children with special health care needs program when the therapy visits are related to the approved list of diagnoses as published by the department.

(7) The department shall not pay for occupational therapy when payment for occupational therapy is included in the reimbursement of other treatment programs including, but not limited to the hospital inpatient diagnosis related group and inpatient physical medicine and rehabilitation services.



[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6150, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6200 Outpatient hospital speech therapy services.** (1) The department shall cover speech therapy services for eligible medical care clients who have a medically recognized disease or defect which requires speech therapy services, except as limited below:

(a) Under the medically needy program the department shall limit therapy to clients twenty years of age and under.

(b) The department shall not pay for specialized speech therapy under the medically indigent program.

(2) The department shall cover speech therapy when provided under a written plan of treatment:

(a) Established by a speech pathologist who has been granted a certificate of clinical competence by the American Speech, Language and Hearing Association; or

(b) An individual who has completed the equivalent educational and work experience necessary for such a certificate; and

(c) That is periodically reviewed by the client's primary care physician.

(3) The department shall cover one medical diagnostic evaluation and twelve speech therapy sessions in a calendar year per client. The department may cover up to twenty-four additional speech therapy sessions only when associated with the specific diagnoses listed in the department's outpatient hospital billing instructions. The department shall make such instructions available to the public.

(4) The department shall require a provider to submit an authorization request to the office of children with special health care needs on the appropriate form for a child with special health care needs who needs more than twelve speech therapy sessions or the additional twenty-four sessions, but does not have any of the specific diagnoses identified in subsection (3) of this section.

(5) The department shall require swallowing (dysphagia) evaluations to be performed by a speech/language pathologist who holds a master's degree in speech pathology and who has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

(6) The department shall require a swallowing evaluation to include:

(a) An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;

(b) Dietary recommendations for oral food and liquid intake therapeutic or management techniques;

(c) Therapeutic or management techniques; and

(d) Videofluoroscopy, when necessary, for further evaluation of swallowing status and aspiration risks.

(7) The provider shall bill outpatient hospital speech therapy services to the department using the appropriate current procedural terminology or department-assigned codes. The department shall not pay the outpatient hospital a facility fee for these services.

(8) The department shall not pay for speech therapy when payment for speech therapy is included in the reimbursement as part of other treatment programs including, but

not limited to the hospital inpatient diagnosis-related group and nursing facility services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6200, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6250 Pregnancy—Enhanced outpatient benefits.** The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 440-25 WAC and certified under chapter 440-22 WAC or its successor.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6250, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6300 Outpatient nutritional counseling.** (1) The department shall cover nutritional counseling services only for eligible Medicaid clients twenty years of age and under referred during an early and periodic screening, diagnosis and treatment screening to a certified dietitian.

(2) Except for children under the children's medical program, the department shall not cover nutritional counseling for clients under the medically indigent and other state-only funded programs.

(3) The department shall pay for nutritional counseling for the following conditions:

(a) Inadequate or excessive growth such as failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile, and obesity;

(b) Inadequate dietary intake, such as formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite;

(c) Infant feeding problems, such as poor suck/swallow reflex, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited caregiver knowledge and/or skills;

(d) Chronic disease requiring nutritional intervention, such as congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, and gastrointestinal disease;

(e) Medical conditions requiring nutritional intervention, such as iron-deficiency anemia, familial hyperlipidemia, and pregnancy;

(f) Developmental disability, such as increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings; or

(g) Psycho-social factors, such as behavior suggesting eating disorders.

(4) The department shall pay for maximum of twenty sessions, in any combination, of assessment/evaluation and/or nutritional counseling in a calendar year.

(5) The department shall require each assessment/evaluation or nutritional counseling session be for a period of twenty-five to thirty minutes of direct interaction with a client and/or the client's caregiver.

(6) The department shall pay the provider for a maximum of two sessions per day per client.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6300, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6350 Outpatient sleep apnea/sleep study programs.** (1) The department shall pay for polysomnograms or multiple sleep latency tests only for clients one year of age or older with obstructive sleep apnea or narcolepsy.

(2) The department shall pay for polysomnograms or multiple sleep latency tests only when performed in outpatient hospitals approved by the medical assistance administration (MAA) as centers of excellence for sleep apnea/sleep study programs.

(3) The department shall not require prior authorization for sleep studies as outlined in WAC 388-550-1800.

(4) Hospitals shall bill the department for sleep studies using current procedural terminology codes. The department shall not reimburse hospitals for these services when billed under revenue codes.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6350, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6400 Outpatient hospital diabetes education.** (1) The department shall pay for outpatient hospital-based diabetes education for an eligible client when:

(a) The facility is approved by the department of health (DOH) as a diabetes education center, and

(b) The client is referred by a licensed health care provider.

(2) The department shall require the diabetes education teaching curriculum to have measurable, behaviorally-stated educational objectives. The diabetes education teaching curriculum shall include all the following core modules:

(a) An overview of diabetes;

(b) Nutrition, including individualized meal plan instruction that is not part of the women, infants, and children program;

(c) Exercise, including an individualized physical activity plan;

(d) Prevention of acute complications, such as hypoglycemia, hyperglycemia, and sick day management;

(e) Prevention of other chronic complications, such as retinopathy, nephropathy, neuropathy, cardiovascular disease, foot and skin problems;

(f) Monitoring, including immediate and long term diabetes control through monitoring of glucose, ketones, and glycosylated hemoglobin; and

(g) Medication management, including administration of oral agents and insulin, and insulin start-up.

(3) The department shall pay for a maximum of six hours of individual core survival skills outpatient diabetes education per lifetime per client.

(4) The department shall require DOH-approved centers to bill the department for diabetes education services on the UB92 billing form using the specific revenue codes assigned and published by the department.

(5) The department shall reimburse for outpatient hospital-based diabetes education based on the individual hospital's current specific ratio of costs-to-charges, or the hospital's customary charge for diabetes education, whichever is less.

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tal's current specific ratio of costs-to-charges, or the hospital's customary charge for diabetes education, whichever is less.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6400, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6450 Outpatient hospital weight loss program.** The department may pay for an outpatient weight loss program only when provided through an outpatient weight loss facility approved by the medical assistance administration. The department shall deny payment for services provided by nonapproved providers.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6450, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6500 Blood and blood products.** (1) The department shall limit Medicaid reimbursement to a hospital for blood derivatives to blood bank service charges for processing the blood and blood products.

(2) Other than payment of blood bank service charges, the department shall not pay for blood and blood derivatives.

(3) The department shall not separately reimburse blood bank service charges for handling and processing blood and blood derivatives provided to an individual who is hospitalized when the hospital is reimbursed under the diagnosis-related group (DRG) system. The department shall bundle these service charges into the total DRG payment.

(4) The department shall reimburse a hospital, which is paid under the cost to charge method, separately for processing blood and blood products.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6500, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6600 Hospital-based physician services.** See chapter 388-531 WAC regarding rules for inpatient and outpatient physician services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6600, filed 12/18/97, effective 1/18/98.]

**WAC 388-550-6700 Hospital services provided out-of-state.** (1) The department shall reimburse only emergency care for an eligible Medicaid client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC 388-501-0175 for a list of border cities.

(2) The department shall authorize and provide comparable medical care services to a Medicaid client who is temporarily outside the state to the same extent that such medical care services are furnished to an eligible Medicaid client in the state, subject to the exceptions and limitations in this section.

(3) The department shall not authorize payment for out-of-state medical care furnished to state-funded clients (medically indigent/medical care services), but may authorize medical services in designated bordering cities.

(4) The department shall cover hospital care provided to Medicaid clients in areas of Canada as described in WAC 388-501-0180.

(5) The department shall review all cases involving out-of-state medical care to determine whether the services are within the scope of the medical assistance program.

(6)(a) If the client can claim deductible or coinsurance portions of Medicare, the provider shall submit the claim to the intermediary or carrier in the provider's own state on the appropriate Medicare billing form.

(b) If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For reimbursement for out-of-state inpatient hospital services, see WAC 388-550-4000.

(8) The department shall reimburse out-of-state outpatient hospital services billed under the physician's current procedural terminology codes at an amount that is the lower of:

- (a) The billed amount; or
- (b) The rate paid by the Washington state Title XIX Medicaid program.

(9) Out-of-state providers shall present final charges to MAA within three hundred sixty-five days of the date of service. In no case shall the state of Washington be liable for payment of charges received beyond one year from the date services were rendered.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-6700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-6700, filed 12/18/97, effective 1/18/98.]

**Chapter 388-551 WAC**

**ALTERNATIVES TO HOSPITAL SERVICES**

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**SUBCHAPTER I—HOSPICE SERVICES**

**Hospice—General**

**WAC 388-551-1000 Hospice program.** (1) Hospice is a twenty-four hour program coordinated by a **hospice interdisciplinary team**. The hospice program allows the **terminally ill** client to choose physical, pastoral/spiritual, and psychosocial comfort rather than cure. Hospitalization is used only for acute symptom management.

(2) Hospice care is initiated by the choice of client, **family**, or physician. The client's physician must certify a client as appropriate for hospice care.

(3) Hospice care may be in a client's temporary or permanent place of **residence**.

(4) Hospice care is ended by the client or family (**revocation**), the hospice agency (**discharge**), or death.

(5) Bereavement care is provided to the **family** of the client who chooses hospice care. It provides emotional and spiritual comfort associated with the death of a hospice client.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1000, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1010 Hospice definitions.** The following definitions and those found in WAC 388-500-0005, Medical definitions have the following meanings for this subchapter. Defined words and phrases are bolded in the text.

**"Biologicals"** means medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

**"Brief period"** means six days or less.

**"CSO"** means the client's community services office of the department's economic services administration.

**"Discharge"** means an agency ends hospice care for a client. See WAC 388-551-1350 for details.

**"Election period"** means the time, ninety or sixty days, that the client is certified as eligible for and chooses to receive hospice care. See WAC 388-551-1310 for details.

**"Family"** means any person(s) important to the client, as defined by the client.

**"HCS"** means the client's home and community services office of the aging and adult services administration.

**"Hospice interdisciplinary team"** means the following health professionals who plan and deliver hospice care to a client as appropriate under the direction of a certified physi-

cian: Home health aides monitored by a registered nurse, therapists (physical, occupational, speech-language), registered nurses, physicians, social workers, counselors, volunteers, and others as necessary.

"**Palliative**" means medical treatment designed to reduce pain or increase comfort, rather than cure.

"**Plan of care.**" See WAC 388-551-1320 for details.

"**Residence**" means where the client lives for an extended period of time.

"**Revoke**" and "**revocation**" mean a client or family member's choice to stop receiving hospice care. See WAC 388-551-1220 for details.

"**Terminally ill**" means the client has a life expectancy of six months or less, assuming the client's disease process runs its natural course.

"**Twenty-four-hour day**" means a day beginning and ending at midnight.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1010, filed 4/9/99, effective 5/10/99.]

### Hospice—Coverage

**WAC 388-551-1200 Client eligibility for hospice care.** (1) A client must be eligible for one of the following Medicaid programs to receive hospice care:

- (a) Categorically needy program (CNP);
- (b) General assistance - disability determination pending (GAX);
- (c) Limited casualty program - medically needy program (LCP-MNP); or
- (d) Children's health (V).

(2) An eligible Medicaid client who voluntarily chooses hospice care must be certified by a physician as **terminally ill** before MAA pays for hospice care.

(3) Clients enrolled in one of MAA's healthy options managed care plans receive all hospice services directly through their plan. The managed care plan must arrange or provide all hospice services for a managed care client.

(4) Hospice clients attain institutional status as described in WAC 388-513-1320 when they elect and are certified for hospice care. See WAC 388-513-1380 for the client's financial participation requirements.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1200, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1210 Services included in the hospice daily rate.** (1) In the client's individual **plan of care**, the **hospice interdisciplinary team** identifies the specific Hospice services and supplies to be provided to the client.

(2) The services must be all of the following:

- (a) Medically necessary for **palliative care**;
- (b) Related to the client's **terminal illness**;
- (c) Prescribed by the client's attending physician, alternate physician, or hospice medical director;
- (d) Supplied or arranged for by the hospice provider; and
- (e) Included in the client's **plan of care**.

(3) The following intermittent services and supplies, paid by MAA's hospice daily rate, must be available from and

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offered by the hospice provider for the client as determined by the client's **hospice interdisciplinary team**:

(a) **Medical equipment and supplies** that are medically necessary for **palliative care**;

(b) **Drugs and biologicals** used primarily for the relief of pain and management of symptoms;

(c) **Home health aide services** furnished by qualified aides of the hospice agency. A registered nurse must complete a home-site supervisory visit every two weeks to assess aide services provided;

(d) **Physical therapy, occupational therapy, and speech-language therapy** to manage symptoms or enable the client to safely perform ADLs (activities of daily living) and basic functional skills;

(e) **Physician services** related to administration of the **plan of care**;

(f) **Nursing care** provided through the hospice agency by either:

(i) A registered nurse; or

(ii) A licensed practical nurse under the supervision of a registered nurse;

(g) **Medical social services** provided through the hospice agency by a social worker under the direction of a physician;

(h) **Counseling services** provided through the hospice agency to the client and his or her **family** members or caregivers;

(i) **Medical transportation services**; and

(j) **Short-term, inpatient care**, provided in a Medicare-certified hospice inpatient unit, hospital, or nursing facility.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1210, filed 4/9/99, effective 5/10/99.]

### Hospice—Provider Requirements

**WAC 388-551-1300 How to become a MAA hospice provider.** (1) To be reimbursed by MAA, a hospice agency must be:

(a) Medicare, Title XVIII certified; and

(b) Enrolled with MAA as a provider of hospice care.

(2) All services provided through a hospice agency must be performed by qualified personnel as required through Medicare's certification process in effect as of February 1, 1999. For more information on Medicare certifications, contact:

Department of Health  
Hospice Certification Program  
Mailstop 47852  
Olympia, Washington, 98504-7852.

(3) Freestanding hospice agencies licensed as hospitals by the department of health must sign an additional selective contract with MAA to receive payment from MAA.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1300, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1310 Certifications (election periods) for hospice clients.** A client chooses to receive Hospice care

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through a series of time-limited periods, called "**election periods.**" An example of this process is WAC 388-551-1315. Hospice providers are responsible for obtaining physician certifications for these **election periods.**

(1) A client's hospice coverage must be available for two initial ninety-day **election periods** followed by an unlimited number of succeeding sixty-day **election periods.**

(2) The hospice provider must document the client's medical prognosis of a specific **terminal illness** in the client's hospice record. This written certification must be filed in the client's hospice record for each election period. The certification must meet all of the following criteria:

(a) For the **initial election period**, signatures of the hospice medical director and the client's attending physician; and

(b) For **subsequent election periods**:

(i) Signature of the hospice medical director; and

(ii) Verbal certifications by the hospice medical director or the client's attending physician must be documented in writing no later than two calendar days after hospice care is initiated or renewed.

(3) The provider must file election statements in the client's hospice medical record. This election statement must include:

(a) Name and address of the hospice;

(b) Proof that client was fully informed about hospice care and waiver of other services;

(c) Effective date of the election; and

(d) Signature of the client or their representative.

(4) When a client's hospice coverage ends within an **election period**, the remainder of that **election period** is forfeited.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1310, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1315 Example of how hospice client certifications (election periods) work.** This is an **example** of how election periods, as described in WAC 388-551-1310, work:

(1) Client chooses hospice care, physician certifies the client;

(2) Client is on hospice care for the first ninety-day period;

(3) Physician recertifies the client for the second ninety-day period;

(4) Client revokes hospice care, on the sixty-third day of the second ninety-day period (one hundred and fifty-three days since original certification);

(5) Hospice care for the client stops on the sixty-third day of the second ninety-day period (one hundred and fifty-three days since original certification);

(6) Client decides to re-elect hospice care, eleven days later, the seventy-fourth day of the second ninety-day period (the one hundred and sixty-fourth day since original certification);

(7) Client forfeits the right to the remaining sixteen days of the second ninety-day period; and

(8) Does the physician re-certify the client for hospice care?:

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(a) If yes, the client may immediately begin a new sixty-day election period; or

(b) If no, the client is not currently eligible to receive hospice care.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1315, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1320 Hospice plan of care.** (1) The hospice agency must establish the client's hospice **plan of care** in accordance with Medicare requirements before hospice services are delivered. Hospice services delivered must be consistent with that **plan of care.**

(2) A registered nurse or physician must conduct an initial assessment of the client and must develop the **plan of care** with at least one other member of the **hospice interdisciplinary team.**

(3) The **hospice interdisciplinary team** must review in a case planning conference the **plan of care**, no later than two working days after it is developed.

(4) The **plan of care** must be reviewed and updated every two weeks by at least three members of the **hospice interdisciplinary team**, including at least:

(a) A registered nurse;

(b) A social worker; and

(c) One other **hospice interdisciplinary team** member.

(5) Also see WAC 246-331-135 for the department of health's plan of care requirements.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1320, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1330 Hospice coordination of care.** (1) Once a client chooses hospice care from a hospice agency, that client gives up the right to:

(a) Covered Medicaid hospice services and supplies received at the same time from another hospice agency; and

(b) Any covered Medicaid services and supplies received from any other provider and which are related to the **terminal illness.**

(2) Services and supplies not covered by the Medicaid hospice benefit are paid separately, if covered under the client's Medicaid eligibility. These services include but are not limited to:

(a) COPES (community options program entry system) as determined and paid by the department's aging and adult services administration (AASA); and

(b) Medically intensive home care program (MIHCP) as determined by the department's division of developmentally disabled.

(3) Clients eligible for coordinated community aids services alternatives (CCASA) are not eligible for hospice coverage.

(4) The hospice provider must coordinate all the client's medical management for the **terminal illness.**

(5) All of the client's providers, including the hospice provider, must coordinate:

(a) The client's health care; and

(b) Services available from other department programs, such as COPES.

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[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1330, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1340 When a client leaves hospice without notice.** When a client chooses to leave hospice care or refuses hospice care without giving the hospice provider a **revocation** statement, as required by WAC 388-551-1360, the hospice provider must do all of the following:

- (1) Notify MAA's hospice coordinator within **five working days** of becoming aware of the client's decision (see WAC 388-551-1400 for further requirements);
- (2) Stop billing MAA for hospice payment;
- (3) Notify the client, or the client's representative, that the client's **discharge** has been reported to MAA; and
- (4) Document the effective date and details of the **discharge** in the client's hospice record.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1340, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1350 Discharges from hospice care.** A hospice provider may **discharge** a client from hospice care when the client:

- (1) Is no longer certified for hospice care;
- (2) Is no longer appropriate for hospice care; or
- (3) Seeks treatment for the **terminal illness** from outside the **plan of care** as defined by the **hospice interdisciplinary team**.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1350, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1360 Ending hospice care (revocations).** (1) A client or a **family member** may choose to stop hospice care at any time by signing a **revocation** statement.

(2) The **revocation** statement documents the client's choice to stop Medicaid Hospice care. The **revocation** statement must include all of the following:

- (a) Client's signature;
- (b) Date the **revocation** was signed; and
- (c) Actual date that the client chose to stop receiving hospice care.

(3) The hospice agency must keep any explanation supporting any difference in the signature and **revocation** dates in the client's hospice records.

(4) The hospice agency must keep the **revocation** statement in the client's hospice record.

(5) After a client **revokes** hospice care, the remaining days on the current **election period** are forfeited. The client may enter the next consecutive **election period** immediately. The client does not have to wait for the forfeited days to pass before entering the next consecutive **election period**.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1360, filed 4/9/99, effective 5/10/99.]

#### Hospice—Notification

**WAC 388-551-1400 Hospice providers must notify the department.** (1) Notification within five working days avoids duplicative payments for services related to a client's

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terminal illness. Hospice providers must notify the MAA hospice coordinator, and either the client's CSO or HCS as appropriate.

(2) Hospice providers must report any changes in the client's hospice status within **five working days** from when a MAA client:

- (a) Begins the first day of hospice care;
- (b) Changes hospice agencies. Clients may change hospice agencies only once per election period. Both the old and new hospice providers must supply the department as described in subsection (1) of this section with:
  - (i) The effective date of **discharge** from the old agency; and
  - (ii) The effective date of the admit to, the name of, and the provider number of the new agency;
- (c) **Revokes** the hospice benefit (home or institutional);
- (d) **Discharges** from hospice care;
- (e) Becomes an institutional facility resident;
- (f) Leaves an institutional facility as a resident; or
- (g) Dies.

(3) A hospice agency must submit a client's assessment to MAA within five working days of MAA's request for that assessment.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1400, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1410 Hospice providers must notify institutional providers.** Hospice providers must notify a client's institutional provider of the changes described in WAC 388-551-1400.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1410, filed 4/9/99, effective 5/10/99.]

#### Hospice—Payment

**WAC 388-551-1500 Availability requirements for hospice care.** All services related to the client's **terminal illness** are included in the daily rate through one of the following four levels of hospice care:

(1) **Routine care** for each day the client is at their **residence**, with no restriction on length or frequency of visits, dependent on the client's needs.

(2) **Continuous care** is acute episodic care received by the client to maintain the client at home and addresses a **brief** period of medical crisis. Continuous care consists predominantly of nursing care. This benefit is limited to:

(a) A minimum of eight hours of care provided during a **twenty-four-hour day**;

(b) Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care; and

(c) Homemaker, home health aide, and attendant services that may be provided as supplements to the nursing care.

(3) **Inpatient respite care** is care received in an approved nursing facility or hospital to relieve the primary caregiver. This benefit is limited to:

- (a) No more than five consecutive days; and
- (b) A client not residing in a nursing facility.



(4) **General inpatient hospice care** is for pain and symptom management that cannot be provided in other settings.

(a) The services must conform to the client's written **plan of care**.

(b) This benefit is limited to **brief** periods of care in MAA-approved:

- (i) Hospitals;
- (ii) Nursing facilities; or
- (iii) Hospice inpatient facilities.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1500, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1510 Payment method for hospice providers.** This section describes payment methods for Hospice care provided under WAC 388-551-1500 to hospice clients.

(1) Prior to submitting a claim to MAA, the hospice provider must file written certification in the client's hospice record per WAC 388-551-1310.

(2) MAA may pay for Hospice care provided to clients in one of the following settings:

- (a) A client's **residence**;
- (b) Inpatient respite services; or
- (c) General inpatient as follows:

DAY OF	PAID AT
Admit	General Inpatient
Brief Period	General Inpatient
Death	General Inpatient
Other Discharge	Routine

(3) To be paid by MAA, the hospice provider must provide and/or coordinate MAA covered:

- (a) Medicaid hospice services; and
- (b) Services that relate to the client's **terminal illness** at the time of the hospice admit.

(4) MAA does not pay hospice providers for the client's last day, except for the day of death.

(5) Hospice providers must bill MAA for their services using hospice-specific revenue codes.

(6) MAA pays hospice providers for services (not room and board) at a daily rate calculated by one of the following methods and adjusted for current wages:

(a) Payments for services delivered in a client's **residence** (routine and continuous home care) are based on the county location of the client's residence for that particular client; or

(b) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(7) MAA pays nursing facility room and board payments to hospice agencies, not licensed as hospitals, at a day rate as follows:

(a) Directly to the hospice provider at ninety-five percent of the nursing facility's lowest current Medicaid day rate;

(b) The hospice agency pays the nursing facility at a day rate no greater than the nursing facility's lowest current Medicaid daily rate; and

(c) The correct amount of the patient's participation must be:

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(i) Collected by the hospice agency as directed by the department each month; and

(ii) Forwarded to the nursing facility.

(8) MAA pays nursing facility room and board payments to free-standing hospice agencies licensed as hospitals by using MAA's administrative statewide average day rate in effect at the time the contract is signed.

(9) The department pays for COPES services clients directly to the COPES provider.

(a) Patient participation in that case is paid separately to the COPES provider.

(b) Hospice providers bill MAA directly for hospice services, not the COPES program.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1510, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1520 Payment method for nonhospice providers.** (1) Hospitals which provide inpatient care to clients in the hospice program for medical conditions not related to their **terminal illness** may be paid according to chapter 388-550 WAC, Hospital services.

(2) MAA pays attending physicians who are not employed by the hospice agency at their usual amount through the resource based relative value scale (RBRVS) fee schedule:

(a) For direct physician care services provided to a hospice client;

(b) When the provided services are not related to the **terminal illness**; and

(c) When the client's providers, including hospice provider, coordinate the health care provided.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1520, filed 4/9/99, effective 5/10/99.]

**WAC 388-551-1530 Payment method for Medicaid-Medicare dual eligible clients.** (1) MAA does not pay for any hospice care provided to a client covered by part A Medicare (hospital insurance).

(2) MAA may pay for hospice care provided to a client:

(a) Covered by part B Medicaid (medical insurance); and

(b) Not covered by part A Medicare.

(3) Hospice providers must bill Medicare before billing Medicaid, except for hospice nursing facility room and board.

(4) All the limitations and requirements related to hospice care described in this chapter apply to the payments described in this section.

[Statutory Authority: RCW 74.09.520 and 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1530, filed 4/9/99, effective 5/10/99.]

**SUBCHAPTER II—HOME HEALTH SERVICES**

**WAC 388-551-2000 Home health services—General.** The purpose of the medical assistance administration (MAA) home health program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in the client's residence, subject to the restrictions and limitations in this subchapter.

Home health skilled services are provided for acute, intermittent, short-term, and intensive courses of treatment. See chapters 388-515 and 388-71 WAC for programs administered to clients who need chronic, long-term maintenance care.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2000, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2000, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2010 Home health services—Definitions.** The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this subchapter:

**"Acute care"** means care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.

**"Brief skilled nursing visit"** means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client:

- (1) An injection;
- (2) Blood draw; or
- (3) Placement of medications in containers.

**"Chronic care"** means long-term care for medically stable clients.

**"Full skilled nursing visit"** means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client:

- (1) Observation;
- (2) Assessment;
- (3) Treatment;
- (4) Teaching;
- (5) Training;
- (6) Management; and
- (7) Evaluation.

**"Home health agency"** means an agency or organization certified under Medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in the patient's place of residence.

**"Home health aide"** means an individual registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

**"Home health aide services"** means services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by or under contract with a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.

**"Home health skilled services"** means skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on an intermittent or part-time basis by a Medicare-certified home health agency with a current medical assistance administration (MAA) provider number. See also WAC 388-551-2000.

**"Long-term care"** is a generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the department's aging and adult services administration (AASA) or division of developmental disabilities (DDD).

**"Plan of care (POC)"** (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider. The plan describes the home health care to be provided at the client's residence. See WAC 388-551-2210.

**"Residence"** means a client's home or place of living. (See WAC 388-551-2030 (2)(g)(ii) for clients in residential facilities whose home health services are not covered through MAA's home health program.)

**"Review period"** means the three-month period the medical assistance administration (MAA) assigns to a home health agency, based on the address of the agency's main office, during which MAA reviews all claims submitted by that agency.

**"Specialized therapy"** means skilled therapy services provided to clients that include:

- (1) Physical;
- (2) Occupational; or
- (3) Speech/audiology services.

(See WAC 388-551-2110.)

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2010, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2010, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2020 Home health services—Eligible clients.** (1) Clients in the following fee-for-service MAA programs are eligible to receive home health services subject to the limitations described in this chapter. Clients enrolled in a healthy options managed care plan receive all home health services through their designated plan.

- (a) Categorically needy program (CNP);
- (b) Limited casualty program - medically needy program (LCP-MNP);
- (c) General assistance expedited (GA-X) (disability determination pending); and
- (d) Medical care services (MCS) under the following programs:
  - (i) General assistance - unemployable (GA-U); and
  - (ii) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) (GA-W).

(2) MAA does not cover home health services under the home health program for clients in the CNP-emergency medical only and LCP-MNP-emergency medical only programs. MAA evaluates a request for home health skilled nursing visits on a case-by-case basis under the provisions of WAC 388-501-0165, and may cover up to two skilled nursing visits

within the eligibility enrollment period if the following criteria are met:

- (a) The client requires hospital care due to an emergent medical condition as described in WAC 388-500-0005; and
- (b) MAA authorizes up to two skilled nursing visits for follow-up care related to the emergent medical condition.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2020, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2020, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2030 Home health skilled services—Requirements.** (1) MAA reimburses for covered home health skilled services provided to eligible clients, subject to the restrictions or limitations in this section and other applicable published WAC.

(2) Home health skilled services provided to eligible clients must:

- (a) Meet the definition of "acute care" in WAC 388-551-2010.
- (b) Provide for the treatment of an illness, injury, or disability.
- (c) Be medically necessary as defined in WAC 388-500-0005.
- (d) Be reasonable, based on the community standard of care, in amount, duration, and frequency.
- (e) Be provided under a plan of care (POC), as defined in WAC 388-551-2010 and described in WAC 388-551-2210. Any statement in the POC must be supported by documentation in the client's medical records.
- (f) Be used to prevent placement in a more restrictive setting. In addition, the client's medical records must justify the medical reason(s) that the services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting. This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in the client's home on a short-term basis.
- (g) Be provided in the client's residence.
  - (i) MAA does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client's place of residence.
  - (ii) Clients in residential facilities contracted with the state and paid by other programs such as home and community programs to provide limited skilled nursing services, are not eligible for MAA-funded limited skilled nursing services unless the services are prior authorized under the provisions of WAC 388-501-0165.
- (h) Be provided by:
  - (i) A home health agency that is Title XVIII (Medicare) certified;
  - (ii) A registered nurse (RN) prior authorized by MAA when no home health agency exists in the area a client resides; or
  - (iii) An RN authorized by MAA when the RN is unable to contract with a Medicare-certified home health agency.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2030, filed 7/15/02, effective 8/15/02.]

**WAC 388-551-2100 Covered home health services—Nursing.** (1) MAA covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider. MAA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165.

(2) MAA covers the following home health acute care skilled nursing services, subject to the limitations in this section:

- (a) Full skilled nursing services that require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse if the services involve one or more of the following:
  - (i) Observation;
  - (ii) Assessment;
  - (iii) Treatment;
  - (iv) Teaching;
  - (v) Training;
  - (vi) Management; and
  - (vii) Evaluation.
- (b) A brief skilled nursing visit if only one of the following activities is performed during the visit:
  - (i) An injection;
  - (ii) Blood draw; or
  - (iii) Placement of medications in containers (e.g., envelopes, cups, medisets).
- (c) Home infusion therapy only if the client:
  - (i) Is willing and capable of learning and managing the client's infusion care; or
  - (ii) Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.
- (d) Infant phototherapy for an infant diagnosed with hyperbilirubinemia:
  - (i) When provided by an MAA-approved infant phototherapy agency; and
  - (ii) For up to five skilled nursing visits per infant.
- (e) Limited high-risk obstetrical services:
  - (i) For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;
  - (ii) For up to three home health visits per pregnancy if:
    - (A) Enrollment in or referral to the following providers of First Steps has been verified:
      - (I) Maternity support services (MSS); or
      - (II) Maternity case management (MCM); and
      - (B) The visits are provided by a registered nurse who has either:
        - (I) National perinatal certification; or
        - (II) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.
- (3) MAA limits skilled nursing visits provided to eligible clients to two per day.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2100, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2100, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2110 Home health services—Specialized therapy.** (1) MAA limits specialized therapy visits to one per client, per day, per type of specialized therapy. Specialized therapy is defined in WAC 388-551-2010.

(2) MAA does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2110, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2110, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2120 Home health aide services.** (1) MAA limits home health aide visits to one per day.

(2) MAA reimburses for home health aide services, as defined in WAC 388-551-2010, only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:

- (a) Skilled nursing services; or
- (b) Specialized therapy services.

(3) MAA covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2120, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2120, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2130 Noncovered home health services.** (1) MAA does not cover the following home health services under the home health program, unless otherwise specified:

(a) Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the department of social and health services aging and adult services administration (AASA) or division of developmental disabilities (DDD).

(i) MAA considers requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for AASA or DDD to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, MAA may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until a long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this section and other applicable published WACs.

- (b) Social work services.
- (c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC 388-551-2100 (2)(e).

(e) Well-baby follow-up care.

(f) Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing services available.

(g) Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services.

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change).

(i) Home health specialized therapies and home health aide visits for clients in the following programs:

- (i) CNP - emergency medical only; and
- (ii) LCP-MNP - emergency medical only.

(j) Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care).

(k) More than one of the same type of specialized therapy and/or home health aide visit per day.

(l) MAA does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

(m) Home health visits made without a written physician's order, unless the verbal order is:

- (i) Documented prior to the visit; and
- (ii) The document is signed by the physician within forty-five days of the order being given.

(2) MAA does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

(3) MAA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2130, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2130, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2200 Home health services—Eligible providers.** The following may contract with MAA to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) A home health agency that:

- (a) Is Title XVIII (Medicare) certified;
- (b) Is department of health (DOH) licensed as a home health agency;
- (c) Submits a completed, signed core provider agreement to MAA; and
- (d) Is assigned a provider number.

(2) A registered nurse (RN) who:

- (a) Is prior authorized by MAA to provide intermittent nursing services when no home health agency exists in the area a client resides;
- (b) Is unable to contract with a Medicare-certified home health agency;
- (c) Submits a completed, signed core provider agreement to MAA; and
- (d) Is assigned a provider number.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2200, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2200, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2210 Home health services—Provider requirements.** For any delivered home health service to be payable, MAA requires home health providers to develop and implement an individualized plan of care (POC) for the client.

- (1) The POC must:
  - (a) Be documented in writing and be located in the client's home health medical record;
  - (b) Be developed, supervised, and signed by a licensed registered nurse or licensed therapist;
  - (c) Reflect the physician's orders and client's current health status;
  - (d) Contain specific goals and treatment plans;
  - (e) Be reviewed and revised by a physician at least every sixty calendar days, signed by a physician within forty-five days of the verbal order, and returned to the home health agency's file; and
  - (f) Be available to department staff or its designated contractor(s) on request.
- (2) The provider must include in the POC all of the following:
  - (a) The client's name, date of birth, and address (to include name of residential care facility, if applicable);
  - (b) The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for home health services) or the diagnosis that is the reason for the visit frequency;
  - (c) All secondary medical diagnoses, including date(s) of onset or exacerbation;
  - (d) The prognosis;
  - (e) The type(s) of equipment required;
  - (f) A description of each planned service and goals related to the services provided;
  - (g) Specific procedures and modalities;
  - (h) A description of the client's mental status;
  - (i) A description of the client's rehabilitation potential;
  - (j) A list of permitted activities;
  - (k) A list of safety measures taken on behalf of the client;
- and
- (l) A list of medications which indicates:
  - (i) Any new prescription; and
  - (ii) Which medications are changed for dosage or route of administration.
- (3) The provider must include in or attach to the POC:
  - (a) A description of the client's functional limits and the effects;
  - (b) Documentation that justifies why the medical services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting;
  - (c) Significant clinical findings;
  - (d) Dates of recent hospitalization;
  - (e) Notification to the DSHS case manager of admittance; and
  - (f) A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge.
- (4) The individual client medical record must comply with community standards of practice, and must include documentation of:
  - (a) Visit notes for every billed visit;

- (b) Supervisory visits for home health aide services as described in WAC 388-551-2120(3);
  - (c) All medications administered and treatments provided;
  - (d) All physician orders, new orders, and change orders, with notation that the order was received prior to treatment;
  - (e) Signed physician new orders and change orders;
  - (f) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;
  - (g) Interdisciplinary and multidisciplinary team communications;
  - (h) Inter-agency and intra-agency referrals;
  - (i) Medical tests and results;
  - (j) Pertinent medical history; and
  - (k) Notations and charting with signature and title of writer.
- (5) The provider must document at least the following in the client's medical record:
- (a) Skilled interventions per the POC;
  - (b) Client response to the POC;
  - (c) Any clinical change in client status;
  - (d) Follow-up interventions specific to a change in status with significant clinical findings; and
  - (e) Any communications with the attending physician.
- (6) The provider must include the following documentation in the client's visit notes when appropriate:
- (a) Any teaching, assessment, management, evaluation, client compliance, and client response;
  - (b) Weekly documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;
  - (c) If a client's wound is not healing, the client's physician has been notified, the client's wound management program has been appropriately altered and, if possible, the client has been referred to a wound care specialist; and
  - (d) The client's physical system assessment as identified in the POC.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2210, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2210, filed 8/2/99, effective 9/2/99.]

**WAC 388-551-2220 Home health services—Provider payments.** (1) In order to be reimbursed, the home health provider must bill MAA according to the conditions of payment under WAC 388-502-0150 and other issuances.

(2) Payment to home health providers is:

- (a) A set rate per visit for each discipline provided to a client;
- (b) Based on the county location of the providing home health agency; and
- (c) Updated by general vendor rate changes.

(3) For clients eligible for both Medicaid and Medicare, MAA may pay for services described in this chapter only when Medicare does not cover those services. The maximum payment for each service is Medicaid's maximum payment.

(4) Providers must submit documentation to MAA during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC 388-551-2210.

(5) After MAA receives the documentation, the MAA medical director or designee reviews the client's medical records for program compliance and quality of care.

(6) MAA may take back or deny payment for any insufficiently documented home health care service when the MAA medical director or designee determines that:

(a) The service did not meet the conditions described in WAC 388-550-2030; or

(b) The service was not in compliance with program policy.

(7) Covered home health services for clients enrolled in a Healthy Options managed care plan are paid for by that plan.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2220, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2220, filed 8/2/99, effective 9/2/99.]

**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 private 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<sub>2</sub>s, 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 388-552 WAC

#### OXYGEN AND RESPIRATORY THERAPY

##### WAC

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**WAC 388-552-001 Scope.** (1) This chapter applies to:

(a) Medical assistance administration (MAA) clients who require medically necessary **oxygen** and/or respiratory therapy equipment, supplies, and services in their homes and nursing facilities; and

(b) Providers who furnish **oxygen** and respiratory therapy equipment, supplies and services to eligible MAA clients.

(2) Instructions for clients covered by Medicare are located in Medicare's Durable Medical Equipment Regional Carrier (DMERC) Manual.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-001, filed 6/9/99, effective 7/10/99.]

(2003 Ed.)

**WAC 388-552-005 Definitions.** The following definitions and those in WAC 388-500-0005 apply to this chapter. If a definition in WAC 388-500-0005 differs with the definition in this section, the definition in this section applies. Defined words and phrases are bolded in the text.

**"Authorized prescriber"** means a health care practitioner authorized by law or rule in the state of Washington to prescribe oxygen and respiratory therapy equipment, supplies, and services.

**"Base year,"** as used in this chapter, means the year in which the oxygen and respiratory therapy billing instructions' current fee schedule is adopted.

**"Maximum allowable"** means the maximum dollar amount MAA reimburses a provider for a specific service, supply, or piece of equipment.

**"Oxygen"** means United States Pure (USP) medical grade liquid or gaseous oxygen.

**"Oxygen and respiratory therapy billing instructions"** means a booklet containing procedures for billing, which is available by writing to Medical Assistance Administration, Division of Program Support, PO Box 45562, Olympia, WA, 98504-5562.

**"Oxygen system"** means all equipment necessary to provide oxygen to a person.

**"Portable system"** means a small system which allows the client to be independent of the stationary system for several hours, thereby providing mobility outside of the residence.

**"Provider"** means a person or company with a signed core provider agreement with MAA to furnish **oxygen** and respiratory therapy equipment, supplies, and services to eligible MAA clients.

**"Respiratory care practitioner"** means a person certified by the department of health according to chapter 18.89 RCW and chapter 246-928 WAC.

**"Stationary system"** means equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-005, filed 6/9/99, effective 7/10/99.]

##### CLIENT ELIGIBILITY

**WAC 388-552-100 Client eligibility.** (1) All MAA fee-for-service clients are eligible for **oxygen** and respiratory therapy equipment, supplies, and services when medically necessary, with the following limitations:

(a) Clients on the medically indigent program are not eligible under this chapter; and

(b) Clients on the categorically needy/qualified Medicare beneficiaries and medically needy/qualified Medicare beneficiaries programs are covered by Medicare and Medicaid as follows:

(i) If Medicare covers the service, MAA will pay the lesser of:

(A) The full co-insurance and deductible amounts due, based upon Medicaid's allowed amount; or

(B) MAA's **maximum allowable** for that service minus the amount paid by Medicare.

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(ii) If Medicare does not cover or denies equipment, supplies, or services that MAA covers according to this chapter, MAA reimburses at MAA's **maximum allowable**; except, MAA does not reimburse for clients on the qualified Medicare beneficiaries (QMB) only program.

(2) Services for clients enrolled in a healthy options managed care plan receive all **oxygen** and respiratory therapy equipment, supplies, and services through their designated plan, subject to the plan's coverages and limitations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-100, filed 6/9/99, effective 7/10/99.]

## PROVIDERS

**WAC 388-552-200 Providers—General responsibilities.** (1) The provider must verify that the client's original prescription is signed and dated by the **authorized prescriber** no more than ninety days prior to the initial date of service. The prescription must include, at a minimum:

(a) The client's medical diagnosis, prognosis, and documentation of the medical necessity for **oxygen** and/or respiratory therapy equipment, supplies, and/or services, and any modifications;

(b) If **oxygen** is prescribed:

(i) Flow rate of **oxygen**;

(ii) Estimated duration of need;

(iii) Frequency and duration of **oxygen** use; and

(iv) Lab values or **oxygen** saturation measurements upon the client's discharge from the hospital.

(2) The provider must provide instructions to the client and/or caregiver on the safe and proper use of equipment provided.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-200, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-210 Required records.** (1) A provider must maintain legible, accurate, and complete charts and records for each client. These records must support and justify claims that the provider submits to MAA for reimbursement. Records must include, at a minimum the:

(a) Date(s) of service;

(b) Client's name and date of birth;

(c) Name and title of person performing the service, when it is someone other than the billing practitioner;

(d) Chief complaint or reason for each visit;

(e) Pertinent medical history;

(f) Pertinent findings on examination;

(g) **Oxygen**, equipment, supplies, and/or services prescribed or provided;

(h) The original and subsequent prescriptions according to the requirements in WAC 388-552-200 and 388-552-220;

(i) Description of treatment (when applicable);

(j) Recommendations for additional treatments, procedures, or consultations;

(k) X-rays, tests, and results;

(l) Plan of treatment/care/outcome;

(m) Logs of oxygen saturations and lab values taken to substantiate the medical necessity of continuous **oxygen**, as required by WAC 388-552-220;

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(n) Logs of oximetry readings if required by WAC 388-552-380 for a client seventeen years of age or younger; and

(o) Recommendations and evaluations if required by WAC 388-552-230 for the infant apnea monitor program.

(2) The provider must make required charts and records available to DSHS or its contractor(s) upon request.

(3) MAA may require additional information in order to process a submitted claim.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-210, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-220 Requirements for oxygen providers.** Oxygen providers must:

(1) Obtain a renewed prescription every six months if the client's condition warrants continued service;

(2) Verify, at least every six months, that **oxygen** saturations or lab values substantiate the need for continued **oxygen** use for each client. The provider may perform the **oxygen** saturation measurements. MAA does not accept lifetime certificates of medical need (CMNs).

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-220, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-230 Requirements for infant apnea monitors.** (1) MAA does not reimburse for apnea monitors unless the provider has a respiratory care practitioner or registered nurse with expertise in pediatric respiratory care who is responsible for their apnea monitor program.

(2) MAA does not require a confirming second opinion for the initial rental period for diagnoses of apnea of prematurity, primary apnea, obstructed airway, or congenital conditions associated with apnea. For other diagnoses, a neonatologist's confirming assessment and recommendation must be maintained as a second opinion in the client's file. The initial rental period must not exceed six months.

(3) Regardless of diagnosis, the provider must maintain in the client's file, a neonatologist's clinical evaluation justifying each subsequent rental period.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-230, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-240 Requirements for respiratory care practitioners.** (1) A respiratory care practitioner must comply with chapter 18.89 RCW and chapter 246-928 WAC to qualify for reimbursement.

(2) A respiratory care practitioner must complete at least the following in each client visit:

(a) Check equipment and ensure equipment settings continue to meet the client's needs; and

(b) Communicate with the client's physician if there are any concerns or recommendations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-240, filed 6/9/99, effective 7/10/99.]

## COVERAGE

**WAC 388-552-300 Coverage.** (1) MAA covers medically necessary oxygen and respiratory therapy equipment,

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supplies, and services subject to the limitations in this chapter. MAA approves additional oxygen and respiratory therapy equipment, supplies, and services on a case-by-case basis if medically necessary.

(2) MAA does not reimburse for a service or product if any of the following apply:

- (a) The service or product is not covered by MAA;
- (b) The service or product is not medically necessary;
- (c) The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or
- (d) The client and provider do not meet the requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-300, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-310 Coverage—Oxygen and oxygen equipment.** (1) MAA reimburses for oxygen provided to:

- (a) Clients eighteen years of age or older with:
  - (i)  $PO_2 < =$  fifty-five mm on room air; or
  - (ii)  $SaO_2 < =$  eighty-eight percent on room air; or
  - (iii)  $PaO_2 < =$  fifty-five mm on room air.
- (b) Clients seventeen years of age or younger to maintain  $SaO_2$  at:
  - (i) Ninety-two percent; or
  - (ii) Ninety-four percent in a child with cor pulmonale or pulmonary hypertension.

(2) MAA may cover spare tanks of oxygen and other equipment if the provider and attending physician document that travel distance or potential weather conditions could reasonably be expected to interfere with routine delivery of such equipment and supplies.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-310, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-320 Coverage—Continuous positive airway pressure (CPAP) and supplies.** (1) MAA covers the rental and/or purchase of medically necessary CPAP equipment and related accessories when all of the following apply:

- (a) The results of a prior sleep study indicate the client has sleep apnea;
- (b) The client's attending physician determines that the client's sleep apnea is chronic;
- (c) CPAP is the least costly, most effective treatment modality;
- (d) The item is to be used exclusively by the client for whom it is requested;
- (e) The item is FDA-approved; and
- (f) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA covers the rental of CPAP equipment for a maximum of two months. Thereafter, if the client's primary physician determines the equipment is tolerated and beneficial to the client, MAA reimburses for its purchase.

(3) Refer to **oxygen and respiratory therapy billing instructions** to determine which CPAP accessories are covered.

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[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-320, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-330 Coverage—Ventilator therapy, equipment, and supplies.** (1) MAA covers medically necessary ventilator equipment rental and related disposable supplies when all of the following apply:

- (a) The ventilator is to be used exclusively by the client for whom it is requested;
- (b) The ventilator is FDA-approved; and
- (c) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA's monthly rental payment includes medically necessary accessories, including, but not limited to: Humidifiers, nebulizers, alarms, temperature probes, adapters, connectors, fittings, and tubing.

(3) MAA covers a secondary (back-up) ventilator at fifty percent of the monthly rental if medically necessary.

(4) MAA covers the purchase of durable accessories for client-owned ventilator systems according to the fee schedule in the current **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-330, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-340 Coverage—Infant apnea monitor program.** (1) A provider must comply with WAC 388-552-230 to qualify for reimbursement for the infant apnea monitor program.

- (2) MAA covers infant apnea monitors on a rental basis.
- (3) MAA includes all home visits, follow-up calls, and training in the rental allowance.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-340, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-350 Coverage—Respiratory and ventilator therapy.** (1) MAA covers prescribed medically necessary respiratory and ventilator therapy services in the home.

- (2) Therapy services must be provided by a certified respiratory care practitioner;
- (3) MAA does not reimburse separately for respiratory and ventilator therapy services provided to clients residing in nursing facilities. This service is included in the nursing facility's per diem.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-350, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-360 Coverage—Suction pumps and supplies.** (1) MAA covers suction pumps and supplies when medically necessary for deep oral or tracheostomy suctioning.

(2) MAA may cover one stationary and one portable suction pump for the same client if warranted by the client's condition. The provider and attending physician must document that either:

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(a) Travel distance or potential weather conditions could reasonably be expected to interfere with the delivery of medically necessary replacement equipment; or

(b) The client requires suctioning while away from the client's place of residence.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-360, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-370 Coverage—Inhalation drugs and solutions.** Inhalation drugs and solutions are included in the prescription drug program. Refer to chapter 388-530 WAC.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-370, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-380 Coverage—Oximeters.** (1) MAA covers oximeters for clients seventeen years of age or younger when the client has one of the following conditions:

(a) Chronic lung disease, is on supplemental oxygen, and is at risk for desaturation with sleep, stress, or feeding;

(b) A compromised or artificial airway, and is at risk for major obstructive events or aspiration events; or

(c) Chronic lung disease, requires ventilator or BIPAP support, and may be at risk for atelectasis or pneumonia as well as hypoventilation.

(2) The provider must review oximetry needs and fluctuations in oxygen levels monthly, and log results in the client's records.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-380, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-390 Coverage—Nursing facilities.** (1) MAA reimburses according to this chapter for the chronic use of medically necessary oxygen, and oxygen and respiratory equipment and supplies to eligible clients who reside in nursing facilities.

(2) Nursing facilities are reimbursed in their per diem rate for:

(a) Oxygen and oxygen equipment and supplies used in emergency situations; and

(b) Respiratory and ventilator therapy services.

(3) Nursing facilities with a "piped" oxygen system may submit a written request to MAA for permission to bill MAA for oxygen. See **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-390, filed 6/9/99, effective 7/10/99.]

## REIMBURSEMENT

**WAC 388-552-400 Reimbursement for covered services.** (1) A provider must bill MAA according to the procedures and codes in the current **oxygen and respiratory therapy billing instructions**.

(2) MAA does not reimburse separately for telephone calls, mileage, or travel time. These services are included in the reimbursement for other equipment and/or services.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-400, filed 6/9/99, effective 7/10/99.]

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**WAC 388-552-410 Reimbursement methods.** MAA bases the decision to rent or purchase medical equipment for a client, or pay for repairs to client-owned equipment, on the least costly and/or equally effective alternative.

### (1) Rental.

(a) Types of rental equipment:

(i) Equipment that normally requires frequent maintenance (such as ventilators and concentrators) is reimbursed on a rental basis for as long as medically necessary; and

(ii) Equipment with lower maintenance requirements (such as suction pumps and humidifiers) is reimbursed on a rental basis for a specified rental period, after which the equipment is considered purchased and owned by the client. Refer to the **oxygen and respiratory therapy billing instructions** for detailed information.

(b) The monthly rental rate includes, but is not limited to:

(i) A full service warranty covering the rental period;

(ii) Any adjustments, modifications, repairs or replacements required to keep the equipment in good working condition on a continuous basis throughout the total rental period;

(iii) All medically necessary accessories and disposable supplies, unless separately billable according to current **oxygen and respiratory therapy billing instructions**;

(iv) Instructions to the client and/or caregiver for safe and proper use of the equipment; and

(v) Cost of pick-up and delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

### (2) Purchase.

(a) Purchased equipment becomes the property of the client;

(b) MAA reimburses for:

(i) Equipment that is new at the time of purchase, unless otherwise specified in current **oxygen and respiratory therapy billing instructions**; and

(ii) One maintenance and service visit every six months for purchased equipment.

(c) MAA does not reimburse for:

(i) Defective equipment;

(ii) The cost of materials covered under the manufacturer's warranty; or

(iii) Repair or replacement of equipment if evidence indicates malicious damage, culpable neglect, or wrongful disposition.

(d) The reimbursement rate for purchased equipment includes, but is not limited to:

(i) A manufacturer's warranty for a minimum warranty period of one year for medical equipment, not including disposable/non-reusable supplies;

(ii) Instructions to the client and/or caregiver for safe and proper use of the equipment; and

(iii) The cost of delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(e) The provider must make warranty information, including date of purchase and warranty period, available to MAA upon request.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-410, filed 6/9/99, effective 7/10/99.]

**WAC 388-552-420 Reimbursement methodology.** MAA, at its discretion, uses the following methods to determine the **maximum allowable** amount for each purchased and rented item and service:

(1) **Monthly rental reimbursement methodology.**

(a) Medicare's fee as of October 31 of the year prior to the base year; or

(b) A **maximum allowable** equal to:

(i) One-tenth of the purchase **maximum allowable** for that product; or

(ii) If MAA does not reimburse for the purchase of that product, one-tenth of the amount calculated using the methodology in subsection (1) of this section.

(2) **Purchase reimbursement methodology.**

(a) Medicare's fee as of October 31 of the year prior to the **base year**; or

(b) A **maximum allowable** equal to the seventieth percentile price of an array of input prices.

(i) The number of input prices included in each array may be limited by MAA based on consideration of product quality, cost, available alternatives, and client needs.

(ii) An input price used in the **maximum allowable** calculation is the lesser of:

(A) Eighty percent of the manufacturer's list or suggested retail price as of October 31 of the **base year**; or

(B) One hundred thirty-five percent of the wholesale acquisition cost as of October 31 of the **base year**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-420, filed 6/9/99, effective 7/10/99.]

**Chapter 388-555 WAC  
INTERPRETER SERVICES**

**WAC**

388-555-1000	Definitions.
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388-555-1400	Recordkeeping and audits.
388-555-1450	Services at federally qualified health clinics.

**WAC 388-555-1000 Definitions.** For the purposes of this chapter, the following definitions apply:

**"Client"** means any individual who has been determined eligible for medical or health care services for any of the medical assistance administration (MAA) programs.

**"Consecutive appointments"** means appointments beginning or scheduled to begin within fifteen minutes of the last completed appointment.

**"Family member"** means any person who is related to the client: a spouse, child, grandmother, grandfather, grandchild, mother, father, sister, brother, cousin, niece, nephew, aunt, uncle, step relations and/or in-laws.

**"Federally qualified health center" (FQHC)** means:

(1) A facility that is receiving grants under section 329, 330, or 340 of the Public Health Services Act; or

(2) Receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service as determined by the secretary to meet the requirements for receiving such a grant; or

(3) A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (P.L. 93-638). Only Health Care Financing Administration-designated FQHCs will be allowed to participate in MAA's Medicaid program.

**"Independent interpreter"** means any fluent, bilingual/multilingual person, certified by language interpretation services and translation (LIST) in medical terminology, who provides interpreter services for payment and who is not employed by, or a contractor of, any interpreter agency enrolled with MAA. Independent interpreter also means any person fluent in American Sign Language, certified by the National Association for the Deaf (NAD) or Registry for Interpreters for the Deaf (RID).

**"Interpreter"** means a person who speaks English and another language fluently or signs American Sign Language fluently. Fluency includes an understanding of nonverbal and cultural patterns necessary to communicate effectively. An interpreter enables clients and medical/health care providers to communicate effectively with each other.

**"Interpreter agency"** means a business entity, organized under and permitted to operate by the laws of the state of Washington, which offers as one of its main objectives or purposes to procure interpreter services by employing or contracting with bilingual/multilingual persons on a permanent or part-time basis to provide medical interpreter services for payment to MAA clients. For purposes of this chapter, interpreter agency does not include:

(1) A business entity that employs a person exclusively or regularly to perform other duties, or to perform interpreter services solely in connection with the affairs of that employer; or

(2) A person who is self-employed and is the only bilingual/multilingual employee contracting for the purpose of providing interpreter services to others.

**"Language interpretation services and translation" (LIST)** means the section within the department of social and health services (DSHS) that is responsible for certifying and qualifying spoken language interpreters.

**"Limited English proficient (LEP)"** means a limited ability or an inability to speak, read, or write English well enough to understand and communicate effectively in normal daily activities. The client decides whether he/she is limited in his/her ability to speak, read, or write English.

**"Primary language"** means the language identified by the client as the language in which he/she wishes to communicate. This may also be referred to as the preferred language.

**"Qualified interpreter for American Sign Language"** means a certified NAD, RID, or noncertified interpreter who is determined to be competent, both receptively and expressively by the consumer to be qualified to effectively meet his/her communication needs, both receptively and expressively.

**"Qualified interpreter for spoken languages"** means an interpreter who has passed DSHS screening tests in languages other than the DSHS certificated languages as specified in RCW 74.04.025.

**"Unit"** means a billable amount of time for interpreter services equal to fifteen minutes.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1000, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1050 Covered services.** Interpreters and/or interpreter agencies shall receive payment for interpreter services that are:

- (1) Provided for a client who is:
  - (a) Deaf;
  - (b) Deaf-blind;
  - (c) Hard of hearing; or
  - (d) Limited English proficient.

(2) Provided during a necessary medical service performed by an eligible provider; and

(3) Covered under a MAA program for which the client is eligible. For exceptions, see WAC 388-555-1100, Noncovered services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1050, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1100 Noncovered services.** Interpreters and/or interpreter agencies shall not receive payment from MAA for interpreter services related to:

- (1) Inpatient hospital services;
- (2) Nursing facility services;
- (3) Community mental health center services;
- (4) The provision of any noncovered service;
- (5) Interpreter services funded or paid for by any other source;
- (6) Interpreter services provided by an interpreter to the interpreter's own family members;
- (7) Any person other than an eligible MAA client;
- (8) Medical assistance client no-shows;
- (9) The interpreter's failure to appear for scheduled services;

(10) The interpreter's transportation costs or travel time;

(11) Waiting time before the scheduled appointment; or

(12) Any block of time when interpreter services are not required by the medical provider to communicate with a medical assistance client.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1100, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1150 Eligible providers.** (1) To provide services other than at FQHCs, independent interpreters and/or interpreter agencies are considered eligible providers when they:

(a) Are enrolled with MAA to provide interpreter services;

(b) Meet the criteria in WAC 388-502-0020 and 388-502-0100.

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(2) To enroll as an independent interpreter for MAA clients, interpreters shall submit the following to the department:

(a) Proof of certification which may be either:

(i) Number and date of medical certificate from LIST; or

(ii) A copy of a RID or NAD certificate for certified sign language interpreters.

(b) A Social Security Number, if the interpreter has one;

(c) A completed interpreter services core provider agreement;

(d) A signed confidentiality pledge;

(e) A completed provider information form; and

(f) Verification of errors and omissions liability insurance at or over one hundred thousand dollars per occurrence.

(3) To enroll with MAA as an interpreter agency, the agency shall submit to the department:

(a) A completed interpreter services core provider agreement;

(b) Verification of errors and omissions liability insurance at or over one million dollars per occurrence;

(c) A completed provider information form; and

(d) A list of interpreters employed/contracted to provide services to MAA clients, including the following information for each interpreter:

(i) A signed confidentiality pledge; and

(ii) Number and date of medical certificate from LIST;

or  
(iii) A copy of a current RID or NAD certificate for certified sign language interpreters or written description of evaluation process for qualified interpreter status.

(4) To qualify as an eligible provider, an interpreter agency shall have the capacity to provide interpreter services in:

(a) American Sign Language; or

(b) At least three spoken languages; or

(c) Fewer than three spoken languages if the languages provided are reflective of a majority of the LEP clients residing within the county(ies) served by the agency. DSHS reports will be used to identify the languages needed in the demographic area.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-555-1150, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1150, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1200 Provider requirements.** (1) An interpreter or interpreter agency shall not determine the need for interpreter services, nor shall the interpreter market interpreter services to MAA clients. See WAC 388-555-1250, Coordination of services.

(2) An interpreter or interpreter agency shall not require a client to obtain interpreter services exclusive of other interpreters or interpreter agencies.

(3) An interpreter or interpreter agency shall adhere to department policies and procedures regarding confidentiality of client records as stated in WAC 388-01-030.

(4) An independent interpreter shall enroll with the department as provided in WAC 388-555-1100 and obtain a current medical assistance provider number.



(5) An interpreter or interpreter agency must participate in an orientation which will be scheduled and given by MAA within their first year of contracting with the department. The department may terminate contracts with any provider who does not participate in the orientation.

(6) Interpreter agencies shall assume full legal and financial liability for interpreter services provided by employees and contractors.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-555-1200, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1200, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1250 Coordination of services.** An interpreter and/or interpreter agency shall:

(1) Coordinate appointment dates and times with the medical provider and the client as requested by the medical provider; and

(2) Notify the medical provider of any changes to scheduled appointments at least twenty-four hours in advance.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1250, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1300 Payment.** (1) Eligible interpreters and/or interpreter agencies shall only provide services when the following conditions are met:

(a) The client or the medical provider determines that an interpreter is necessary in order for the client to appropriately access necessary medical and health care services covered by the client's medical assistance program;

(b) The medical provider has informed the client that interpreter services are available at no cost to the client; and

(c) The interpreter presents a current identification card with his/her name, such as a driver's license, prior to providing interpreter services.

(2) To the extent permitted under federal law and regulation, the department may provide federal financial participation to match funds expended by public agencies for interpreter services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1300, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1350 Payment methodology.** (1) An interpreter and/or interpreter agency providing services at facilities other than FQHCs shall receive payment for interpreter services based on:

(a) Funds legislatively provided for interpreter services;

(b) Department allocation of vendor rate increases appropriated by the legislature;

(c) Billable units of time; and

(d) Submitting claims to the department according to billing instructions provided by MAA. All eligible interpreters will be provided with billing instructions.

(2) An interpreter and/or interpreter agency providing services at an FQHC shall seek payment according to WAC 388-55-1450.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1350, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1400 Recordkeeping and audits.** Interpreters and/or interpreter agencies shall maintain legible, accurate, and complete records in order to support and justify interpretation services provided to medical assistance clients. The types of records that must be maintained are described in the billing instructions.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1400, filed 7/10/98, effective 7/10/98.]

**WAC 388-555-1450 Services at federally qualified health clinics.** (1) A federally qualified health center shall receive payment for interpreter services when the FQHC:

(a) Uses interpreters certified or qualified by LIST; and

(b) Bills MAA fee-for-service.

(2) Interpreters providing services at an FQHC shall:

(a) Be certified and qualified by LIST; and

(b) Meet the requirements described in WAC 388-555-1200 (1), (2) and (3), and 388-555-1250; and

(c) Seek payment from the FQHC.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1450, filed 7/10/98, effective 7/10/98.]

**Chapter 388-556 WAC**

**MEDICAL CARE—OTHER SERVICES PROVIDED**

**WAC**

388-556-0100	Chemical dependency treatment services.
388-556-0200	Chiropractic services for children.
388-556-0300	Personal care services.
388-556-0400	Limitations on services available to recipients of categorically needy medical assistance.
388-556-0500	Medical care services under state-administered cash programs.
388-556-0600	Mental health services.

**WAC 388-556-0100 Chemical dependency treatment services.** The department covers chemical dependency treatment services, as defined in chapter 388-805 WAC, for Medicaid and children's health clients. Coverage is limited to services performed by providers defined in WAC 388-502-0010.

[Statutory Authority: RCW 74.08.090, 74.09.035, and 74.50.055. 00-18-032, § 388-556-0100, filed 8/29/00, effective 9/29/00.]

**WAC 388-556-0200 Chiropractic services for children.** (1) MAA will pay only for chiropractic services:

(a) For MAA clients who are:

(i) Under twenty-one years of age; and

(ii) Referred by a screening provider under the healthy kids/early and periodic screening, diagnosis, and treatment (EPSDT) program.

(b) That are:

(i) Medically necessary, safe, effective, and not experimental;

(ii) Provided by a chiropractor licensed in the state where services are provided; and

(iii) Within the scope of the chiropractor's license.

(c) Limited to:

(i) Chiropractic manipulative treatments of the spine; and

(ii) X-rays of the spine.

(2) Chiropractic services are paid according to fees established by MAA using methodology set forth in WAC 388-531-1850.

[Statutory Authority: RCW 74.08.090, 74.09.035, 00-16-031, § 388-556-0200, filed 7/24/00, effective 8/24/00.]

**WAC 388-556-0300 Personal care services.** The department pays for personal care services for a Title XIX categorically needy Medicaid client as provided under chapter 388-71 WAC, Home and community programs.

[Statutory Authority: RCW 74.08.090, 00-17-057, § 388-556-0300, filed 8/9/00, effective 9/9/00.]

**WAC 388-556-0400 Limitations on services available to recipients of categorically needy medical assistance.** (1) Organ transplants are limited to the cornea, heart, heart-lung, kidney, kidney-pancreas, liver, pancreas, single lung, and bone marrow.

(2) The department shall provide treatment, dialysis, equipment, and supplies for acute and chronic nonfunctioning kidneys when the client is in the home, hospital, or kidney center as described under WAC 388-540-005.

(3) Detoxification and medical stabilization are provided to chemically-using pregnant women in a hospital.

(4) The department shall provide detoxification of acute alcohol or other drug intoxication only in a certified detoxification center or in a general hospital having a detoxification provider agreement with the department.

(5) The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 275-25 WAC and certified under chapter 275-19 WAC or its successor.

(6) The department may require a second opinion and/or consultation before the approval of any elective surgical procedure.

(7) The department designates diagnoses that may require surgical intervention:

(a) Performed in other than a hospital in-patient setting; and

(b) Requiring prior approval by the department for a hospital admission.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-556-0400, filed 12/29/00, effective 1/29/01; 00-11-183, recodified as § 388-556-0400, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-18-079, § 388-86-005, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090, 95-22-039 (Order 3913, #100246), § 388-86-005, filed 10/25/95, effective 10/28/95; 93-17-038 (Order 3620), § 388-86-005, filed 8/11/93, effective 9/11/93; 92-03-084 (Order 3309), § 388-86-005, filed 1/15/92, effective 2/15/92; 90-17-122 (Order 3056), § 388-86-005, filed 8/21/90, effective 9/21/90; 90-12-051 (Order 3009), § 388-86-005, filed 5/31/90, effective 7/1/90; 89-18-033 (Order 2860), § 388-86-005, filed 8/29/89, effective 9/29/89; 89-13-005 (Order 2811), § 388-86-005, filed 6/8/89; 88-06-083 (Order 2600), § 388-86-005, filed 3/2/88. Statutory Authority: 1987 1st ex.s. c 7, 88-02-034 (Order 2580), § 388-86-005, filed 12/31/87. Statutory Authority: RCW 74.08.090, 87-12-050 (Order 2495), § 388-86-005, filed 6/1/87; 84-02-052 (Order 2060), § 388-86-005, filed 1/4/84; 83-17-073 (Order 2011), § 388-86-005, filed 8/19/83; 83-01-056 (Order 1923), § 388-86-005, filed 12/15/82; 82-10-062 (Order 1801), § 388-86-005, filed 5/5/82; 82-01-001 (Order 1725), § 388-86-005, filed 12/3/81; 81-16-033 (Order 1685), § 388-86-005, filed 7/29/81; 81-10-015 (Order 1647), § 388-86-005, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-005, filed 10/9/80; 78-06-081 (Order 1299), § 388-86-005, filed 6/1/78; 78-02-024 (Order 1265), § 388-86-005, filed 1/13/78;

[Title 388 WAC—p. 994]

Order 994, § 388-86-005, filed 12/31/74; Order 970, § 388-86-005, filed 9/13/74; Order 911, § 388-86-005, filed 3/1/74; Order 858, § 388-86-005, filed 9/27/73; Order 781, § 388-86-005, filed 3/16/73; Order 738, § 388-86-005, filed 11/22/72; Order 680, § 388-86-005, filed 5/10/72; Order 630, § 388-86-005, filed 11/24/71; Order 581, § 388-86-005, filed 7/20/71; Order 549, § 388-86-005, filed 3/31/71, effective 5/1/71; Order 453, § 388-86-005, filed 5/20/70, effective 6/20/70; Order 419, § 388-86-005, filed 12/31/69; Order 264 (part); § 388-86-005, filed 11/24/67.]

**WAC 388-556-0500 Medical care services under state-administered cash programs.** Medical care services (MCS) are state-administered medical care services provided to a client receiving cash benefits under the general assistance-unemployable (GA-U) program or the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program. For a client eligible for MCS:

(1) The department of social and health services (DSHS) covers only the medically necessary services within the notated applicable program limitations listed in the MCS column under WAC 388-529-0200.

(2) DSHS does not cover medical services received outside the state of Washington unless the medical services are provided in a border area listed under WAC 388-501-0175.

[Statutory Authority: RCW 74.08.090 and 74.09.035, 01-01-009, § 388-556-0500, filed 12/6/00, effective 1/6/01.]

**WAC 388-556-0600 Mental health services.** Mental health-related services are available to eligible clients under chapter 388-862 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.530, 71.24.035, 00-24-053, § 388-556-0600, filed 11/30/00, effective 12/31/00.]

## Chapter 388-561 WAC

### TRUSTS, ANNUITIES, AND LIFE ESTATES— EFFECT ON MEDICAL PROGRAMS

#### WAC

388-561-0001	Definitions.
388-561-0100	Trusts.
388-561-0200	Annuities.
388-561-0300	Life estates.

**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 benefi-

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ciary. 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.]

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**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 non-excluded 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 388-700 WAC

## JUVENILE REHABILITATION ADMINISTRATION—PRACTICES AND PROCEDURES

(Formerly chapter 275-37 WAC)

### WAC

388-700-0005 What definitions apply to this chapter?

#### BACKGROUND CHECKS

388-700-0010 When are background checks required?

388-700-0015 What crimes prohibit "regular access" to juveniles?

388-700-0020 What are the reporting requirements for criminal convictions?

388-700-0025 Is a contracting agency required to do background checks?

#### SEXUAL MISCONDUCT BY JRA EMPLOYEES

388-700-0030 What action must be taken if there is a belief that sexual misconduct by a JRA employee has occurred?

388-700-0035 What disciplinary action is required if there is evidence that sexual misconduct by a JRA employee has occurred?

#### SEXUAL MISCONDUCT BY JRA CONTRACTORS

388-700-0040 What action must be taken if there is a belief that sexual misconduct by a JRA contractor has occurred?

388-700-0045 What action is required if there is evidence that sexual misconduct by a JRA contractor has occurred?

#### SEXUAL MISCONDUCT BY JRA EMPLOYEES OR CONTRACTORS

388-700-0050 What action will be taken if an employee or contractor has sexual intercourse or sexual contact against their will?

**WAC 388-700-0005 What definitions apply to this chapter?** The following definitions apply to this chapter:

[Title 388 WAC—p. 997]

"Assistant secretary" means the assistant secretary of the juvenile rehabilitation administration.

"Community facility" means a group care facility operated for the care of juveniles committed to the department under RCW 13.40.185. A county detention facility that houses juveniles committed to the department under RCW 13.40.185 pursuant to an interagency agreement with the department is not a community facility.

"Contractor" means a department of social and health services (DSHS)/juvenile rehabilitation administration (JRA) contractor and all employees and all subcontractors of that contractor.

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

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

"JRA youth" or "juvenile" means a juvenile offender under the jurisdiction of JRA or a youthful offender under the jurisdiction of the department of corrections who is placed in a JRA facility.

"Limited access" means supervised access to a juvenile(s) that is the result of the person's regularly scheduled activities or work duties.

"Preponderance of the evidence" means a determination by the secretary that the alleged sexual misconduct more likely than not occurred, or an admission of sexual misconduct has been made.

"Program administrator" means institution superintendent, regional administrator, or their designees.

"Reasonable cause" means a reason that would motivate a person of ordinary intelligence under the circumstances to believe that an act of sexual misconduct may have occurred.

"Regular access" means unsupervised access to a juvenile(s), for more than a nominal amount of time, that is the result of the person's regularly scheduled activities or work duties.

"Secretary" means the secretary of the department of social and health services.

"Sexual contact" means any touching of the sexual or other intimate parts of a person done for the purpose of gratifying sexual desire of either party or a third party.

"Sexual intercourse" has its ordinary meaning and:

(1) Occurs upon any penetration, however slight; and  
 (2) Also means any penetration of the vagina or anus however slight, by an object, when committed on one person by another, whether such persons are of the same or opposite sex, except when such penetration is accomplished for medically recognized treatment or diagnostic purposes; and

(3) Also means any act of sexual contact between persons involving the sex organs of one person and the mouth or anus of another whether such persons are of the same or opposite sex.

"Suspend" means to remove from unsupervised access to any JRA youth.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0005, filed 11/27/00, effective 12/28/00.]

[Title 388 WAC—p. 998]

## BACKGROUND CHECKS

**WAC 388-700-0010 When are background checks required?** JRA must conduct background checks on prospective employees, volunteers, and individual contracted service providers who will have regular access to juveniles. Background checks may be conducted on prospective employees, volunteers, and individual contracted service providers who will have limited access to juveniles.

(1) Procedures must be established in order to investigate and determine suitability of a person in a position who will have regular access or limited access to juveniles.

(2) Employees, volunteers or individual contracted service providers who are authorized for regular access do not require the presence of another person cleared through the designated background check process during the performance of their duties.

(3) The presence of another person cleared through the designated background check process is required for people authorized to have limited access to juveniles.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0010, filed 11/27/00, effective 12/28/00.]

**WAC 388-700-0015 What crimes prohibit "regular access" to juveniles?** Effective September 1, 1998, potential employees, volunteers, and individual contracted service providers must not be hired, engaged, or authorized in a position which allows regular access if the individual has been convicted of:

(1) Any felony sex offense as defined in RCW 9.94A.030 and 9A.44.130;

(2) Any crime specified in chapter 9A.44 RCW when the victim was a juvenile in the custody of or under the jurisdiction of JRA as stated in RCW 13.40.570; or

(3) Any violent offense as defined in RCW 9.94A.030.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0015, filed 11/27/00, effective 12/28/00.]

**WAC 388-700-0020 What are the reporting requirements for criminal convictions?** Effective September 1, 1998 employees, volunteers, and individual contracted service providers who are authorized for regular access to a juvenile(s) must report any conviction of a crime identified in WAC 388-700-0015. The report must be made to the person's supervisor within seven days of conviction. Failure to report within seven days constitutes misconduct under Title 50 RCW. Employees, volunteers, and individual contracted service providers who have been convicted of offenses in WAC 388-700-0015 must not have regular access to a juvenile(s).

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0020, filed 11/27/00, effective 12/28/00.]

**WAC 388-700-0025 Is a contracting agency required to do background checks?** JRA must require background checks to be conducted on prospective employees and volunteers of contracting agencies if the person will have regular access to juveniles.



(1) Requirements of WAC 388-700-0010, 388-700-0015, and 388-700-0020 must be met by contracted service providers.

(2) The contracted service provider or designee of an agency contracting with JRA for the provision of a community facility must ensure background check investigations are conducted according to department licensing requirements.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0025, filed 11/27/00, effective 12/28/00.]

### SEXUAL MISCONDUCT BY JRA EMPLOYEES

**WAC 388-700-0030** What action must be taken if there is a belief that sexual misconduct by a JRA employee has occurred? If there is reasonable cause to believe that sexual intercourse or sexual contact between a JRA employee and a JRA youth has occurred, the secretary must immediately remove the JRA employee from access to JRA youth, and follow reporting requirements in chapter 26.44 RCW, Reporting abuse and neglect of a child.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0030, filed 11/27/00, effective 12/28/00.]

**WAC 388-700-0035** What disciplinary action is required if there is evidence that sexual misconduct by a JRA employee has occurred? If the preponderance of the evidence finds that sexual intercourse or sexual contact between a JRA employee and a JRA youth has occurred, or upon a guilty plea or conviction for any crime specified in chapter 9A.44 RCW when the victim was an offender, the secretary must immediately institute proceedings to terminate the employee.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0035, filed 11/27/00, effective 12/28/00.]

### SEXUAL MISCONDUCT BY JRA CONTRACTORS

**WAC 388-700-0040** What action must be taken if there is a belief that sexual misconduct by a JRA contractor has occurred? The secretary requires the individual contractor, or employee of a contractor, when there is reasonable cause to believe he/she has had sexual intercourse or sexual contact with a JRA youth, to be immediately removed from access to any JRA youth, and follow reporting requirements in chapter 26.44 RCW, Reporting abuse and neglect of a child.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0040, filed 11/27/00, effective 12/28/00.]

**WAC 388-700-0045** What action is required if there is evidence that sexual misconduct by a JRA contractor has occurred? (1) If there is a preponderance of evidence that sexual intercourse or sexual contact between a JRA contractor and a JRA youth occurred, the secretary must inform the contractor that the individual employee is disqualified from employment with a contractor in any position with access to JRA youth.

(2) A contract with a contractor who has had an employee who has been disqualified for employment based

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on a preponderance of evidence that he or she has had sexual intercourse or sexual contact with a JRA youth, must not be renewed until the secretary determines that significant progress has been made by the contractor to reduce the likelihood that any of its employees or subcontractors have sexual intercourse or sexual contact with a JRA youth.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0045, filed 11/27/00, effective 12/28/00.]

### SEXUAL MISCONDUCT BY JRA EMPLOYEES OR CONTRACTORS

**WAC 388-700-0050** What action will be taken if an employee or contractor has sexual intercourse or sexual contact against their will? DSHS will not take any action against a person who is employed or contracted by JRA who has sexual intercourse or sexual contact with a JRA youth and it is found to have been against the employed or contracted person's will.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0050, filed 11/27/00, effective 12/28/00.]

## Chapter 388-710 WAC CONSOLIDATED JUVENILE SERVICES PROGRAMS

### WAC

388-710-0005	Definitions.
388-710-0010	Establishment of a consolidated juvenile services program.
388-710-0015	General provisions.
388-710-0020	Organization.
388-710-0025	Administration.
388-710-0030	Monitoring of performance and evaluation of program impact.
388-710-0035	Distribution of funds and fiscal management.
388-710-0040	Exceptions to rules.

**WAC 388-710-0005** Definitions. "Administration" means activities and costs necessary for management and support of a consolidated juvenile services program.

"Application" means the document requesting state funds for specific projects under the consolidated juvenile services program.

"Community input" means information received from local entities which must include, unless impracticable: Providers, judges, law enforcement, juvenile court staff, social service agencies, schools, tribes, organizations representing communities of color, as well as other persons with an interest in juvenile justice. An existing advisory group, committee, or public forum may be used to gather input provided such groups include representation from the entities listed above.

"Director" means the director of the division of community programs/juvenile rehabilitation administration or his or her designee.

"Division" means the division of community programs of the juvenile rehabilitation administration.

"Outcome" means specific changes in the lives of youth and families which lead to a decrease in recidivism.

"Participating county" means a county or counties applying under this chapter.

**"Program administrator"** or **"administrator"** means the person designated to administer the consolidated juvenile services program in the juvenile court.

**"Project"** means a specific intervention or program performed as a part of consolidated juvenile services.

**"Project supervisor"** or **"supervisor"** means a person designated to supervise a project or projects in the consolidated juvenile services program.

**"Regional administrator"** means the regional administrator of one of the division's six administrative regions, or his or her designee.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0005, filed 7/24/00, effective 8/24/00.]

**WAC 388-710-0010 Establishment of a consolidated juvenile services program.** (1) Request to participate.

A request by a county or group of counties to participate under this chapter must include a signed resolution or letter of intent submitted to the regional administrator by the executive body expressing intent to participate. The request must include a statement that consolidated juvenile services funds will not be used to replace county funds for existing programs. For those counties with juvenile detention facilities, the counties must include a statement indicating standards of operation as outlined under RCW 13.06.050 are in place.

(2) Program planning process and approval.

(a) Each participating county must develop a program application for the delivery of services and must agree to comply with the provisions of this chapter.

(b) The application must incorporate community input and respond to community comments, which must include but not be limited to:

(i) Efforts to identify and utilize existing community services;

(ii) Appropriate linkage to and support from other elements of the existing juvenile justice, education, and social service systems to reduce or eliminate barriers to effective family centered service delivery;

(iii) Efforts to address racial disproportionality; and

(iv) Efforts to address issues specific to the Americans with Disabilities Act as it relates to client and family service delivery.

(c) Written guidelines and instructions for the application must be provided by the division. The application must be developed in consultation with the regional administrator to ensure the coordination of state, county, and private sector resources within regional boundaries and must be submitted to the regional administrator for review and approval.

(d) The division may provide technical assistance in the development of the application.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0010, filed 7/24/00, effective 8/24/00.]

**WAC 388-710-0015 General provisions.** (1) Access to services and use of existing community resources. Program administrators must ensure all juveniles participating in the program have access to appropriate services, activities, and opportunities.

[Title 388 WAC—p. 1000]

(2) All juveniles served by projects covered under this chapter must be afforded judicial due process in all contacts, especially those which may result in a more restrictive intervention.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0015, filed 7/24/00, effective 8/24/00.]

**WAC 388-710-0020 Organization.** The organizational structure of the program is the prerogative of the juvenile court participating under this chapter and must not be dictated by these standards.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0020, filed 7/24/00, effective 8/24/00.]

**WAC 388-710-0025 Administration.** (1) Administrators and supervisors are responsible for the implementation of the program and the accomplishment of stated activities and outcomes.

(2) Administrators or supervisors must meet at least annually with the regional administrator to review progress toward the achievement of outcomes.

(3) Case records and management information.

(a) Juvenile offender records must minimally contain a case plan, based upon assessed factors related to risk to reoffend, methods of intervention and a termination/closing report summarizing case activity and outcomes.

(b) The provisions of chapter 13.50 RCW pertaining to the maintenance and confidentiality of social and legal information apply to all programs and projects covered under this chapter.

(c) Administrators and/or supervisors must provide necessary statistical data to maintain the division's management information system and must maintain sufficient data to evaluate program effectiveness and outcomes.

(4) Change in project.

(a) Modification of a project requires the advance written approval of the regional administrator.

(b) The administrator must send written notification to the regional administrator prior to the movement of funds between programs. The regional administrator must confirm in writing all notifications received.

(c) Contract amendments must be processed through the juvenile rehabilitation administration regional office and are necessary when:

(i) Total contract budget amounts are increased or decreased;

(ii) A project is added or deleted;

(iii) The total number of full-time employees in the consolidated programs increases from the original contract number.

(5) Each participating county must ensure program staff receive training necessary to implement programs covered under this chapter.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0025, filed 7/24/00, effective 8/24/00.]

**WAC 388-710-0030 Monitoring of performance and evaluation of program impact.** (1) It is the responsibility of the administrator to submit monthly reports, annual narrative

reports, corrective action plans and reports, and other reports as specified in the division's application, budget, and monitoring instructions to the regional administrator.

(2) The regional administrator must submit to the director a biennial report of each program.

(3) The regional administrator, may at any time, request a formal program/project or fiscal audit and may also request other available technical services to assist in monitoring and evaluating the program/projects.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0030, filed 7/24/00, effective 8/24/00.]

**WAC 388-710-0035 Distribution of funds and fiscal management.** Funding constraints.

(1) Funds for programs covered by this chapter must be utilized for the achievement of the outcomes stated for each project.

(2) Failure on the part of any project to perform in accordance with the provisions of this chapter may result in the termination or reduction of funds.

(3) The administrator is responsible for the management of all fiscal matters related to the program. The program must comply with state and local policies and procedures, the terms and conditions of the contract, and the application, budget, and monitoring instructions as outlined by the juvenile rehabilitation administration.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0035, filed 7/24/00, effective 8/24/00.]

**WAC 388-710-0040 Exceptions to rules.** The juvenile court may request in writing to the director a waiver of the specific requirements of this chapter when the imposition of such requirements can be shown to be detrimental or impractical to overall program operations. The director must consider each waiver request individually and promptly advise the applicant in writing of the director's decision regarding the waiver and explain the basis for such decision.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0040, filed 7/24/00, effective 8/24/00.]

Monthly Gross Income

Monthly Gross Income	Percentage of Gross Income Ordered for Reimbursement of Costs							
	Number of Parents and Dependents Remaining in Household							
	1	2	3	4	5	6	7	8+
AFDC or \$0 - 600	0	0	0	0	0	0	0	0
\$601 - 1000	8%	6%	4%	2%	0	0	0	0
\$1001 - 2000	12%	10%	8%	6%	4%	2%	0	0
\$2001 - 3000	16%	14%	12%	10%	8%	6%	4%	2%
\$3001 - 4000+	18%	16%	14%	12%	10%	8%	6%	4%

(1) Within fifteen days of receipt, a parent shall mail to the department a certified financial statement on forms provided by the department. Based on the statement and on other information available to it, the department shall determine the parent's gross income, the number of parents and dependents, and the reimbursement obligation, and shall serve on the parent a notice and finding of financial responsibility.

(2) If a parent fails to timely provide a financial statement, the reimbursement obligation shall be twenty-three hundred dollars per month.

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**Chapter 388-720 WAC**  
**COLLECTION OF COSTS OF SUPPORT,**  
**TREATMENT, AND CONFINEMENT OF JUVENILES**  
**UNDER RCW 13.40.220**  
 (Formerly chapter 275-47 WAC)

**WAC**

- 388-720-0010 Definitions.
- 388-720-0020 Cost reimbursement schedule.
- 388-720-0030 Hearing.
- 388-720-0040 Modifications.
- 388-720-0050 Powers of the administrative law judge.

**WAC 388-720-0010 Definitions.** (1) "Juvenile" means juvenile offender sentenced to confinement in the department, other than an offender for whom a parent is approved to receive adoption support under chapter 74.13 RCW.

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

(3) "Gross income" means the total income from all sources, received by the parent, the juvenile, or other children of the parent remaining in the household, other than a stepchild, as determined by the department.

(4) "Parent" means the parent of the juvenile or other person legally-obligated to care for and support the juvenile, not including a stepparent.

(5) "Parents and dependents" means the juvenile's parent or parents, a stepparent living in the home who has no income, any child on whom the parent may claim a federal income tax deduction, not including the juvenile confined to the department, and any stepchild for whom the parent is the sole means of support.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0010, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-010, filed 7/8/94, effective 8/8/94.]

**WAC 388-720-0020 Cost reimbursement schedule.** A parent shall pay a percentage of gross income to the department for the cost of support, treatment, and confinement of the juvenile in accordance with the reimbursement schedule below:

(3) If the juvenile's parents reside in separate households, each parent shall be liable for reimbursement.

(4) The gross income of a parent shall be reduced by the amount the parent pays in spousal maintenance to the juvenile's parent, which is gross income to the receiving parent. The gross income of a parent shall be reduced by the amount of current child support paid for any child, including the juvenile offender. This credit shall be available when the support is paid to any section of the department or to any other person legally entitled to receive those support payments, pursuant to court order or administrative order for a child the parent

did not claim as a dependent under the reimbursement schedule.

(5) Reimbursement may not exceed the cost of care as determined by the department.

(6) The reimbursement obligation commences the day the juvenile enters the custody of the department, regardless of when the notice and finding of financial responsibility is received by the parent. A monthly reimbursement obligation shall be reduced on a pro rata basis for any days in which the juvenile was not in the custody of the department.

(7) The parent of the juvenile shall be exempt from the payment of the cost of the juvenile's care in the state facility if the parent receives adoption support or is eligible to receive adoption support for the juvenile offender; or if the parent, or other legally obligated person, or such person's child, spouse, or spouse's child, was the victim of the offense for which the juvenile was committed to the department.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0020, filed 10/20/00, effective 11/20/00; 96-24-075, § 275-47-020, filed 12/2/96, effective 1/2/97; 94-15-009 (Order 3752), § 275-47-020, filed 7/8/94, effective 8/8/94.]

**WAC 388-720-0030 Hearing.** A parent may request a hearing under RCW 13.40.220(5) to contest a notice and finding of financial responsibility issued by the department. The department shall ensure the hearing is governed by chapter 34.05 RCW and chapter 388-02 WAC. The sole issues at the hearing include whether the:

(1) Person receiving the notice and finding of financial responsibility is a parent of the juvenile; and

(2) Department correctly:

(a) Determined the parent's gross income and the number of parents and dependents; and

(b) Calculated the reimbursement obligation in accordance with the reimbursement schedule as described under WAC 388-720-0020.

[Statutory Authority: RCW 13.40.220. 00-22-019, amended and recodified as § 388-720-0030, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-030, filed 7/8/94, effective 8/8/94.]

**WAC 388-720-0040 Modifications.** (1) A parent may modify the parent's financial statement upon a change in gross income or in the number of persons residing in the household only if the change decreases the reimbursement obligation by one hundred dollars per month or more. A decrease may be granted only from the date on which the request for modification is made, and may not be applied retroactively.

(2) A parent shall file a financial statement modification if a change in gross income or the number of persons residing in the household increases the reimbursement obligation by one hundred dollars per month or more. An increase may be applied retroactively.

(3) The department will issue a new notice and finding of financial responsibility upon receipt of a modified financial statement as defined in subsections (1) or (2) of this section. The department may also issue a new notice based upon its own review if the conditions of subsection (1) or (2) of this section are met.

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[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0040, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-040, filed 7/8/94, effective 8/8/94.]

**WAC 388-720-0050 Powers of the administrative law judge.** The administrative law judge in the final order rendered after the hearing conducted in accordance with WAC 388-720-0030 shall include the name and age of the juvenile in that final order. The administrative law judge shall also indicate the parent's or other legally obligated person's monthly liability amount for the period of the juvenile's confinement beginning with the date the child enters the custody of the department. The administrative law judge shall not establish in the final order any amount constituting a repayment figure of any accrued obligation of the parent but shall indicate in the final order that any accrued obligation shall be paid by the parent to the department's office of financial recovery (OFR) and that OFR will be responsible for determining the method of repayment of the parent's accrued obligation.

The administrative law judge shall also include a statement in the final order that the parent's financial obligation is collectible by OFR and that should the parent fail to comply with any payment plan entered into by OFR and the parent, or the parent fails to pay the amount set out in the final order, OFR shall be authorized to take legal collection action to recover the amounts due from the parent. Legal collection action can include, but is not limited to:

(1) The filing of liens against the real and personal property of the parent; or

(2) The issuance of a garnishment order against the wages, bank accounts, or other property of the responsible persons.

[Statutory Authority: RCW 34.05.020, 13.40.220. 03-01-044, § 388-720-0050, filed 12/10/02, effective 1/10/03. Statutory Authority: RCW 13.40.220. 00-22-019, amended and recodified as § 388-720-0050, filed 10/20/00, effective 11/20/00; 96-24-075, § 275-47-050, filed 12/2/96, effective 1/2/97.]

## Chapter 388-730 WAC

### PLACEMENT OF JUVENILE OFFENDERS COMMITTED TO THE JUVENILE REHABILITATION ADMINISTRATION (JRA)

(Formerly chapter 275-46 WAC)

#### WAC

388-730-0010	Definitions.
388-730-0015	Assessment.
388-730-0020	Security classifications.
388-730-0030	Maximum security.
388-730-0040	Medium security.
388-730-0050	Institutional minimum.
388-730-0060	Minimum security.
388-730-0065	Special placement restrictions.
388-730-0070	Residential disciplinary standards.
388-730-0080	Documenting and reporting violations committed by juveniles in residential facilities.
388-730-0090	Service provider penalty schedule.

**WAC 388-730-0010 Definitions.** As used in this chapter:

(1) "Community facility" means a group care facility operated for the care of juveniles committed to the department under RCW 13.40.185. A county detention facility that

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houses juveniles committed to the department under RCW 13.40.185 pursuant to an interagency agreement with the department is not a community facility.

(2) "Community placement eligibility requirements" means requirements developed by JRA that must be met by a youth to demonstrate progress in treatment and low public safety risk, which justify an institutional minimum or minimum security classification for the youth.

(3) "Initial security classification assessment" means a written instrument, developed by JRA and administered by diagnostic staff, to determine to what extent a juvenile is a threat to public safety for the purpose of determining the juvenile's security classification when the juvenile initially is committed to JRA.

(4) "JRA" means juvenile rehabilitation administration, department of social and health services.

(5) "Juvenile" means a person under the age of twenty-one who has been sentenced to a term of confinement under the supervision of the department under RCW 13.40.185.

(6) "Program administrator" means institution superintendent, regional administrator, or their designees.

(7) "Separate living unit" means sleeping quarters and areas used for daily living activities not specific to treatment and education programs located in a building, wing, or on a different floor which separates resident groups.

(8) "Service provider" means the entity that operates a community facility.

(9) "Specialized treatment program" means a program that addresses additional rehabilitation needs such as sex offender treatment, drug/alcohol treatment, mental health interventions, gang intervention, gender/age specific intervention and other programs meeting specific rehabilitation needs of juveniles.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0010, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-010, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-010, filed 8/29/96, effective 9/29/96.]

**WAC 388-730-0015 Assessment.** (1) Risk assessment and treatment needs must be the basis of placement decisions involving juveniles.

(2) JRA must ensure juveniles are assessed to determine appropriate placement and treatment programming. Ongoing risk and needs assessment must occur during a juvenile's commitment to JRA.

(3) Risk assessment must include:

- (a) Risk to public safety;
- (b) Risk for sexually aggressive behavior; and
- (c) Risk for vulnerability to sexual aggression.

(4) JRA must use a security classification system to assist in placement decisions.

(5) Student records and information as described in RCW 72.05.425 are required for juvenile offender risk assessment, security classification assignment, and JRA community placement decisions. Designated school officials must ensure student records are provided to the identified juvenile court or JRA representative as required in RCW 28A.600.475 and 13.40.480.

(2003 Ed.)

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0015, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-015, filed 8/31/98, effective 9/1/98.]

**WAC 388-730-0020 Security classifications.** (1) There are four JRA security classifications:

- (a) Maximum;
- (b) Medium;
- (c) Institutional minimum; and
- (d) Minimum.

(2) A juvenile's initial security classification is determined using the initial security classification assessment. A juvenile's security classification may be changed at any time, and be reviewed at regular intervals as determined by JRA policy.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0020, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-020, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-020, filed 8/29/96, effective 9/29/96.]

**WAC 388-730-0030 Maximum security.** (1) A maximum security classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment; or

(b) Following the initial security classification, it is determined the juvenile:

(i) Does not meet the community placement eligibility requirements for minimum security; and

(ii) Requires maximum security restrictions to protect public safety, encourage the juvenile to participate in treatment and follow facility rules, or enhance the safe and orderly operation of the facility.

(2) A juvenile classified as maximum security must:

(a) Reside in an institution with the capability of:

- (i) Security windows;
- (ii) Locked exterior doors;
- (iii) Lockable single-person rooms; and
- (iv) A security fence.

(b) Be permitted movement between secured buildings only if accompanied by a close staff escort;

(c) Be confined to facility grounds, except for court appearances or emergencies, in which case a staff escort, and transportation in restraints and in a security vehicle, are required; and

(d) Be allowed authorized leave only for emergency and medical purposes pursuant to RCW 13.40.205.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0030, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-030, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-030, filed 8/29/96, effective 9/29/96.]

**WAC 388-730-0040 Medium security.** (1) A medium security classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment; or

[Title 388 WAC—p. 1003]

(b) Following the initial security classification, it is determined the juvenile:

(i) Does not meet the community placement eligibility requirements for minimum security; and

(ii) Requires medium security restrictions to protect public safety, encourage the juvenile to participate in treatment and follow facility rules, or enhance the safe and orderly operation of the facility.

(2) A juvenile classified as medium security must:

(a) Reside in an institution with the capability of at least:

(i) Lockable exterior doors or fire exit doors fitted with alarms; and

(ii) A security fence or windows without egress.

(b) Receive during movement a staff escort, continuous visual surveillance, or telephone/radio staff verification of departures and arrivals, unless the program administrator determines such measures are unnecessary;

(c) Be confined to facility grounds, except for:

(i) Participation in work crews or other programs outside the facility that require a close staff escort; and

(ii) Court appearances or emergencies, in which case a staff escort, and transportation in a security vehicle and/or in restraints, are required.

(d) Be allowed authorized leave only for emergency or medical purposes pursuant to RCW 13.40.205.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0040, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-040, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-040, filed 8/29/96, effective 9/29/96.]

**WAC 388-730-0050 Institutional minimum.** (1) An institutional minimum classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment;

(b) Indicated by the community placement eligibility requirements unless a recent incident indicates the juvenile no longer meets these requirements; or

(c) The assistant secretary for JRA or designee approves an override of the medium security classification.

(2) Even if eligible under subsection (1) of this section, a juvenile must not receive an institutional minimum security classification if:

(a) The assistant secretary for JRA, or designee, signs an administrative override disapproving institutional minimum classification and assigning the juvenile a higher security classification; or

(b) The juvenile is a sex offender who meets the requirements for civil commitment referral under chapter 71.09 RCW or is classified as a risk level III under RCW 13.40.217.

(3) A juvenile classified as institutional minimum security:

(a) Must reside in an institution with the capability of at least:

(i) Lockable exterior doors or fire exit doors fitted with alarms; and

(ii) A security fence or windows without egress.

(b) May be permitted:

(i) Unescorted movement on facility grounds;

(ii) Participation in work crews or other programs outside the facility with a close staff escort;

(iii) Unescorted participation in community work, educational and community service programs, and family treatment or other activities to strengthen family ties, for up to twelve hours per day; and

(iv) Authorized leave pursuant to RCW 13.40.205.

(4) A juvenile on institutional minimum security must be transferred to minimum security upon the availability of an appropriate community placement if:

(a) Ten percent of the juvenile's sentence, and in no case less than thirty days, has been served in a secure facility; and

(b) All placement assessment requirements have been met.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0050, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-050, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-050, filed 8/29/96, effective 9/29/96.]

**WAC 388-730-0060 Minimum security.** (1) The provisions of WAC 388-730-0050 also apply to a juvenile classified as minimum security, except the juvenile must reside in a community facility or a community commitment program facility (CCP) rather than in an institution.

(2) Juveniles must not be placed in a community facility until:

(a) Ten percent of the juvenile's sentence, and in no case less than thirty days, has been served in a secure facility; and

(b) All placement assessment requirements have been met.

(3) In addition to the provisions of WAC 388-730-0050 (3)(b)(iii), minimum security juveniles may be permitted unescorted participation in treatment programs in the community that do not involve the family for up to twelve hours per day.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0060, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-060, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-060, filed 8/29/96, effective 9/29/96.]

**WAC 388-730-0065 Special placement restrictions.** Certain placement restrictions apply to community facilities that are commonly used by and under the jurisdiction of both JRA and the children's administration.

(1) When juveniles under commitment to JRA are assessed as a high to moderate risk for sexually aggressive behavior, they may not be placed in a community facility with youths under the jurisdiction of children's administration unless:

(a) They are placed in a separate living unit solely for juveniles currently under the jurisdiction of JRA; or

(b) They are placed in a program that contracts specifically for the provision of services to sexually aggressive youth.

(2) Juveniles under commitment to JRA for a class A felony may not be placed in these community facilities unless:



(a) They are housed in a separate living unit solely for juveniles currently under the jurisdiction of JRA;

(b) They are placed in a community facility that is a specialized treatment program and the juvenile is not assessed as sexually aggressive under RCW 13.40.470; or

(c) They are placed in a community facility that is a specialized treatment program housing one or more sexually aggressive youth and the juvenile is not assessed as sexually vulnerable under RCW 13.40.470.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0065, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.1405, [72.05.1410, [72.05.1415, [72.05.1425, [72.05.1430, [72.05.1435, [72.05.1440, 74.15.210, 13.40.460 and [13.40.1480. 98-18-056, § 275-46-065, filed 8/31/98, effective 9/1/98.]

**WAC 388-730-0070 Residential disciplinary standards.** (1) Serious violations by a juvenile include:

(a) Escape or attempted escape;

(b) Violence toward others with intent to harm and/or resulting in significant bodily injury;

(c) Involvement in or conviction of a criminal offense under investigation by law enforcement or awaiting adjudication for behavior that occurred during current placement;

(d) Extortion or blackmail that threatens the safety or security of the facility or community;

(e) Setting or causing an unauthorized fire with intent to harm self, others, or property, or with reckless disregard for the safety of others;

(f) Possession or manufacture of weapons or explosives, or tools intended to assist in escape;

(g) Interfering with staff in performing duties relating to the security and/or safety of the facility or community;

(h) Intentional property damage in excess of one thousand five hundred dollars;

(i) Possession, use, or distribution of drugs or alcohol, or use of inhalants;

(j) Rioting or inciting others to riot;

(k) Refusal of urinalysis or search; or

(l) Other behaviors which threaten the safety or security of the facility, its staff, or residents or the community.

(2) Other violations by a juvenile placed in a community facility include:

(a) Unaccounted for time when a juvenile is away from the community facility;

(b) Violation of conditions of authorized leave;

(c) Intimidation or coercion against any person;

(d) Misuse of medication such as hoarding medication or taking another person's medication;

(e) Self-mutilation, self tattooing, body piercing, or assisting others to do the same;

(f) Intentional destruction of property valued at less than fifteen hundred dollars;

(g) Fighting;

(h) Unauthorized withdrawal of funds with intent to commit other violations;

(i) Suspensions or expulsions from school or work;

(j) Violations of school, employment or volunteer work agreements related to custody and security concerns;

(k) Escape talk;

(l) Sexual contact or any other behavior, not defined as a serious violation, resulting in a referral to the department of licensing, child protective services, or law enforcement; or

(m) Lewd or disruptive behavior in the community.

(3) Juveniles must be held accountable when there is reasonable cause to believe they have committed a violation.

(a) Whenever a juvenile placed in a community facility commits a serious violation, the juvenile must be returned to an institution. The JRA program administrator who receives a service provider report of a serious violation must make arrangements to transfer the juvenile to an institution as soon as possible. Juveniles may be placed in a secure JRA or contracted facility pending transportation to an institution.

(b) Sanctions for serious violations committed by juveniles in an institution, and additional sanctions for serious violations committed by juveniles returned to an institution, must include one or more of the following:

(i) Loss of privileges for up to thirty days;

(ii) Loss of program level; or

(iii) Room confinement up to seventy-two hours.

(c) Sanctions for serious violations may also include, but are not limited to, one or more of the following:

(i) Change in release date;

(ii) Referral for prosecution;

(iii) Transfer to an intensive management unit;

(iv) Increase in security classification;

(v) Reprimand and loss of points;

(vi) Restitution; or

(vii) Community service.

(d) Sanctions for violations listed in WAC 388-730-0070(2) may include transfer to a higher security facility and must include one or more of the following:

(i) Loss or privileges;

(ii) Loss of program level;

(iii) Room confinement up to seventy-two hours;

(iv) Change in release date;

(v) Reprimand and/or loss of points;

(vi) Additional restitution; or

(vii) Community service.

(4) When a sanction is imposed, the juvenile must also receive a counseling intervention to address the violation.

(5) If the proposed sanctions for any violation includes extending the juvenile's established release date, the juvenile must be entitled to:

(a) Notice of an administrative review to consider extension of the release date and a written statement of the incident;

(b) An opportunity to be heard before a neutral review chairperson;

(c) Present oral or written statements, and call witnesses unless testimony of a witness would be irrelevant, repetitive, unnecessary, or would disrupt the orderly administration of the facility;

(d) Imposition of the sanction only if the administrative review chairperson finds by a preponderance of the evidence that the serious violation did occur; and

(e) A written decision, stating the reasons for the decision, by the administrative review chairperson.

(6) Each superintendent and service provider must clearly post the list of serious violations and possible sanctions in all living units.

(7) Each program administrator must adopt procedures for implementing the requirements of this section.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0070, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-070, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-070, filed 8/29/96, effective 9/29/96.]

#### **WAC 388-730-0080 Documenting and reporting violations committed by juveniles in residential facilities.** (1)

All serious violations and violations listed in WAC 388-730-0070(2) must be documented in an incident report. The incident report must include:

- (a) Circumstances leading up to the violation(s);
- (b) A description of the violation;
- (c) Response by staff;
- (d) Response by the juvenile(s) involved in the incident;

and

(e) Sanctions imposed or recommended for the violation(s).

(2) Service providers must:

(a) Forward all incident reports to the JRA program administrator no later than twenty-four hours after the behavior is discovered; and

(b) Verbally report serious violations to the JRA program administrator immediately.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0080, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-080, filed 8/31/98, effective 9/1/98.]

**WAC 388-730-0090 Service provider penalty schedule.** (1) Whenever a service provider contracts with the JRA to operate a community facility, the contracted service provider must report any known violation as required in WAC 388-730-0080.

(2) If the contracted service provider fails to report violations within the prescribed time frames, the JRA must impose one or more of the following remedies:

(a) Imposition of a corrective action plan to be completed as determined by the program administrator.

(b) Imposition of the following monetary penalties:

(i) The first time fines are imposed on a service provider, the penalty must be at the rate of fifty dollars per day for each juvenile involved in a violation that was not reported as required. The penalty must be assessed for each day the report was late, and may continue until a corrective action plan is approved by the program administrator.

(ii) Subsequent fines imposed on the service provider during the same calendar year must be at the rate of seventy-five dollars per day for each juvenile involved in a violation that was not reported as required. The penalty must be assessed for each day the report was late, and may continue until a corrective action plan is approved by the program administrator.

[Title 388 WAC—p. 1006]

(c) Order to stop placement until a corrective action plan is submitted, approved by the program administrator, and implemented.

(d) Termination of the contract for convenience if it is determined such termination is in the best interests of the department.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0090, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-090, filed 8/31/98, effective 9/1/98.]

### **Chapter 388-740 WAC**

#### **JUVENILE PAROLE REVOCATION**

(Formerly chapter 275-30 WAC)

#### **WAC**

388-740-0010	Definitions.
388-740-0030	Parole arrest warrant.
388-740-0040	Parole revocation petition.
388-740-0060	Parole revocation hearing.
388-740-0070	Confinement.

**WAC 388-740-0010 Definitions.** "Department" means the department of social and health services.

"Detention" means physical custody in Washington state by the department of social and health services in a juvenile rehabilitation administration operated or contracted facility or a Washington state detention facility as defined in RCW 13.40.020(9).

"Juvenile parole officer" means a state employee, or person under contract to the state, whose responsibilities include supervising juvenile parolees.

"Juvenile parolee" means a person under age twenty-one released from a juvenile rehabilitation administration residential facility and placed under the supervision of a juvenile parole officer.

"Modification of parole conditions" means a change in the "order of parole conditions" provided by the juvenile parole officer with full knowledge of the change by the juvenile parolee.

"Parole" means a period of supervision following release from a juvenile rehabilitation administration residential facility, during which time certain parole conditions are to be followed.

"Parole conditions" mean interventions or expectations that include, but are not limited to, those listed in RCW 13.40.210, intended to facilitate the juvenile parolee's reintegration into the community and/or to reduce the likelihood of reoffending.

"Secretary" means secretary of the department of social and health services or his/her designee.

"Violation" means behavior by a juvenile parolee contrary to written parole conditions which may result in sanctions that include, but are not limited to, modification of parole conditions and/or confinement.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, amended and recodified as § 388-740-0010, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-010, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-010, filed 10/5/88.]

(2003 Ed.)

**WAC 388-740-0030 Parole arrest warrant.** (1) A juvenile parole officer:

(a) Must issue a parole arrest warrant when the juvenile parole officer has reason to believe a juvenile parolee possessed a firearm or used a deadly weapon during the parole period; or

(b) May issue a parole arrest warrant when the juvenile parole officer has reason to believe a juvenile parolee has violated a condition of parole, other than possession of a firearm or use of a deadly weapon.

(2) The parole arrest warrant, on department forms, must include a statement of the nature of the violation(s) and the date it occurred.

(3) A juvenile parolee held in detention for an alleged violation of parole conditions is entitled to an informal hearing to determine whether there is probable cause to believe a parole violation occurred and whether continued detention pending a parole revocation hearing is necessary. The hearing must be:

(a) Held within twenty-four hours (excluding Saturdays, Sundays, and holidays) of being placed in detention for an alleged violation of parole conditions; and

(b) Conducted by a parole supervisor or designee not directly involved in the case. The parole supervisor or designee must:

(i) Interview both the juvenile parolee and a juvenile parole staff with knowledge of the alleged violation(s). If such a parole staff is unavailable, documentation of the allegation(s) may be reviewed in place of the staff interview; and

(ii) Issue a decision, immediately following the hearing, with reasons for either releasing the juvenile parolee or authorizing continued detention. The decision must be documented on department forms. In no event shall a juvenile parolee be held in detention for an alleged violation of parole conditions longer than seventy-two hours (excluding Saturdays, Sundays, and holidays) without a parole revocation petition being filed pursuant to WAC 275-30-040.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0030, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-030, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-030, filed 10/5/88.]

**WAC 388-740-0040 Parole revocation petition.** (1) The juvenile parole officer:

(a) Must initiate a parole revocation petition if the juvenile parole officer has reason to believe the juvenile parolee possessed a firearm or used a deadly weapon during the parole period; or

(b) May initiate a parole revocation petition if the juvenile parole officer has reason to believe the juvenile parolee has violated a condition of parole, other than possession of a firearm or use of a deadly weapon.

(2) The petition, on department forms, must include:

(a) A statement of the nature of the violation and the date it occurred;

(b) The relief requested by the juvenile parole officer as a result of the violation;

(c) Notice of the juvenile parolee's right to be represented by an attorney, either one of his/her own choosing or one appointed at public expense;

(2003 Ed.)

(d) A parole revocation hearing waiver agreement;

(e) The dated signature of the regional administrator or designee; and

(f) If the parole revocation hearing is not waived, notice of the time, date, and location of the parole revocation hearing and notice that failure to appear may result in default.

(3) An initial copy of the petition that includes the information described in subsection (2)(a) through (e) must:

(a) Be provided to the juvenile parolee or the juvenile parolee's attorney; and

(b) Be provided to the juvenile parolee's parent/guardian, if reasonably possible. The juvenile parole officer must document the date and time he/she provided the initial copy of the petition to the juvenile parolee or the juvenile parolee's attorney.

(4) A juvenile parolee, only through an attorney, may waive the right to a parole revocation hearing and agree to the parole revocation and agreed upon relief. The decision to waive must be documented with dated signatures on the original petition.

(5) If the juvenile parolee through his/her attorney does not waive the right to a hearing, the parole revocation petition must be filed with the local office of the state office of administrative hearings within seventy-two hours (excluding Saturdays, Sundays, and holidays) of:

(a) The juvenile parolee being placed in detention for an alleged violation of parole conditions; or

(b) The juvenile parolee or his/her attorney being provided with a copy of the petition under subsection (3) of this section if the juvenile parolee is not detained.

(6) The filed petition must include notice that failure to appear may result in default, and the time, date, and location of the parole revocation hearing, as determined by the state office of administrative hearings. A copy of the filed petition must:

(a) Be served either personally or by certified mail, return receipt requested, on the juvenile parolee or the juvenile parolee's attorney; and

(b) Be provided to the juvenile parolee's parent/guardian, if reasonably possible.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0040, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-040, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-040, filed 10/5/88.]

**WAC 388-740-0060 Parole revocation hearing.** (1)

After the petition is filed a parole revocation hearing must be held to determine whether the alleged parole violation occurred unless the juvenile parolee waives his/her right to a parole revocation hearing. If the juvenile parolee is held in detention as described under WAC 275-30-030, the administrative law judge must hold the hearing within seventy-two hours (excluding Saturdays, Sundays, and holidays) of the petition being served. Otherwise the administrative law judge must hold a hearing no sooner than seven days after the petition is served, but no later than fourteen days after the petition is served.

(2) At the parole revocation hearing, the juvenile may waive the right to be represented by an attorney. A juvenile

waiving the right to an attorney may either contest or agree to the parole revocation.

(3) The administrative law judge must:

(a) Conduct a parole revocation hearing in accordance with chapter 10-08 WAC except as otherwise indicated in these rules;

(b) Grant the parole revocation petition if the administrative law judge finds, by a preponderance of the evidence, the violation occurred and the violation warrants revocation;

(c) Order the relief requested in the petition, if the parole revocation petition is granted;

(d) Issue an oral decision immediately following the parole revocation hearing;

(e) Issue a written decision within forty-eight hours of the hearing; and

(f) Provide a copy of the decision to the juvenile parole officer, the juvenile parolee and his/her attorney, the juvenile parolee's parent/guardian, and the department. The administrative law judge's decision shall constitute a final administrative decision.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0060, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-060, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 90-22-072 (Order 3091), § 275-30-060, filed 11/6/90, effective 12/7/90; 88-20-083 (Order 2709), § 275-30-060, filed 10/5/88.]

**WAC 388-740-0070 Confinement.** (1) A juvenile's confinement for violating one or more conditions of parole, as alleged in a parole revocation petition, may not exceed thirty days. Confinement may be continuous, or for a portion of each day, or for certain days each week with the balance of time under supervision. The department must give the juvenile credit against any period of confinement for days served in detention pending a parole revocation hearing. The juvenile must serve his or her confinement in a county detention facility as defined in RCW 13.40.020, a juvenile rehabilitation administration facility, or, if the juvenile parolee is eighteen years old or older, the juvenile may serve his or her confinement in a county jail.

(2) If a juvenile's parole is revoked two or more times during one parole period, the secretary or designee must approve any period of confinement exceeding a combined total of thirty days.

(3) Instead of confinement under subsection (1) of this section, the secretary or designee may return the offender to confinement in an institution for the remainder of the sentence range if:

(a) The offense for which the offender was sentenced is rape in the first or second degree, rape of a child in the first or second degree, child molestation in the first degree, indecent liberties with forcible compulsion, or a sex offense that is also a serious violent offense as defined under RCW 9.94A.030; or

(b) As otherwise authorized in RCW 13.40.210.

(4) Unless conditions of parole are otherwise amended, the order of parole conditions in effect at the time the parole was revoked shall be deemed reinstated immediately following any period of confinement.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0070, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW

[Title 388 WAC—p. 1008]

72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-070, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 90-22-072 (Order 3091), § 275-30-070, filed 11/6/90, effective 12/7/90; 88-20-083 (Order 2709), § 275-30-070, filed 10/5/88.]

## Chapter 388-745 WAC

### TRANSFER OF JUVENILE OFFENDER TO THE DEPARTMENT OF CORRECTIONS

(Formerly Chapter 275-33 WAC)

#### WAC

388-745-020	Notification to juvenile.
388-745-030	Composition of board.
388-745-040	Attendance at hearing.
388-745-050	Consideration of evidence.
388-745-060	Record of decision.

**WAC 388-745-020 Notification to juvenile.** A juvenile being considered for transfer to DOC shall be notified in writing at least five days in advance of the review board hearing convened to consider the matter. Notification to the juvenile offender will include the reasons the transfer is being considered and a copy of the rules pertaining to the review board hearing. Prior to any review board hearing, the juvenile being considered for transfer to DOC, or the juvenile's attorney, shall have the right of access to, and adequate opportunity to examine any files or records of the department pertaining to the proposed transfer of the juvenile to the department of corrections.

[00-16-078, recodified as § 388-745-020, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-020, filed 4/30/84.]

**WAC 388-745-030 Composition of board.** The review board will be composed of the director of DJR or designee and two other juvenile rehabilitation administrators appointed by the chairman.

[00-16-078, recodified as § 388-745-030, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-030, filed 4/30/84.]

**WAC 388-745-040 Attendance at hearing.** Attendance at a review board shall be limited to parties directly concerned. The chairperson may exclude unauthorized persons unless the parties agree to their presence. Parties shall have the right to present evidence, cross-examine witnesses and make recommendations to the board. All relevant and material evidence is admissible which, in the opinion of the chairperson, is the best evidence reasonably obtainable, having due regard for its necessity, availability and trustworthiness.

[00-16-078, recodified as § 388-745-040, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-040, filed 4/30/84.]

**WAC 388-745-050 Consideration of evidence.** At the conclusion of the hearing, the review board will consider all evidence presented and make a decision whether continued placement of the juvenile offender in an institution for juvenile offenders presents a continuing and serious threat to the safety of others in the institution.

(2003 Ed.)

[00-16-078, recodified as § 388-745-050, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-050, filed 4/30/84.]

**WAC 388-745-060 Record of decision.** The chair of the review board will prepare a written record of the decision and reasons therefore. The review board shall be recorded manually, or by mechanical, electronic, or other device capable of transcription.

[00-16-078, recodified as § 388-745-060, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-060, filed 4/30/84.]

## Chapter 388-750 WAC

### IMPACT ACCOUNT—CRIMINAL JUSTICE COST REIMBURSEMENT

#### WAC

388-750-010	Definitions.
388-750-020	Limitation of funds.
388-750-030	Institutions and eligible impacted political subdivisions.
388-750-040	Maximum allowable reimbursement for law enforcement costs.
388-750-050	Maximum allowable reimbursement for prosecutorial costs.
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388-750-070	Maximum allowable reimbursement for jail facilities.
388-750-080	Billing procedure.
388-750-090	Exceptions.
388-750-100	Effective date.
388-750-110	Audits.

**WAC 388-750-010 Definitions.** The following words and phrases shall have the following meaning when used in these regulations regarding the interpretation of regulations for the reimbursement from impacts caused by criminal behavior of state institutional residents:

**"Department"** means the department of social and health services.

**"Incremental"** means efforts or costs incurred by cities, towns, and/or counties that are not otherwise incurred and are only as a result of the criminal behavior of state institutional residents.

**"Resident"** means any person committed to a state institution by the courts for confinement as an offender pursuant to chapters 10.64, 10.77, and 13.40 RCW.

**"Institution"** means any state institution operated by the department for the confinement of offenders committed under chapters 10.64, 10.77, and 13.40 RCW.

**"Law enforcement cost"** means costs incurred to apprehend escapees or to investigate crimes committed by institutional residents within or outside state institutions listed in this chapter.

**"Resident"** means any person committed to a state institution by the courts for confinement as an offender under chapters 10.64, 10.77, and 13.40 RCW.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-010, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-020 Limitation of funds.** The secretary shall make reimbursement to the extent funds are available. Reimbursement shall be strictly limited to political subdivisions in which state institutions, as defined in WAC 388-750-

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030, are located. Only incremental costs directly, specifically, and exclusively associated with criminal activities of offenders who are residents of state institutions shall be considered for reimbursement. Reimbursement shall be restricted to fully documented law enforcement, prosecutorial, judicial, and jail facilities costs. No such costs shall be paid under these rules if they are reimbursable under other chapters of the Washington Administrative Code. During each biennium, claims for incidents which occurred during the biennium will be paid in the order in which they are received until the biennial appropriation is fully expended.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-020, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-030 Institutions and eligible impacted political subdivisions.** Reimbursement shall be limited to the following city, town, and county governments impacted by the offenses from residents committed to institutions listed in this section.

Institution	Cities/County
(1) Echo Glen Children's Center	Snoqualmie/King
(2) Green Hill Training School	Chehalis/Lewis
(3) Maple Lane School	Rochester/Thurston
(4) Mission Creek Youth Camp	Belfair/Mason
(5) Naselle Youth Camp	Naselle/Pacific
(6) Woodinville Treatment Center	Woodinville/King
(7) Canyon View Community Facility	East Wenatchee/Douglas
(8) Sunrise Community Facility	Ephrata/Graut
(9) Twin Rivers Community Facility	Richland/Benton
(10) Oakridge Community Facility	Tacoma/Pierce
(11) Park Creek Treatment Center	Kittitas/Kittitas
(12) Ridgeview Community Facility	Yakima/Yakima
(13) Western State Hospital	Steilacoom/Pierce
(14) Eastern State Hospital	Medical Lake/Spokane
(15) Child Study and Treatment Center	Steilacoom/Pierce

(16) For any institution not listed in this section, reimbursement shall be limited to the political subdivisions where the institution is located. The institutions include juvenile community facilities, community treatment and community care facilities, as defined in WAC 388-750-010.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-030, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-040 Maximum allowable reimbursement for law enforcement costs.** The department shall limit reimbursement to the specific political subdivisions listed in WAC 388-750-030. The maximum reimbursement rates shall be twenty-three dollars and ninety-six cents per hour. These reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-040, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-050 Maximum allowable reimbursement for prosecutorial costs.** The department shall reimburse claims, at the rate set forth in WAC 388-750-040, for pretrial investigations of crimes committed inside or outside

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institutions, to the political subdivision courts in WAC 388-750-040. If, after investigation, criminal charges are filed, the department may reimburse documented prosecutorial and defense attorney fees. Reimbursement shall not exceed the following rates for each attorney, reimbursement includes costs for paralegals: Fifty-seven dollars and thirty-two cents per hour. These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-050, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-060 Maximum allowable reimbursement for judicial costs.** (1) The department shall limit judicial costs strictly to cases involving inmates of institutions listed in WAC 388-750-030 and the listed subdivision in which they reside. Reimbursement shall be limited to judges, court reporters, transcript typing, and witness and jury fees.

(2) The department shall reimburse judges hearing cases including services provided by court clerks and bailiffs at fifty-seven dollars and thirty-two cents per hour. Reimburse court reporters at the rate of twenty-four dollars and seventy-one cents per hour. Reimburse for the typing of transcripts at four dollars and seventy-nine cents per page. If required, reimburse expert witnesses at eighty dollars and forty-three cents per hour.

(3) Reimbursement for witness fees (other than experts) and jury fees shall be at the rate established by the local governmental legislative authority but not in excess of thirty-six dollars and eleven cents per day.

(4) These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-060, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-070 Maximum allowable reimbursement for jail facilities.** The department shall limit jail facility cost reimbursement strictly to incremental costs as defined in WAC 388-750-010. Requests for reimbursement shall be fully documented and shall include the resident's name and all appropriate admission and release dates. Limit reimbursement to thirty-four dollars and eighty cents per resident day. The department shall not reimburse for costs incurred for holding persons regarding parole revocations or for holding persons involved in civil litigation. The department shall reimburse costs of providing security when residents require hospitalization at the rate of fourteen dollars and nineteen cents per hour. These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-070, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-080 Billing procedure.** Requests for reimbursement should be made on the standard Washington State Invoice Voucher, Form A19, with supporting documen-

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tation attached. All claims may be subject to periodic audits at the discretion of the secretary, per WAC 388-750-110.

(1) All requests for reimbursement under this section shall note the name of the offender for whom costs were incurred, and the institution to which the offender was assigned.

(2) Requests for reimbursement may only be submitted by the jurisdiction's responsible fiscal officer, e.g., city manager, city supervisor, county auditor, county administrator, etc.

(3) All requests for reimbursement must be submitted to: DSHS and the pertinent Accounts Payable Section of either Juvenile Rehabilitation Administration, Mailstop 45720, Olympia, Washington 98504; or Mental Health Division, Mail Stop 45320, Olympia, Washington 98504.

(4) If the appropriation for a biennium is fully expended prior to the end of the biennium, political subdivisions should continue to submit claims for the purpose of providing justification for requests for adequate funding levels in future biennia.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-080, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-090 Exceptions.** The secretary, of the department, may allow exceptions to these rules.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-090, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-100 Effective date.** Claims submitted according to this chapter may only be for costs incurred for appropriate actions, as defined in this chapter, taken by criminal justice agencies on or after August 30, 1979.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-100, filed 11/14/00, effective 12/15/00.]

**WAC 388-750-110 Audits.** The department has the right to audit any or all claims.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-110, filed 11/14/00, effective 12/15/00.]

## Chapter 388-800 WAC CHEMICAL DEPENDENCY ASSISTANCE PROGRAMS

WAC	
388-800-0005	What is the purpose of this chapter?
388-800-0020	What detoxification services will the department pay for?
388-800-0025	What information does the department use to decide if I am eligible for the detoxification program?
388-800-0030	Who is eligible for detoxification services?
388-800-0035	How long am I eligible to receive detoxification services?
388-800-0040	What is ADATSA?
388-800-0045	What services are offered by ADATSA?
388-800-0048	Who is eligible for ADATSA?
388-800-0050	When am I eligible for ADATSA treatment services?
388-800-0055	What clinical incapacity must I meet to be eligible for ADATSA treatment services?
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388-800-0060	What is the role of the certified chemical dependency service provider in determining ADATSA eligibility?



- 388-800-0065 What are the responsibilities of the certified chemical dependency service provider in determining eligibility?
- 388-800-0070 What happens after I am found eligible for ADATSA services?
- 388-800-0075 What criteria does the certified chemical dependency service provider use to plan my treatment?
- 388-800-0085 Do I have to contribute to the cost of residential treatment?
- 388-800-0090 What happens when I withdraw or am discharged from treatment?
- 388-800-0100 What are the groups that receive priority for ADATSA services?
- 388-800-0110 What cash benefits am I eligible for through ADATSA if I am in residential treatment?
- 388-800-0115 What cash benefits can I receive through ADATSA if I am in outpatient treatment?
- 388-800-0120 As an eligible ADATSA client, when would I get state-funded medical assistance?
- 388-800-0130 What are ADATSA shelter services?
- 388-800-0135 When am I eligible for ADATSA shelter services?
- 388-800-0140 What incapacity criteria must I meet to be eligible for ADATSA shelter services?
- 388-800-0145 How does the department review my eligibility for ADATSA shelter services?
- 388-800-0150 Who is my protective payee?
- 388-800-0155 What are the responsibilities of my protective payee?
- 388-800-0160 What are the responsibilities of an intensive protective payee?
- 388-800-0165 What happens if my relationship with my protective payee ends?

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

- 388-800-0080 What are the time limits for receiving types of chemical dependency treatment through ADATSA? [Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0080, filed 7/28/00, effective 9/1/00.] Repealed by 03-02-079, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.50.080 and 2002 c 64.

**WAC 388-800-0005 What is the purpose of this chapter?** This chapter explains chemical dependency treatment services available through public assistance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0005, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0020 What detoxification services will the department pay for?** (1) The department only pays for services that are:

- (a) Provided to eligible persons (see WAC 388-800-0030);
- (b) Directly related to detoxification; and
- (c) Performed by a certified detoxification center or by a general hospital that has a contract with the department to provide detoxification services.

(2) The department limits on paying for detoxification services are:

- (a) Three days for an acute alcoholic condition; or
- (b) Five days for acute drug addiction.

(3) The department only pays for detoxification services when notified within ten working days of the date detoxification began and all eligibility factors are met.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0020, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0025 What information does the department use to decide if I am eligible for the detoxification program?** (1) The department uses the information

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you provide on the department's application form to determine if you are eligible for the detoxification program.

(2) The department may require an interview, documents or other verification if the department has questions about or needs to confirm the information you provided on your application.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0025, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0030 Who is eligible for detoxification services?** (1) You are eligible for detoxification services if you:

(a) Receive benefits from temporary aid for needy families (TANF), general assistance unemployable (GAU), a medical assistance program, or Supplemental Security Income (SSI); or

(b) Do not have a combined nonexempt income and/or resources that exceed the payment standards for TANF.

(2) To determine your financial eligibility for the detoxification program the department deducts or exempts the following:

- (a) A home;
- (b) Household furnishings and personal clothing essential for daily living;
- (c) Other personal property used to reduce need for assistance or for rehabilitation;
- (d) A used and useful automobile;
- (e) Mandatory expenses of employment;
- (f) Total income and resources of a noninstitutionalized SSI beneficiary;
- (g) Support payments paid under a court order; and
- (h) Payments to a wage earner plan specified by a court in bankruptcy proceedings, or previously contracted major household repairs, when failure to make such payments will result in garnishment of wages or loss of employment.

(3) The following resources are not exempt:

- (a) Cash;
- (b) Marketable securities; and
- (c) Any other resource not specifically exempted that can be converted to cash.

(4) If you receive detoxification services you shall not incur a deductible as a factor of eligibility for the covered period of detoxification.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0030, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0035 How long am I eligible to receive detoxification services?** You are eligible for detoxification services from the date detoxification begins through the end of the month in which you complete the detoxification.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0035, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0040 What is ADATSA?** (1) ADATSA stands for the Alcohol and Drug Addiction Treatment and Support Act which is a legislative enactment providing state-financed treatment and support to chemically dependent indigent persons.

(2) ADATSA provides eligible people with:

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(a) Treatment if you are chemically dependent and would benefit from it; or

(b) A program of shelter services if you are chemically dependent and your chemical dependency has resulted in incapacitating physiological or cognitive impairments.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0040, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0045 What services are offered by ADATSA?** If you qualify for the ADATSA program you may be eligible for:

(1) Alcohol/drug treatment services and support described under WAC-388-800-0080.

(2) Shelter services as described under WAC 388-800-0130.

(3) Medical care services as described under WAC 388-556-0500 and 388-529-0200.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0045, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0045, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0048 Who is eligible for ADATSA?** To be eligible for ADATSA services you must:

(1) Be eighteen years of age or older;

(2) Be a resident of Washington as defined in WAC 388-468-0005;

(3) Meet citizenship requirements as described in WAC 388-424-0005.

(4) Provide your social security number; and

(5) Meet the same income and resource criteria for the GA-U program; OR be receiving federal assistance under SSI or TANF.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0048, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0050 When am I eligible for ADATSA treatment services?** (1) You are eligible for ADATSA treatment services when you meet the:

(a) Financial eligibility criteria in WAC 388-800-0048; and

(b) Incapacity eligibility criteria in WAC 388-800-0055.

(2) If you are able to access, at no cost, state-approved chemical dependency treatment comparable to ADATSA treatment services, you may choose it rather than ADATSA.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0050, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0055 What clinical incapacity must I meet to be eligible for ADATSA treatment services?** You are clinically eligible for ADATSA treatment services when you:

(1) Are diagnosed as having a mild, moderate, or severe dependency on a psychoactive substance class other than nicotine or caffeine, using the current criteria for Psychoactive Substance Dependence in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (DSM IV or its successor);

(2) Have not abstained from alcohol and drug use for the last ninety days, excluding days spent while incarcerated;

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(3) Have not been gainfully employed in a job in the competitive labor market at any time during the last thirty days. For the purposes of this chapter, "gainfully employed" means performing in a regular and predictable manner an activity for pay or profit. Gainful employment does not include noncompetitive jobs such as work in a department-approved sheltered workshop or sporadic or part-time work, if the person, due to functional limitation, is unable to compete with unimpaired workers in the same job; and

(4) Are incapacitated, i.e., unable to work. Incapacity exists if you are one or more of the following:

(a) Currently pregnant or up to two months postpartum;

(b) Diagnosed as at least moderately psychoactive substance dependent and referred for treatment by child protective services;

(c) Diagnosed as severely psychoactive substance dependent and currently an intravenous drug user;

(d) Diagnosed as severely psychoactive substance dependent and has at least one prior admission to a department-approved alcohol/drug treatment or detoxification program;

(e) Diagnosed as severely psychoactive substance dependent and have had two or more arrests for offenses directly related to the chemical dependency; or

(f) Lost two or more jobs during the last six months as a direct result of chemical dependency.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0055, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0055, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0057 Will I still be eligible for ADATSA outpatient services if I abstain from using alcohol or drugs, become employed, or have a relapse?** When you are successfully participating in ADATSA outpatient treatment services you are still considered incapacitated and eligible for ADATSA treatment through completion of the planned treatment, even if you:

(1) Become employed;

(2) Abstain from alcohol or drug use; or

(3) Relapse (resumption of your psychoactive substance abuse dependence).

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0057, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0060 What is the role of the certified chemical dependency service provider in determining ADATSA eligibility?** (1) A department-certified chemical dependency service provider determines your clinical incapacity based on alcoholism and/or drug addiction.

(2) The certified chemical dependency service provider provides a written current assessment needed to determine your eligibility.

(3) This assessment is the department's sole source of medical evidence required for the diagnosis and evaluation of your chemical dependency and its effects on employability.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0060, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0060, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0065 What are the responsibilities of the certified chemical dependency service provider in determining eligibility?** (1) The role of the certified chemical dependency service provider is to:

(a) Provide your diagnostic evaluation and decide your initial treatment placement;

(b) Conduct a face-to-face diagnostic assessment, according to WAC 388-805-310, to determine if you:

(i) Are chemically dependent;

(ii) Meet incapacity standards for treatment under WAC 388-800-0055; and

(iii) Are willing, able, and eligible to undergo a course of ADATSA chemical dependency treatment, once determined incapacitated.

(c) Determines a course of treatment based on your individual assessment of alcohol/drug involvement and treatment needs in accordance with RCW 70.96A.100.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0065, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0065, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0070 What happens after I am found eligible for ADATSA services?** Once your financial and clinical eligibility is established, the certified chemical dependency service provider:

(1) Develops your ADATSA treatment plan;

(2) Arranges your initial chemical dependency treatment placements taking into account the treatment priorities described under WAC 388-800-0100;

(3) Provides you with written notification of your right to return to the community service office (CSO) at any time while receiving ADATSA treatment;

(4) Provides you with written notification of your right to request a fair hearing to challenge any action affecting eligibility for ADATSA treatment; and

(5) Notifies the CSO promptly of your placement or eligibility status changes.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0070, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0070, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0075 What criteria does the certified chemical dependency service provider use to plan my treatment?** When evaluating a treatment plan which will benefit you the most, the certified chemical dependency service provider considers clinical or medical factors utilizing the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC).

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0075, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0075, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0085 Do I have to contribute to the cost of residential treatment?** Once you have been determined financially eligible to receive ADATSA residential treatment services the department does not require you to contribute toward the cost of care.

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[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0085, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0090 What happens when I withdraw or am discharged from treatment?** (1) You will be terminated from ADATSA treatment services if you leave treatment.

(2) If you are discharged from treatment for any other reason, you will be referred to the next appropriate level of treatment.

(3) If you are absent from any residential treatment services for less than seventy-two hours you may reenter that program without being considered as having dropped out. This is done at the discretion of the treatment service administrator and without requiring you to apply for readmittance through the certified chemical dependency service provider.

(4) Once you voluntarily leave treatment you must reapply and be referred again to the certified chemical dependency service provider to receive further ADATSA treatment services.

(5) If you are terminated from treatment you are not eligible for benefits beyond the month in which treatment services end. Rules regarding advance and adequate notice still apply, but you are not eligible for continued assistance pending a fair hearing.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0090, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0090, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0100 What are the groups that receive priority for ADATSA services?** (1) When assigning treatment admissions, the ADATSA/Adult assessment certified chemical dependency service provider:

(a) Gives first priority to you if you are a pregnant woman or a parent with a child under eighteen years old in the home;

(b) Provides priority access for admission if you are:

(i) Referred by the department's children's protective services (CPS) program; and/or

(ii) An injecting drug user (IDU).

(2) If you are completing residential treatment you have priority access to outpatient treatment.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0100, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0100, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0110 What cash benefits am I eligible for through ADATSA if I am in residential treatment?** When you are in ADATSA residential treatment and are below the department payment standard for clothing and personal incidentals (CPI) you may be eligible to receive CPI.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0110, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0110, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0115 What cash benefits can I receive through ADATSA if I am in outpatient treatment?** When you are in ADATSA outpatient treatment, you may be eligi-

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ble for a treatment living allowance for housing and other living expenses.

(1) Your living allowance maximum amount will be based on the current ADATSA payment standard as provided under WAC 388-478-0030.

(2) Your outpatient provider will act as your protective payee and administer your living allowance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0115, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0120 As an eligible ADATSA client, when would I get state-funded medical assistance?** You are eligible for state-funded medical assistance when you are in one of the following situations:

(1) You meet the requirements in WAC 388-800-0048 and are waiting to receive ADATSA treatment services;

(2) When you are participating in ADATSA residential or outpatient treatment;

(3) You choose opiate dependency (methadone maintenance) chemical dependency treatment services instead of other ADATSA treatment, but only if these treatment services are from a state-approved, publicly funded opiate dependency/methadone maintenance program; or

(4) You meet the requirements of WAC 388-800-0135, for shelter services but choose not to receive shelter assistance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0120, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0130 What are ADATSA shelter services?** (1) Your shelter assistance in independent housing consists of a monthly shelter assistance payment through an intensive protective payee defined under WAC 388-800-0160; and

(2) You continue to receive benefits for ADATSA shelter if you request a fair hearing within the advance notice period before termination is to occur.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0130, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0135 When am I eligible for ADATSA shelter services?** You are eligible for ADATSA shelter services when you meet the:

(1) Financial eligibility criteria in WAC 388-800-0040; and

(2) Incapacity eligibility criteria in WAC 388-800-0140.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0135, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0140 What incapacity criteria must I meet to be eligible for ADATSA shelter services?** You are eligible for ADATSA shelter services when you:

(1) Are actively addicted, meaning having used alcohol or drugs within the sixty-day period immediately preceding the latest assessment center evaluation, as determined by the ADATSA/Adult assessment center; and

(2) Have resulting physiological or organic damage, or have resulting cognitive impairment not expected to dissipate within sixty days of sobriety or detoxification, which either:

(a) Limits your functioning because of physiological or organic damage that result in a significant restriction on ability to perform work activities, or

(b) At least a moderate impairment of your ability to understand, remember, and follow complex instructions; and

(c) An overall moderate impairment in your ability to:

(i) Learn new tasks;

(ii) Exercise judgment;

(iii) Make decisions, and

(iv) Perform routine tasks without undue supervision.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0140, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0145 How does the department review my eligibility for ADATSA shelter services?** The department:

(1) Redetermines your incapacity and financial and medical eligibility for ADATSA shelter every six months or more often; and

(2) Provides you adequate and advance notice of adverse action.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0145, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0150 Who is my protective payee?** Your protective payee is either:

(1) Your outpatient treatment provider while in ADATSA treatment; or

(2) An agency under contract with the department to provide you with intensive protective payee services if you are an ADATSA shelter client.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0150, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0155 What are the responsibilities of my protective payee?** Your protective payee:

(1) Has the authority and responsibility to make decisions about the expenditure of your outpatient treatment stipends;

(2) Encourages you to participate in the decision making process. The amount of decision-making the protective payee allows you depends upon the level of responsibility you demonstrate; and

(3) Disburses funds to meet your basic needs of shelter, utilities, food, clothing, and personal incidentals.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0155, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0160 What are the responsibilities of an intensive protective payee?** If you are receiving shelter services, your intensive protective payee provides you with case management services including, but not be limited to:

(1) Disbursing payment for shelter and utilities, such as a check directly to the landlord, mortgage company, utility company, etc.;

(2) Directing payment to vendors directly for goods or services provided to you including personal and incidental expenses.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0160, filed 7/28/00, effective 9/1/00.]

**WAC 388-800-0165 What happens if my relationship with my protective payee ends?** If the relationship with your protective payee is terminated for any reason, the protective payee shall return any remaining funds to the department or its designee.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0165, filed 7/28/00, effective 9/1/00.]

**Chapter 388-805 WAC**

**CERTIFICATION REQUIREMENTS FOR CHEMICAL DEPENDENCY SERVICE PROVIDERS**  
(Formerly chapter 440-22 WAC)

**WAC**

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## SECTION I—PURPOSE AND DEFINITIONS

**WAC 388-805-001** What is the purpose of this chapter? These rules describe the standards and processes necessary to be a certified chemical dependency treatment program. The rules have been adopted under the authority and purposes of the following chapters of law.

- (1) Chapter 10.05 RCW, Deferred prosecution—Courts of limited jurisdiction;
- (2) Chapter 46.61 RCW, Rules of the road;
- (3) Chapter 49.60 RCW, Discrimination—Human rights commission;
- (4) Chapter 70.96A RCW, Treatment for alcoholism, intoxication and drug addiction; and
- (5) Chapter 74.50 RCW, Alcoholism and Drug Addiction Treatment and Support Act (ADATSA).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-001, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-005** What definitions are important throughout this chapter? "Added service" means the adding of certification for chemical dependency levels of care to an existing certified agency at an approved location.

"Addiction counseling competencies" means the knowledge, skills, and attitudes of chemical dependency counselor professional practice as described in Technical Assistance Publication No. 21, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services 1998.

"Administrator" means the person designated responsible for the operation of the certified treatment service.

"Adult" means a person eighteen years of age or older.

"Alcoholic" means a person who has the disease of alcoholism.

"Alcoholism" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Approved supervisor" means a person who meets the education and experience requirements described in WAC 246-811-030 and 246-811-045 through 246-811-049 and who is available to the person being supervised.

"Authenticated" means written, permanent verification of an entry in a patient treatment record by an individual, by means of an original signature including first initial, last name, and professional designation or job title, or initials of the name if the file includes an authentication record, and the date of the entry. If patient records are maintained electronically, unique electronic passwords, biophysical or passcard equipment are acceptable methods of authentication.

"Authentication record" means a document that is part of a patient's treatment record, with legible identification of all persons initialing entries in the treatment record, and includes:

- (1) Full printed name;
- (2) Signature including the first initial and last name; and
- (3) Initials and abbreviations indicating professional designation or job title.

"Bloodborne pathogens" means pathogenic microorganisms that are present in human blood and can cause disease in humans. The pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

"Branch site" means a physically separate certified site where qualified staff provides a certified treatment service, governed by a parent organization. The branch site is an extension of a certified provider's services to one or more sites.

"Certified treatment service" means a discrete program of chemical dependency treatment offered by a service provider who has a certificate of approval from the department of social and health services, as evidence the provider meets the standards of chapter 388-805 WAC.

"Change in ownership" means one of the following conditions:

- (1) When the ownership of a certified chemical dependency treatment provider changes from one distinct legal entity (owner) to a distinct other;
- (2) When the type of business changes from one type to another; or
- (3) When the current ownership takes on a new owner of five percent or more of the organizational assets.

"Chemical dependency" means a person's alcoholism or drug addiction or both.

"Chemical dependency counseling" means face-to-face individual or group contact using therapeutic techniques that are:

- (1) Led by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP;
- (2) Directed toward patients and others who are harmfully affected by the use of mood-altering chemicals or are chemically dependent; and
- (3) Directed toward a goal of abstinence for chemically dependent persons.

"Chemical dependency professional" means a person certified as a chemical dependency professional by the Washington state department of health under chapter 18.205 RCW.

"Child" means a person less than eighteen years of age, also known as adolescent, juvenile, or minor.

"County coordinator" means the person designated by the chief executive officer of a county to carry out administrative and oversight responsibilities of the county chemical dependency program.

"Criminal background check" means a search by the Washington state patrol for any record of convictions or civil adjudication related to crimes against children or other persons, including developmentally disabled and vulnerable adults, per RCW 43.43.830 through 43.43.842 relating to the Washington state patrol.



**"Danger to self or others,"** for purposes of WAC 388-805-520, means a youth who resides in a chemical dependency treatment agency and creates a risk of serious harm to the health, safety, or welfare to self or others. Behaviors considered a danger to self or others include:

- (1) Suicide threat or attempt;
- (2) Assault or threat of assault; or
- (3) Attempt to run from treatment, potentially resulting in a dangerous or life-threatening situation.

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

**"Detoxification"** or **"detox"** means care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

**"Disability, a person with"** means a person whom:

- (1) Has a physical or mental impairment that substantially limits one or more major life activities of the person;
- (2) Has a record of such an impairment; or
- (3) Is regarded as having such an impairment.

**"Discrete treatment service"** means a chemical dependency treatment service that:

- (1) Provides distinct chemical dependency supervision and treatment separate from any other services provided within the facility;
- (2) Provides a separate treatment area for ensuring confidentiality of chemical dependency treatment services; and
- (3) Has separate accounting records and documents identifying the provider's funding sources and expenditures of all funds received for the provision of chemical dependency treatment services.

**"Domestic violence"** means:

- (1) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;
- (2) Sexual assault of one family or household member by another;
- (3) Stalking as defined in RCW 9A.46.110 of one family or household member by another family or household member; or
- (4) As defined in RCW 10.99.020, 26.50.010, or other Washington state statutes.

**"Drug addiction"** means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. Drug addiction is characterized by impaired control over use of drugs, preoccupation with drugs, use of a drug despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

**"Essential requirement"** means a critical element of chemical dependency treatment services that must be present in order to provide effective treatment.

**"First steps"** means a program available across the state for low-income pregnant women and their infants. First steps provides maternity care for pregnant and postpartum women and health care for infants and young children.

**"Governing body"** means the legal entity responsible for the operation of the chemical dependency treatment service.

**"HIV/AIDS brief risk intervention (BRI)"** means an individual face-to-face interview with a client or patient, to help that person assess personal risk for HIV/AIDS infection and discuss methods to reduce infection transmission.

**"HIV/AIDS education"** means education, in addition to the brief risk intervention, designed to provide a person with information regarding HIV/AIDS risk factors, HIV antibody testing, HIV infection prevention techniques, the impact of alcohol and other drug use on risks and the disease process, and trends in the spread of the disease.

**"Medical practitioner"** means a physician, advanced registered nurse practitioner (ARNP), or certified physician's assistant. ARNPs and midwives with prescriptive authority may perform practitioner functions related only to indicated specialty services.

**"Misuse"** means use of alcohol or other drugs by a person in:

- (1) Violation of any law; or
- (2) Breach of agency policies relating to the drug-free work place.

**"Off-site treatment"** means provision of chemical dependency treatment by a certified provider at a location where treatment is not the primary purpose of the site; such as in schools, hospitals, or correctional facilities.

**"Opiate substitution treatment agency"** means an organization that administers or dispenses an approved drug as specified in 212 CFR Part 291 for treatment or detoxification of opiate substitution. The agency is:

- (1) Approved by the Federal Food and Drug Administration;
- (2) Registered with the Federal Drug Enforcement Administration;
- (3) Registered with the state board of pharmacy;
- (4) Licensed by the county in which it operates; and
- (5) Certified as an opiate substitution treatment agency by the department.

**"Outcomes evaluation"** means a system for determining the effectiveness and efficiency of results achieved by patients during or following service delivery, and patient satisfaction with those results for the purpose of program improvement.

**"Patient"** is a person receiving chemical dependency treatment services from a certified program.

**"Patient contact"** means time spent with a client or patient to do assessments, individual or group counseling, or education.

**"Patient placement criteria (PPC)"** means admission, continued service, and discharge criteria found in the Patient Placement Criteria for the Treatment of Substance-Related Disorders as published and revised by the American Society of Addiction Medicine (ASAM).

**"Probation assessment officer (PAO)"** means a person employed at a certified district or municipal court probation assessment service that meets the PAO requirements of WAC 388-805-220.

**"Probation assessment service"** means a certified assessment service offered by a misdemeanor probation department or unit within a county or municipality.

**"Progress notes"** are a permanent record of ongoing assessments of a patient's participation in and response to treatment, and progress in recovery.

**"Qualified personnel"** means trained, qualified staff, consultants, trainees, and volunteers who meet appropriate legal, licensing, certification, and registration requirements.

**"Registered counselor"** means a person registered, or certified by the state department of health as required by chapter 18.19 RCW.

**"Relocation"** means change in location from one office space to a new office space, or moving from one office building to another.

**"Remodeling"** means expansion of existing office space to additional office space at the same address, or remodeling of interior walls and space within existing office space.

**"Restraint,"** for purposes of WAC 388-805-520, means the use of methods, by a trained staff person, to prevent or limit free body movement in case of out-of-control behavior.

**"Restraint"** includes:

- (1) Containment or seclusion in an unlocked quiet room;
- (2) Physical restraint, meaning a person physically holds or restricts another person in a safe manner for a short time in an immediate crisis; or
- (3) Use of a safe and humane apparatus, which the person cannot release by oneself.

**"Service provider"** or **"provider"** means a legally operated entity certified by the department to provide chemical dependency services. The components of a service provider are:

- (1) Legal entity/owner;
- (2) Facility; and
- (3) Staff and services.

**"Sexual abuse"** means sexual assault, incest, or sexual exploitation.

**"Sexual harassment"** means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

- (1) Submission to such conduct is made either explicitly or implicitly a term or condition of employment or treatment; or
- (2) Such conduct interferes with work performance or creates an intimidating, hostile, or offensive work or treatment environment.

**"Substance abuse"** means a recurring pattern of alcohol or other drug use that substantially impairs a person's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.

**"Summary suspension"** means an immediate suspension of certification, per RCW 34.05.422(4), by the department pending administrative proceedings for suspension, revocation, or other actions deemed necessary by the department.

**"Supervision"** means:

- (1) Regular monitoring of the administrative, clinical, or clerical work performance of a staff member, trainee, student,

volunteer, or employee on contract by a person with the authority to give directions and require change; and

(2) **"Direct supervision"** means the supervisor is on the premises and available for immediate consultation.

**"Suspend"** means termination of the department's certification of a provider's treatment services for a specified period or until specific conditions have been met and the department notifies the provider of reinstatement.

**"Treatment services"** means the broad range of emergency, detoxification, residential, and outpatient services and care. Treatment services include diagnostic evaluation, chemical dependency education, individual and group counseling, medical, psychiatric, psychological, and social services, vocational rehabilitation and career counseling that may be extended to alcoholics and other drug addicts and their families, persons incapacitated by alcohol or other drugs, and intoxicated persons.

**"Urinalysis"** means analysis of a patient's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a provider who is exempted from licensure by the department of health:

(1) **"Negative urine"** is a urine sample in which the lab does not detect specific levels of alcohol or other specified drugs; and

(2) **"Positive urine"** is a urine sample in which the lab confirms specific levels of alcohol or other specified drugs.

**"Vulnerable adult"** means a person who lacks the functional, mental, or physical ability to care for oneself.

**"Young adult"** means an adult who is eighteen, nineteen, or twenty years old.

**"Youth"** means a person seventeen years of age or younger.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-005, filed 11/21/00, effective 1/1/01.]

## SECTION II—APPLICATION FOR CERTIFICATION

**WAC 388-805-010 What chemical dependency services are certified by the department?** (1) The department certifies the following types of chemical dependency services:

(a) **Detoxification services**, which assist patients in withdrawing from alcohol and other drugs including:

(i) **Acute detox**, which provides medical care and physician supervision for withdrawal from alcohol or other drugs; and

(ii) **Subacute detox**, which is nonmedical detoxification or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment.

(b) **Residential treatment services**, which provide chemical dependency treatment for patients and include room and board in a twenty-four-hour-a-day supervised facility, including:

(i) **Intensive inpatient**, a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families;

(ii) **Recovery house**, a program of care and treatment with social, vocational, and recreational activities to aid in

patient adjustment to abstinence and to aid in job training, employment, or other types of community activities; and

(iii) **Long-term treatment**, a program of treatment with personal care services for chronically impaired alcoholics and addicts with impaired self-maintenance capabilities. These patients need personal guidance to maintain abstinence and good health.

(c) **Outpatient treatment services**, which provide chemical dependency treatment to patients less than twenty-four hours a day, including:

(i) **Intensive outpatient**, a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts and their families;

(ii) **Outpatient**, individual and group treatment services of varying duration and intensity according to a prescribed plan; and

(iii) **Opiate substitution outpatient treatment**, which meets both outpatient and opiate substitution treatment service requirements.

(d) **Assessment services**, which include:

(i) **ADATSA assessments**, alcohol and other drug assessments of clients seeking financial assistance from the department due to the incapacity of chemical dependency. Services include assessment, referral, case monitoring, and assistance with employment; and

(ii) **DUI assessments**, diagnostic services requested by the courts to determine a client's involvement with alcohol and other drugs and to recommend a course of action.

(e) **Information and assistance services**, which include:

(i) **Alcohol and drug information school**, an education program about the use and abuse of alcohol and other drugs, for persons referred by the courts and others, who do not present a significant chemical dependency problem, to help those persons make informed decisions about the use of alcohol and other drugs;

(ii) **Information and crisis services**, response to persons having chemical dependency needs, by phone or in person;

(iii) **Emergency service patrol**, assistance provided to intoxicated persons in the streets and other public places;

(iv) **Treatment alternatives to street crime (TASC)**, is a referral and case management service. TASC providers furnish a link between the criminal justice system and the treatment system. TASC identifies, assesses, and refers appropriate alcohol and other drug dependent offenders to community-based substance abuse treatment and monitors the outcome for the criminal justice system.

(2) The department may certify a provider for more than one of the services listed under subsection (1) of this section when the provider complies with the specific requirements of the selected services.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-010, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-015 How do I apply for certification as a chemical dependency service provider?** (1) A potential new chemical dependency service provider, otherwise

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referred to as applicant, seeking certification for one or more services, as described under WAC 388-805-010, must:

(a) Request from the department an application packet of information on how to become a certified chemical dependency service provider; and

(b) Obtain a license as a residential treatment facility from the department of health, if planning to offer residential services.

(2) The applicant must submit a completed application to the department that includes:

(a) If the applicant is a sole provider: The name and address of the applicant, and a statement of sole proprietorship;

(b) If the applicant is a partnership: The name and address of every partner, and a copy of the written partnership agreement;

(c) If the applicant is a limited liability company: The name and addresses of its officers, and any owner of five percent or more of the organizational assets, and a copy of the certificate of formation issued by the state of Washington, secretary of state;

(d) If the applicant is a corporation: The names and addresses of its officers, board of directors and trustees, and any owner of five percent or more of the organizational assets, and a copy of the corporate articles of incorporation and bylaws;

(e) A copy of the master business license authorizing the organization to do business in Washington state;

(f) The social security number or Federal Employer Identification Number for the governing organization or person;

(g) The name of the individual administrator under whose management or supervision the services will be provided;

(h) A copy of the report of findings from a criminal background check of any owner of five percent or more of the organizational assets and the administrator;

(i) Additional disclosure statements or background inquiries if the department has reason to believe that offenses, specified under RCW 43.43.830, have occurred since completion of the original application;

(j) The physical location of the facility where services will be provided including, in the case of a location known only by postal route and box numbers, and the street address;

(k) A plan of the premises assuring the chemical dependency treatment service is discrete from other programs, indicating capacities of the location for the proposed uses;

(l) Floor plan showing use of each room and location of:

(i) Windows and doors;

(ii) Restrooms;

(iii) Floor to ceiling walls;

(iv) Areas serving as confidential counseling rooms;

(v) Other therapy and recreation areas and rooms;

(vi) Confidential patient records storage; and

(vii) Sleeping rooms, if a residential facility.

(m) A completed facility accessibility self-evaluation form;

(n) Policy and procedure manuals specific to the agency at the proposed site, and meet the manual requirements described later in this regulation, including the:

- (i) Administrative manual;
- (ii) Personnel manual; and
- (iii) Clinical manual.
- (o) Sample patient records for each treatment service applied for; and
- (p) Evidence of sufficient qualified staff to deliver services.

(3) The agency owner or legal representative must:

- (a) Sign the completed application form and submit the original to the department;
- (b) Send a copy of the completed application form to the county coordinator in the county where services will be provided;
- (c) Submit the application fee with the application materials; and
- (d) Report any changes occurring during the certification process.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-015, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-020 How do I apply for certification of a branch agency or added service?** (1) A certified chemical dependency service provider applying for a branch site or an additional certified service must request an abbreviated application packet from the department.

(2) The applicant must submit an abbreviated application, including:

- (a) The name of the individual administrator providing management or supervision of the services;
- (b) A written declaration that a current copy of the agency policy and procedure manual will be maintained at the branch site and that the manual has been revised to accommodate the differences in business and clinical practices at that site;
- (c) An organization chart, showing the relationship of the branch to the main organization, job titles, and lines of authority;
- (d) Evidence of sufficient qualified staff to deliver services at the branch site; and
- (e) Evidence of meeting the requirements of:
  - (i) WAC 388-805-015 (1)(b);
  - (ii) WAC 388-805-015 (2)(h) through (2)(l) and (m); and
  - (iii) WAC 388-805-015(3).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-020, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-030 How do I apply for opiate substitution treatment service certification?** In addition to WAC 388-805-015 or 388-805-020 requirements, a potential opiate substitution treatment service provider must submit to the department:

- (1) Evidence of licensure from the county served, or evidence the county has authorized a specific certified agency to provide opiate substitution treatment, per RCW 70.96A.400 through 70.96A.420.
- (2) A copy of the registration certificate from the Washington state board of pharmacy.
- (3) A copy of the application to the Federal Drug Enforcement Administration.

[Title 388 WAC—p. 1020]

(4) A copy of the application to the Federal Food and Drug Administration.

(5) Policies and procedures identified under WAC 388-805-700 through 388-805-750.

(6) Certification for opiate substitution treatment is contingent on the concurrent approval by the applicable county, state, and federal regulatory authorities.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-030, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-060 How does the department conduct an examination of nonresidential facilities?** The department must conduct an on-site examination of each new nonresidential applicant's facility or branch facility. The department must determine if the applicant's facility is:

- (1) Substantially as described.
- (2) Suitable for the purposes intended.
- (3) Not a personal residence.
- (4) Approved as meeting all building and safety requirements.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-060, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-065 How does the department determine disqualification or denial of an application?** The department must consider the ability of each person named in the application to operate in accord with this chapter before the department grants or renews certification of a chemical dependency service.

(1) The department must deny an applicant's certification when any of the following conditions occurred and was not satisfactorily resolved, or when any owner or administrator:

- (a) Had a license or certification for a chemical dependency treatment service or health care agency denied, revoked, or suspended;
- (b) Was convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse;
- (c) Obtained or attempted to obtain a health provider license, certification, or registration by fraudulent means or misrepresentation;
- (d) Committed, permitted, aided, or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180;
- (e) Demonstrated cruelty, abuse, negligence, misconduct, or indifference to the welfare of a patient or displayed acts of discrimination;

- (f) Misappropriated patient property or resources;
- (g) Failed to meet financial obligations or contracted service commitments that affect patient care;

(h) Has a history of noncompliance with state or federal regulations in an agency with which the applicant has been affiliated;

(i) Knowingly, or with reason to know, made a false statement of fact or failed to submit necessary information in:

- (i) The application or materials attached; and
- (ii) Any matter under department investigation.
- (j) Refused to allow the department access to records, files, books, or portions of the premises relating to operation of the chemical dependency service;

(k) Willfully interfered with the preservation of material information or attempted to impede the work of an authorized department representative;

(l) Is in violation of any provision of chapter 70.96A RCW; or

(m) Does not meet criminal background check requirements.

(2) The department may deny certification when an applicant:

(a) Fails to provide satisfactory application materials; or

(b) Advertises itself as certified when certification has not been granted, or has been revoked or canceled.

(3) The applicant may appeal department decisions in accord with chapter 34.05 RCW, the Washington Administrative Procedure Act and chapter 388-02 WAC.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-065, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-070 What happens after I make application for certification?** (1) The department may grant an applicant initial certification after a review of application materials and an on-site visit confirms the applicant has the capacity to operate in compliance with this chapter.

(2) A provider's failure to meet and maintain conditions of the initial certification may result in suspension of certification.

(3) An initial certificate of approval may be issued for up to one year.

(4) The provider must post the certificate in a conspicuous place on the premises.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-070, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-075 How do I apply for an exemption?**

(1) The department may grant an exemption from compliance with specific requirements in this WAC chapter when a provider submits an exemption request in writing. The provider must assure the exemption request does not:

(a) Jeopardize the safety, health, or treatment of patients; and

(b) Impede fair competition of another service provider.

(2) Providers must submit a signed letter requesting the exemption to the Supervisor, Certification Section, Division of Alcohol and Substance Abuse, P.O. Box 45331, Olympia, WA 98504-5331.

(3) The department must approve or deny all exemption requests in writing.

(4) The department and the provider must maintain a copy of the decision.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-075, filed 11/21/00, effective 1/1/01.]

**SECTION III—CERTIFICATION FEES**

**WAC 388-805-080 What are the fee requirements for certification?** (1) The department must set fees to be charged for certification.

(2) Providers must pay certification fees:

(a) At the time of application. One-half of the application fee may be refunded if an application is withdrawn before certification or denial; and

(b) Within thirty days of receiving an invoice.

(3) Payment must be made by check, draft, or money order made payable to the department of social and health services.

(4) Fees will not be refunded when certification is denied, revoked, or suspended.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-080, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-085 What are the fees for agency certification?** (1) Application fees:

- (a) New agency \$500
- (b) Branch agency \$500
- (c) Application for adding one or more services \$200
- (d) Change in ownership \$500

(2) Initial and annual certification fees:

(a) For detoxification and residential services: \$26 per licensed bed

(b) For nonresidential services:

(i) Large size agencies: \$1,125 per year  
3,000 or more clients served per year

(ii) Medium size agencies: \$750 per year  
1,000-2,999 clients served per year

(iii) Small size agencies: \$375 per year  
0-999 clients served per year

(c) For agencies certified through deeming per WAC 388-805-0115 \$200 per year

(3) Each year providers must complete a declaration form provided by the department indicating the number of patients served annually, the provider's national accreditation status, and other information necessary for establishing fees and updating certification information.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-085, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-090 May certification fees be waived?**

(1) Certification fees may be waived when the fees would not be in the interest of public health and safety, or when the fees would be to the financial disadvantage of the state.

(2) Providers may submit a letter requesting a waiver of fees to the Supervisor, Certification Section, Division of Alcohol and Substance Abuse, P.O. Box 45331, Olympia, Washington, 98504-5331.

(3) Fee waivers may be granted to qualified providers who receive funding from tribal, federal, state or county government resources as follows:

(a) For residential providers: The twenty-six dollar per bed annual fee will be assessed only for those beds not funded by a governmental source;

(b) For nonresidential providers: The amount of the fee waiver must be determined by the percent of the provider's revenues that come from governmental sources, according to the following schedule:

Percent Government Revenues	90-100%	75-89%	50-74%	0-49%
Small agency	No fee	\$90	\$185	\$375
Medium agency	No fee	\$185	\$375	\$750
Large agency	No fee	\$285	\$565	\$1,125

(4) Requests for fee waiver must be mailed to the department and include the following:

(a) The reason for the request;

(b) For residential providers:

(i) Documentation of the number of beds currently licensed by the department of health;

(ii) Documentation showing the number of beds funded by a government entity including, tribal, federal, state or county government sources.

(c) For nonresidential providers:

(i) Documentation of the number of clients served during the previous twelve-month period;

(ii) Documentation showing the amount of government revenues received during the previous twelve-month period;

(iii) Documentation showing the amount of private revenues received during the previous twelve-month period.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-090, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-095 How long are certificates effective?** Certificates are effective for one year from the date of issuance unless:

(1) The department has taken action for noncompliance under WAC 388-805-065, 388-805-125, or 388-805-130; or

(2) The provider does not pay required fees.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-095, filed 11/21/00, effective 1/1/01.]

#### SECTION IV—MAINTAINING CERTIFICATION

**WAC 388-805-100 What do I need to do to maintain agency certification?** (1) A service provider's continued certification and renewal is contingent upon:

(a) Completion of an annual declaration of certification;

and

(b) Payment of certification fees, if applicable.

(2) Providing the essential requirements for chemical dependency treatment, including the following elements:

(a) Treatment process:

(i) Assessments, as described in WAC 388-805-310;

(ii) Treatment planning, as described in WAC 388-805-315 (2)(a) and 388-805-325(11);

(iii) Documenting patient progress, as described in WAC 388-805-315 (1)(c) and 388-805-325(13);

(iv) Treatment plan reviews and updates, as described in WAC 388-805-315 (2)(b), 388-805-325 (11)(g) and 388-805-325 (13)(c);

(v) Patient compliance reports, as described in WAC 388-805-315 (4)(b), 388-805-325(17), and 388-805-330;

[Title 388 WAC—p. 1022]

(vi) Continuing care, and discharge planning, as described in WAC 388-805-315 (2)(e)(f) and (7), and 388-805-325 (18) and (19).

(b) Staffing: Provide sufficient qualified personnel for the care of patients as described in WAC 388-805-140(4) and 388-805-145(4);

(c) Facility:

(i) Provide sufficient facilities, equipment, and supplies for the care and safety of patients as described in WAC 388-805-140 (4) and (5);

(ii) If a residential provider, be licensed by the department of health as described by WAC 388-805-015 (1)(b).

(3) Findings during periodic on-site surveys and complaint investigations to determine the provider's compliance with this chapter. During on-site surveys and complaint investigations, provider representatives must cooperate with department representatives to:

(a) Examine any part of the facility at reasonable times and as needed;

(b) Review and evaluate records, including patient clinical records, personnel files, policies, procedures, fiscal records, data, and other documents as the department requires to determine compliance; and

(c) Conduct individual interviews with patients and staff members.

(4) The provider must post the notice of a scheduled department on-site survey in a conspicuous place accessible to patients and staff.

(5) The provider must correct compliance deficiencies found at such surveys immediately or as agreed by a plan of correction approved by the department.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-100, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-105 What do I need to do for a change in ownership?** (1) When a certified chemical dependency service provider plans a change in ownership, the current service provider must submit a change in ownership application form sixty or more days before the proposed date of ownership change.

(2) The current provider must include the following information with the application:

(a) Name and address of each new prospective owner of five percent or more of the organizational assets as required by WAC 388-805-015 (2)(a) through (d);

(b) Current and proposed name (if applicable) of the affected;

(c) Date of the proposed transaction;

(d) A copy of the transfer agreement between the outgoing and incoming owner(s);

(e) If a corporation, the names and addresses of the proposed responsible officers or partners;

(f) A statement regarding the disposition and management of patient records, as described under 42 CFR, Part 2 and WAC 388-805-320; and

(g) A copy of the report of findings from a criminal background check of any new owner of five percent or more of the organizational assets and new administrator when applicable.

(3) The department must determine which, if any, WAC 388-805-015 or 388-805-020 requirements apply to the



potential new service provider, depending on the extent of ownership and operational changes.

(4) The department may grant certification to the new owner when the new owner:

- (a) Successfully completes the application process; and
- (b) Ensures continuation of compliance with rules of this chapter and implementation of plans of correction for deficiencies relating to this chapter, when applicable.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-105, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-110 What do I do to relocate or remodel a facility?** When a certified chemical dependency service provider plans to relocate or change the physical structure of a facility in a manner that affects patient care, the provider must:

(1) Submit a completed agency relocation approval request form, or a request for approval in writing if remodeling, sixty or more days before the proposed date of relocation or change.

(2) Submit a sample floor plan that includes information identified under WAC 388-805-015 (2)(f) through (k).

(3) Submit a completed facility accessibility self-evaluation form.

(4) Provide for department examination of nonresidential premises before approval, as described under WAC 388-805-060.

(5) Contact the department of health for approval before relocation or remodel if a residential treatment facility.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-110, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-115 How does the department deem national accreditation?** (1) The department must deem accreditation by a national chemical dependency accreditation body, recognized by the department, if the treatment provider was initially certified by the department and when:

(a) A major portion of the national accreditation body requirements meet or exceed chapter 388-805 WAC requirements;

(b) The national accreditation time intervals meet or exceed state expectations;

(c) The provider notifies the department of scheduled on-site surveys;

(d) The provider promptly sends a copy of survey findings, corrective action plans, and follow-up responses to the department; and

(e) WAC 388-805-001 through 388-805-135 continue to apply at all times.

(2) The department may apply an abbreviated department survey, which includes requirements specific to Washington state at its regular certification intervals.

(3) The department must act upon:

(a) Complaints received; and

(b) Deficiencies cited by the national accreditation body for which there is no evidence of correction.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-115, filed 11/21/00, effective 1/1/01.]

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**WAC 388-805-120 How does the department assess penalties?** (1) When the department determines that a service provider fails to comply with provider entry requirements or ongoing requirements of this chapter, the department may:

(a) Assess fees to cover costs of added certification activities;

(b) Cease referrals of new patients who are recipients of state or federal funds; and

(c) Notify the county alcohol and drug coordinator and local media of ceased referrals, involuntary cancellations, suspensions, revocations, or nonrenewal of certification.

(2) When the department determines a service provider knowingly failed to report to the court a patient's noncompliance with treatment ordered by the court under chapter 46.61 RCW, the department must assess the provider a fine of two hundred fifty dollars for each incident of nonreporting.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-120, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-125 How does the department cancel certification?** The department may cancel a provider's certification if the provider:

(1) Ceases to provide services for which the provider is certified.

(2) Voluntarily cancels certification.

(3) Fails to submit required certification fees.

(4) Changes ownership without prior notification and approval.

(5) Relocates without prior notification and approval.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-125, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-130 How does the department suspend or revoke certification?** (1) The department must suspend or revoke a provider's certification when a disqualifying situation described under WAC 388-805-065 applies to a current service provider.

(2) The department must revoke a provider's certification when the provider knowingly failed to report to the court, within a continuous twelve-month period, three incidents of patient noncompliance with treatment ordered by the court under chapter 46.61 RCW.

(3) The department may suspend or revoke a provider's certification when any of the following provider deficiencies or circumstances occur:

(a) A provider fails to provide the essential requirements of chemical dependency treatment as described in WAC 388-805-100(2), and one or more of the following conditions occur:

(i) Violation of a rule threatens or results in harm to a patient;

(ii) A reasonably prudent provider should have been aware of a condition resulting in significant violation of a law or rule;

(iii) A provider failed to investigate or take corrective or preventive action to deal with a suspected or identified patient care problem;

(iv) Noncompliance occurs repeatedly in the same or similar areas;

(v) There is an inability to attain compliance with laws or rules within a reasonable period of time.

(b) The provider fails to submit an acceptable and timely plan of correction for cited deficiencies; or

(c) The provider fails to correct cited deficiencies.

(4) The department may suspend certification upon receipt of a providers written request. Providers requesting voluntary suspension must submit a written request for reinstatement of certification within one year from the effective date of the suspension. The department will review the request for reinstatement, determine if the provider is able to operate in compliance with certification requirements, and notify the provider of the results of the review for reinstatement.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-130, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-135 What is the prehearing, hearing and appeals process?** (1) In case of involuntary certification cancellation, suspension, or revocation of the certification, or a penalty for noncompliance, the department must:

(a) Notify the service provider and the county coordinator of any action to be taken; and

(b) Inform the provider of pre-hearing and dispute conferences, hearing, and appeal rights under chapter 388-02 WAC.

(2) The department may order a summary suspension of the provider's certification pending completion of the appeal process when the preservation of public health, safety, or welfare requires emergency action.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-135, filed 11/21/00, effective 1/1/01.]

## SECTION V—ORGANIZATIONAL STANDARDS

**WAC 388-805-140 What are the requirements for a provider's governing body?** The provider's governing body, legally responsible for the conduct and quality of services provided, must:

(1) Appoint an administrator responsible for the day-to-day operation of the program.

(2) Maintain a current job description for the administrator including the administrator's authority and duties.

(3) Establish the philosophy and overall objectives for the treatment services.

(4) Notify the department within thirty days, of changes of the agency administrator.

(5) Provide personnel, facilities, equipment, and supplies necessary for the safety and care of patients.

(6) If a nonresidential provider, ensure:

(a) Safety of patients and staff; and

(b) Maintenance and operation of the facility.

(7) Review and approve written administrative, personnel, and clinical policies and procedures required under WAC 388-805-150, 388-805-200, and 388-805-300.

(8) Ensure the administration and operation of the agency is in compliance with:

(a) Chapter 388-805 WAC requirements;

(b) Applicable federal, state, and local laws and rules; and

[Title 388 WAC—p. 1024]

(c) Federal, state, and local licenses, permits, and approvals.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-140, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-145 What are the key responsibilities required of an agency administrator?** (1) The administrator is responsible for the day-to-day operation of the certified treatment service, including:

(a) All administrative matters;

(b) Patient care services; and

(c) Meeting all applicable rules and ethical standards.

(2) When the administrator is not on duty or on call, a staff person must be delegated the authority and responsibility to act in the administrator's behalf.

(3) The administrator must ensure administrative, personnel, and clinical policy and procedure manuals:

(a) Are developed and adhered to; and

(b) Are reviewed and revised as necessary, and at least annually.

(4) The administrator must employ sufficient qualified personnel to provide adequate chemical dependency treatment, facility security, patient safety and other special needs of patients.

(5) The administrator must ensure all persons providing counseling services are registered, certified or licensed by the department of health.

(6) The administrator must ensure full-time chemical dependency professionals (CDPs) or CDP trainees do not exceed one hundred twenty hours of patient contact per month.

(7) The administrator must assign the responsibilities for a clinical supervisor to a least one person within the organization.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-145, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-150 What must be included in an agency administrative manual?** Each service provider must have and adhere to an administrative manual that contains at a minimum:

(1) The organization's:

(a) Articles and certificate of incorporation if the owner is a corporation;

(b) Partnership agreement if the owner is a partnership; or

(c) Statement of sole proprietorship.

(2) The agency's bylaws if the owner is a corporation.

(3) Copies of a current master license and state business licenses or a current declaration statement that they are updated as required.

(4) The provider's philosophy on and objectives of chemical dependency treatment with a goal of total abstinence, consistent with RCW 70.96A.011.

(5) Policies and procedures describing how services will be made sensitive to the needs of each patient, including assurance that:

(a) Certified interpreters or other acceptable alternatives are available for persons with limited English-speaking proficiency and persons having a sensory impairment; and

(b) Assistance will be provided to persons with disabilities in case of an emergency.

(6) A policy addressing special needs and protection for youth and young adults, and for determining whether a youth or young adult can fully participate in treatment, before admission of:

- (a) A youth to a treatment service caring for adults; or
  - (b) A young adult to a treatment service caring for youth.
- (7) An organization chart specifying:

- (a) The governing body;
- (b) Each staff position by job title, including volunteers, students, and persons on contract; and
- (c) The number of full- or part-time persons for each position.

(8) A delegation of authority policy.

(9) A copy of current fee schedules.

(10) Policies and procedures implementing state and federal regulations on patient confidentiality, including provision of a summary of 42 CFR Part 2.22 (a)(1) and (2) to each patient.

(11) Policies and procedures for reporting suspected child abuse and neglect.

(12) Policies and procedures for reporting the death of a patient to the department when:

- (a) The patient is in residence; or
- (b) An outpatient dies on the premises.

(13) Patient grievance policy and procedures.

(14) Policies and procedures on reporting of incidents and actions taken.

(15) Smoking policies consistent with the Washington Clean Indoor Air Act, chapter 70.160 RCW.

(16) For a residential provider, a facility security policy and procedures, including:

- (a) Preventing entry of unauthorized visitors; and
- (b) Use of passes for leaves of patients.

(17) For a nonresidential provider, an evacuation plan for use in the event of a disaster, addressing:

- (a) Communication methods for patients, staff, and visitors including persons with a visual or hearing impairment or limitation;

- (b) Evacuation of mobility-impaired persons;

- (c) Evacuation of children if child care is offered;

- (d) Different types of disasters;

- (e) Placement of posters showing routes of exit; and

- (f) The need to mention evacuation routes at public meetings.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-150, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-155 What are the requirements for provider facilities?** (1) The administrator must ensure the treatment service site:

- (a) Is accessible to a person with a disability;

- (b) Has a reception area separate from living and therapy areas;

- (c) Has adequate private space for personal consultation with a patient, staff charting, and therapeutic and social activities, as appropriate;

- (d) Has secure storage of active and closed confidential patient records; and

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(e) Has one private room available if youth are admitted to a detox or residential facility.

(2) The administrator of a nonresidential facility must ensure:

- (a) Evidence of a current fire inspection approval;

- (b) Facilities and furnishings are kept clean, in good repair;

- (c) Adequate lighting, heating, and ventilation; and

- (d) Separate and secure storage of toxic substances, which are used only by staff or supervised persons.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-155, filed 11/21/00, effective 1/1/01.]

## SECTION VI—HUMAN RESOURCE MANAGEMENT

**WAC 388-805-200 What must be included in an agency personnel manual?** The administrator must have and adhere to a personnel manual, which contains policies and procedures describing how the agency:

- (1) Meets the personnel requirements of WAC 388-805-210 through 388-805-260.

- (2) Conducts criminal background checks on its employees in order to comply with the rules specified in RCW 43.43.830 through 43.43.842.

- (3) Provides for a drug free work place which includes:

- (a) A philosophy of nontolerance of illegal drug-related activity;

- (b) Agency standards of prohibited conduct; and

- (c) Actions to be taken in the event a staff member misuses alcohol or other drugs.

- (4) If a nonresidential provider, provides for prevention and control of communicable disease, including specific training and procedures on:

- (a) Bloodborne pathogens, including HIV/AIDS and Hepatitis B;

- (b) Tuberculosis; and

- (c) Other communicable diseases.

- (5) Provides staff orientation prior to assigning unsupervised duties, including orientation to:

- (a) The administrative, personnel and clinical manuals;

- (b) Staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities;

- (c) Staff and patient grievance procedures; and

- (d) The facility evacuation plan.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-200, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-205 What are agency personnel file requirements?** (1) The administrator must ensure that there is a current personnel file for each employee, trainee, student, and volunteer, and for each contract staff person who provides or supervises patient care.

- (2) The administrator must designate a person to be responsible for management of personnel files.

- (3) Each person's file must contain:

- (a) A copy of the results of a tuberculin skin test or evidence the person has completed a course of treatment approved by a physician or local health officer if the results are positive;

(b) Documentation of training on bloodborne pathogens, including HIV/AIDS and hepatitis B for all employees, volunteers, students, and treatment consultants on contract;

(i) At the time of staff's initial assignment to tasks where occupational exposure may take place;

(ii) Annually thereafter for bloodborne pathogens;

(c) A signed and dated commitment to maintain patient confidentiality in accordance with state and federal confidentiality requirements; and

(d) A record of an orientation to the agency as described in WAC 388-805-200(5).

(4) For residential facilities, documentation of current cardiopulmonary resuscitation (CPR) and first aid training for at least one person on each shift.

(5) Documentation of health department training and approval for any staff administering or reading a TB test.

(6) Employees who are patients or have been patients of the agency must have personnel records:

(a) Separate from clinical records; and

(b) Have no indication of current or previous patient status.

(7) In addition, each patient care staff member's personnel file must contain:

(a) Verification of qualifications for their assigned position including:

(i) For a chemical dependency professional (CDP): A copy of the person's valid CDP certification issued by the department of health (DOH);

(ii) For approved supervisors: Documentation to substantiate the person meets the qualifications of an approved supervisor as defined in WAC 246-811-010.

(iii) For other persons providing counseling, a copy of a valid registration, certification, or license issued by the DOH.

(iv) For probation assessment officers (PAO): Documentation that the person has met the education and experience requirements described in WAC 388-805-220;

(v) For probation assessment officer trainees:

(A) Documentation that the person meets the qualification requirements described in WAC 388-805-225; and

(B) Documentation of the PAO trainee's supervised experience as described in WAC 388-805-230 including an individual education and experience plan and documentation of progress toward completing the plan.

(vi) For information school instructors:

(A) A copy of a certificate of completion of an alcohol and other drug information school instructor's training course approved by the department; and

(B) Documentation of continuing education as specified in WAC 388-805-250.

(b) A copy of a current job description, signed and dated by the employee and supervisor which includes:

(i) Job title;

(ii) Minimum qualifications for the position;

(iii) Summary of duties and responsibilities;

(iv) For contract staff, formal agreements or personnel contracts, which describe the nature and extent of patient care services, may be substituted for job descriptions.

(c) A written performance evaluation for each year of employment:

(i) Conducted by the immediate supervisor of each staff member; and

(ii) Signed and dated by the employee and supervisor.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-205, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-210 What are the requirements for approved supervisors of chemical dependency professional trainees?** (1) When an administrator decides to provide training opportunities for persons seeking to become chemical dependency professionals (CDP) trainees, the administrator must assign an approved supervisor, as defined in WAC 388-805-005, to each CDP trainee.

(2) Approved supervisors must provide the CDP trainees assigned to them with documentation substantiating their qualifications as an approved supervisor before the initiation of training.

(3) Approved supervisors must decrease the hours of patient contact allowed under WAC 388-805-145(6) by twenty percent for each full-time CDP trainee supervised.

(4) Approved supervisors are responsible for all patients assigned to the CDP trainees under their supervision.

(5) An approved supervisor must provide supervision to a CDP trainee as required by WAC 246-811-048.

(6) CDPs must review and co-authenticate all clinical documentation of CDP trainees.

(7) Approved supervisors must supervise, assess and document the progress the CDP trainees under their supervision are making toward meeting the requirements described in WAC 246-811-030 and 246-811-047. This documentation must be provided to trainees upon request.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-210, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-220 What are the requirements to be a probation assessment officer?** A probation assessment officer (PAO), must:

(1) Be employed as a probation officer at a misdemeanor probation department or unit within a county or municipality;

(2) Be certified as a chemical dependency professional, or

(3) Have obtained a bachelor's or graduate degree in a social or health sciences field and have completed twelve quarter or eight semester credits from an accredited college or university in courses that include the following topics:

(a) Understanding addiction and the disease of chemical dependency;

(b) Pharmacological actions of alcohol and other drugs;

(c) Substance abuse and addiction treatment methods;

(d) Understanding addiction placement, continuing care, and discharge criteria, including ASAM PPC criteria;

(e) Cultural diversity including people with disabilities and its implication for treatment;

(f) Chemical dependency clinical evaluation (screening and referral to include co-morbidity);

(g) HIV/AIDS brief risk intervention for the chemically dependent;

(h) Chemical dependency confidentiality;

(i) Chemical dependency rules and regulations.

(4) In addition, a PAO must complete:

(a) Two thousand hours of supervised experience as a PAO trainee in a state-certified DUI assessment service program if a PAO possesses a baccalaureate degree;

(b) One thousand five hundred hours of experience as a PAO trainee in a state-certified DUI assessment service program if a PAO possesses a masters or higher degree.

(5) PAOs, must complete fifteen clock hours of continuing education each year in chemical dependency subject areas which will enhance competency as a PAO beginning on January 1 of the year following the year of initial qualification.

(6) A PAO is grandparented if they were qualified as a PAO by June 30, 2000, under WAC 440-22-240(2).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-220, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-225 What are the requirements to be a probation assessment officer (PAO) trainee?** A probation assessment officer (PAO) trainee must:

(1) Be employed as a probation officer at a misdemeanor probation department or unit within a county or municipality; and

(2) Be directly supervised and tutored by a PAO.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-225, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-230 What are the requirements for supervising probation assessment officer trainees?** (1) Probation assessment officers (PAO) are responsible for all offenders assigned to PAO trainees under their supervision.

(2) PAO trainee supervisors must:

(a) Review and co-authenticate all trainee assessments entered in each offender's assessment record;

(b) Assist the trainee to develop and maintain an individualized education and experience plan (IEEP) designed to assist the trainee in obtaining the education and experience necessary to become a PAO;

(c) Provide the trainee orientation to the various laws and regulations that apply to the delivery of chemical dependency assessment and treatment services;

(d) Instruct the trainee in assessment methods and the transdisciplinary foundations described in the addiction counseling competencies;

(e) Observe the trainee conducting assessments; and

(f) Document quarterly evaluations of the progress of each trainee.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-230, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-240 What are the requirements for student practice in treatment agencies?** (1) The treatment provider must have a written agreement with each educational institution using the treatment agency as a setting for student practice.

(2) The written agreement must describe the nature and scope of student activity at the treatment setting and the plan for supervision of student activities.

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(3) Each student and academic supervisor must sign a confidentiality statement, which the provider must retain.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-240, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-250 What are the requirements to be an information school instructor?** (1) An information school instructor must:

(a) Have a certificate of completion of an alcohol and other drug information school instructor's training course approved by the department; and

(b) Not have a history of alcohol or other drug misuse for two years before being qualified by the department.

(2) To remain qualified, the information school instructor must:

(a) Not display misuse of alcohol or other drugs while serving as an information school instructor; and

(b) Maintain information school instructor status by completing fifteen clock hours of continuing education:

(i) During each two-year period beginning January of the year following initial qualification; and

(ii) In subject areas that increase knowledge and skills in training, teaching techniques, curriculum planning and development, presentation of educational material, laws and rules, and developments in the chemical dependency field.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-250, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-260 What are the requirements for using volunteers in a treatment agency?** (1) Each volunteer assisting a provider must be oriented as required under WAC 388-805-200(5).

(2) A volunteer must meet the qualifications of the position to which the person is assigned.

(3) A volunteer may provide counseling services when the person meets the requirements for a chemical dependency professional trainee or is a chemical dependency professional.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-260, filed 11/21/00, effective 1/1/01.]

## SECTION VII—PROFESSIONAL PRACTICES

**WAC 388-805-300 What must be included in the agency clinical manual?** Each chemical dependency service provider must have and adhere to a clinical manual containing patient care policies and procedures, including:

(1) How the provider meets WAC 388-805-305 through 388-805-350 requirements.

(2) How the provider will meet applicable certified service requirements of WAC 388-805-400 through 388-805-840, including a description of each service offered, detailing:

(a) The number of hours of treatment and education for each certified service; and

(b) Allowance of up to twenty percent of education time to consist of film or video presentations.

[Title 388 WAC—p. 1027]

(3) Identification of resources and referral options so staff can make referrals required by law and as indicated by patient needs.

(4) Assurance that there is an identified clinical supervisor who:

(a) Is a chemical dependency professional (CDP);

(b) Reviews a sample of patient records of each CDP quarterly; and

(c) Ensures implementation of assessment, treatment, continuing care, transfer and discharge plans in accord with WAC 388-805-315.

(5) Patient admission and discharge criteria using PPC:

(a) The administrator must not admit or retain a person unless the person's treatment needs can be met;

(b) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must assess and refer each patient to the appropriate treatment service; and

(c) A person needing detoxification must immediately be referred to a detoxification provider, unless the person needs acute care in a hospital.

(6) Tuberculosis screening for prevention and control of TB in all detox, residential, and outpatient programs, including:

(a) Obtaining a history of preventive or curative therapy;

(b) Screening and related procedures for coordinating with the local health department; and

(c) Implementing TB control as provided by the department of health TB control program.

(7) HIV/AIDS information, brief risk intervention, and referral.

(8) Limitation of group counseling sessions to twelve or fewer patients.

(9) Counseling sessions with nine to twelve youths to include a second adult staff member.

(10) Provision of education to each patient on:

(a) Alcohol, other drugs, and chemical dependency;

(b) Relapse prevention; and

(c) HIV/AIDS, hepatitis, and TB.

(11) Provision of education or information to each patient on:

(a) The impact of chemical use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of chemical use during pregnancy;

(b) Emotional, physical, and sexual abuse; and

(c) Nicotine addiction.

(12) An outline of each lecture and education session included in the service, sufficient in detail for another trained staff person to deliver the session in the absence of the regular instructor.

(13) Assigning of work to a patient by a CDP when the assignment:

(a) Is part of the treatment program; and

(b) Has therapeutic value.

(14) Use of self-help groups.

(15) Patient rules and responsibilities, including disciplinary sanctions for noncomplying patients.

(16) If youth are admitted, a policy and procedure for assessing the need for referral to child welfare services.

(17) Implementation of the deferred prosecution program.

(18) Policy and procedures for reporting status of persons convicted under chapter 46.61 RCW to the department of licensing.

(19) Nonresidential providers must have policies and procedures on:

(a) Medical emergencies;

(b) Suicidal and mentally ill patients;

(c) Medical oversight, including provision of a physical examination by a medical practitioner, on a person who:

(i) Is at risk of withdrawal from barbiturates or benzodiazepines; or

(ii) Used intravenous drugs in the thirty days before admission;

(d) Laboratory tests;

(e) Services and resources for pregnant women:

(i) A pregnant woman who is not seen by a private physician must be referred to a physician or the local first steps maternity care program for determination of prenatal care needs; and

(ii) Services include discussion of pregnancy specific issues and resources.

(f) If using medication services:

(i) A medical practitioner must evaluate each patient who is taking disulfiram at least once every ninety days;

(ii) Patient medications are stored, disbursed, and recorded in accord with chapter 246-326 WAC; and

(iii) Only a licensed nurse or medical practitioner may administer medication.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-300, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-305 What are patients' rights requirements in certified agencies?** (1) Each service provider must ensure each patient:

(a) Is admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria;

(b) Is reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;

(c) Is treated in a manner sensitive to individual needs and which promotes dignity and self-respect;

(d) Is protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;

(e) Has all clinical and personal information treated in accord with state and federal confidentiality regulations;

(f) Has the opportunity to review their own treatment records in the presence of the administrator or designee;

(g) Has the opportunity to have clinical contact with a same gender counselor, if requested and determined appropriate by the supervisor, either at the agency or by referral;

(h) Is fully informed regarding fees charged, including fees for copying records to verify treatment and methods of payment available;

(i) Is provided reasonable opportunity to practice the religion of their choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. The patient has the right to refuse participation in any religious practice;



- (j) Is allowed necessary communication:
- (i) Between a minor and a custodial parent or legal guardian;
  - (ii) With an attorney; and
  - (iii) In an emergency.
- (k) Is protected from abuse by staff at all times, or from other patients who are on agency premises, including:
- (i) Sexual abuse or harassment;
  - (ii) Sexual or financial exploitation;
  - (iii) Racism or racial harassment; and
  - (iv) Physical abuse or punishment.
- (l) Is fully informed and receives a copy of counselor disclosure requirements established under RCW 18.170.060;
- (m) Receives a copy of patient grievance procedures upon request; and
- (n) In the event of an agency closure or treatment service cancellation, each patient must be:
- (i) Given thirty days notice;
  - (ii) Assisted with relocation;
  - (iii) Given refunds to which the person is entitled; and
  - (iv) Advised how to access records to which the person is entitled.
- (2) A service provider must obtain patient consent for each release of information to any other person or entity. This consent for release of information must include:
- (a) Name of the consenting patient;
  - (b) Name or designation of the provider authorized to make the disclosure;
  - (c) Name of the person or organization to whom the information is to be released;
  - (d) Nature of the information to be released, as limited as possible;
  - (e) Purpose of the disclosure, as specific as possible;
  - (f) Specification of the date or event on which the consent expires;
  - (g) Statement that the consent can be revoked at any time, except to the extent that action has been taken in reliance on it;
  - (h) Signature of the patient or parent, guardian, or authorized representative, when required, and the date; and
  - (i) A statement prohibiting further disclosure unless expressly permitted by the written consent of the person to whom it pertains.
- (3) A service provider must notify patients that outside persons or organizations which provide services to the agency are required by written agreement to protect patient confidentially.
- (4) A service provider must notify an ADATSA recipient of the recipient's additional rights as required by WAC 388-800-0090.
- (5) The administrator must ensure a copy of patients' rights is given to each patient receiving services, both at admission and in case of disciplinary discharge.
- (6) The administrator must post a copy of patients' rights in a conspicuous place in the facility accessible to patients and staff.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-305, filed 11/21/00, effective 1/1/01.]

(2003 Ed.)

**WAC 388-805-310 What are the requirements for chemical dependency assessments?** A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must conduct and document an assessment of each client's involvement with alcohol and other drugs. The CDP's assessment must include:

- (1) A face-to-face diagnostic interview with each client to obtain, review, evaluate, and document the following:
  - (a) A history of the client's involvement with alcohol and other drugs, including:
    - (i) The type of substances used;
    - (ii) The route of administration; and
    - (iii) Amount, frequency, and duration of use.
  - (b) History of alcohol or other drug treatment or education;
  - (c) The client's self-assessment of use of alcohol and other drugs;
  - (d) A relapse history; and
  - (e) A legal history.
- (2) If the client is in need of treatment, a multidimensional assessment of the person's:
  - (a) Acute intoxication and/or withdrawal risk;
  - (b) Biomedical conditions and complications;
  - (c) Emotional/behavioral conditions and complications;
  - (d) Treatment acceptance/resistance;
  - (e) Relapse/continued use potential; and
  - (f) Recovery environment.
- (3) If an assessment is conducted on a youth, and the client is in need of treatment, the CDP, or CDP trainee under supervision of a CDP, must also obtain the following information:
  - (a) Parental and sibling use of drugs;
  - (b) History of school assessments for learning disabilities or other problems, which may affect ability to understand written materials;
  - (c) Past and present parent/guardian custodial status, including running away and out-of-home placements;
  - (d) History of emotional or psychological problems;
  - (e) History of child or adolescent developmental problems; and
  - (f) Ability of parents/guardians to participate in treatment.
- (4) Documentation of the information collected, including:
  - (a) A written summary interpreting the data gathered in subsections (1), (2), and (3) of this section including patient strengths and needs for each dimension;
  - (b) A diagnostic assessment statement including applicable criteria and severity of involvement with alcohol and other drugs;
  - (c) A statement regarding provision of an HIV/AIDS brief risk intervention, and referrals made; and
  - (d) Evidence the client:
    - (i) Was notified of the assessment results; and
    - (ii) Documentation of treatment options provided, and the client's choice; or
    - (iii) If the client was not notified of the results and advised of referral options, the reason must be documented.
- (5) Documentation of the treatment recommended, using PPC.

[Title 388 WAC—p. 1029]

(6) Completion and submission of all reports required by the courts, department of licensing, and department of social and health services in a timely manner.

(7) Referral of an adult or minor who requires assessment for involuntary chemical dependency treatment to the county-designated chemical dependency specialist.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-310, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-315 What are the requirements for treatment, continuing care, transfer, and discharge plans?** (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must be responsible for the overall treatment plan for each patient, including:

(a) Patient involvement in treatment planning;  
(b) Documentation of progress toward patient attainment of goals; and

(c) Completeness of patient records.

(2) A CDP or a CDP trainee under supervision of a CDP must:

(a) Develop the individualized treatment plan based on PPC;

(b) Conduct individual and group counseling;

(c) Evaluate the patient and conduct ongoing assessments in accord with PPC. In cases where it is not possible to place or provide the patient with the clinically indicated treatment, the reason must be documented as well as whether other treatment will be provided;

(d) Update the treatment plan, and determine continued service needs using PPC;

(e) Develop the continuing care plan using PPC; and

(f) Complete the discharge summary using PPC.

(3) A CDP, or CDP trainee under supervision of a CDP, must also include in the treatment plan for youth problems identified in specific youth assessment, including any referrals to school and community support services.

(4) A CDP, or CDP trainee under supervision of a CDP, must follow up when a patient misses an appointment to:

(a) Try to motivate the patient to stay in treatment; and

(b) Report a noncompliant patient to the committing authority as appropriate.

(5) A CDP, or CDP trainee under supervision of a CDP, must involve each patient's family or other support persons, when the patient gives written consent:

(a) In the treatment program; and

(b) In self-help groups.

(6) When transferring a patient from one certified treatment service to another within the same agency, at the same location, a CDP, or a CDP trainee under supervision of a CDP, must:

(a) Update the patient assessment and treatment plan using PPC; and

(b) Provide a summary report of the patient's treatment and progress, in the patient's record. In detox, this may be done by a nurse or physician.

(7) A CDP, or CDP trainee under supervision of a CDP, must meet with each patient at the time of discharge from any treatment agency, unless in detox or when a patient leaves treatment without notice, to:

(a) Finalize a continuing care plan using PPC to assist in determining appropriate recommendation for care;

(b) Assist the patient in making contact with necessary agencies or services; and

(c) Provide the patient a copy of the plan.

(8) When transferring a patient to another treatment provider, the current provider must forward copies of the following information to the receiving provider when a release of confidential information is signed by the patient:

(a) Patient demographic information;

(b) Diagnostic assessment statement and other assessment information, including:

(i) Documentation of the HIV/AIDS intervention;

(ii) TB test result;

(iii) A record of the patient's detox and treatment history;

(iv) The reason for the transfer, based on using PPC; and

(v) Court mandated or agency recommended follow-up treatment.

(c) Discharge summary; and

(d) The plan for continuing care or treatment.

(9) A CDP, or CDP trainee under supervision of a CDP, must complete a discharge summary, within seven days of each patient's discharge from the agency, which includes:

(a) The date of discharge or transfer;

(b) A summary of the patient's progress toward each treatment goal, except in detox; and

(c) In detox, a summary of the patient's physical condition.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-315, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-320 What are the requirements for a patient record system?** Each service provider must have a comprehensive patient record system maintained in accord with recognized principles of health record management. The provider must ensure:

(1) A designated individual is responsible for the record system;

(2) A secure storage system which:

(a) Promotes confidentiality of and limits access to both active and inactive records; and

(b) Protects active and inactive files from damage during storage.

(3) Patient record policies and procedures on:

(a) Who has access to records;

(b) Content of active and inactive patient records;

(c) A systematic method of identifying and filing individual patient records so each can be readily retrieved;

(d) Assurance that each patient record is complete and authenticated by the person providing the observation, evaluation, or service;

(e) Retention of patient records for a minimum of five years after the discharge or transfer of the patient; and

(f) Destruction of patient records.

(4) In addition to subsection (1) through (3) of this section, providers maintaining electronic patient records must:

(a) Make records available in paper form upon request:

(i) For review by the department;

(ii) By patients requesting record review as authorized by WAC 388-805-305 (1)(f).

(b) Provide secure, limited access through means that prevent modification or deletion after initial preparation;

(c) Provide for back up of records in the event of equipment, media or human error;

(d) Provide for protection from unauthorized access, including network and Internet access.

(5) In case of an agency closure, the provider closing its treatment agency must arrange for the continued management of all patient records. The closing provider must notify the department in writing of the mailing and street address where records will be stored and specify the person managing the records. The closing provider may:

(a) Continue to manage the records and give assurance they will respond to authorized requests for copies of patient records within a reasonable period of time;

(b) Transfer records of patients who have given written consent to another certified provider;

(c) Enter into a qualified service organization agreement with a certified provider to store and manage records, when the outgoing provider will no longer be a chemical dependency treatment provider; or

(d) In the event none of the arrangements listed in (a) through (c) of this subsection can be made, the closing provider must arrange for transfer of patient records to the department.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-320, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-325 What are the requirements for patient record content?** The service provider must ensure patient record content includes:

(1) Demographic information;

(2) A chemical dependency assessment and history of involvement with alcohol and other drugs;

(3) Documentation the patient was informed of the diagnostic assessment and options for referral or the reason not informed;

(4) A report of a physical examination by a medical practitioner in accord with a nonresidential provider's policy on medical oversight, when a patient is at risk of withdrawal from barbiturates or benzodiazepines, or used intravenous drugs within thirty days of admission;

(5) Documentation the patient was informed of federal confidentiality requirements and received a copy of the patient notice required under 42 CFR, Part 2;

(6) Treatment service rules, translated when needed, signed and dated by the patient before beginning treatment;

(7) Voluntary consent to treatment signed and dated by the patient, parent or legal guardian, except as authorized by law for protective custody and involuntary treatment;

(8) Evidence of counselor disclosure information, acknowledged by the provider and patient by signature and date;

(9) Evidence of a tuberculosis test and results;

(10) Evidence of the HIV/AIDS brief risk intervention;

(11) Initial and updated individual treatment plans, including results of the initial assessment and periodic reviews, addressing:

(a) Patient biopsychosocial problems;

(b) Short- and long-term treatment goals;

(c) Estimated dates for completion of each treatment goal;

(d) Approaches to resolve the problems;

(e) Identification of persons responsible for implementing the approaches;

(f) Medical orders, if appropriate.

(12) Documentation of referrals made for specialized care or services;

(13) At least weekly individualized documentation of ongoing services in residential services, and as required in intensive outpatient and outpatient services, including:

(a) Date, duration, and content of counseling and other treatment sessions;

(b) Ongoing assessments of each patient's participation in and response to treatment and other activities;

(c) Progress notes as events occur, each shift in detox, and treatment plan reviews as specified under each treatment service of chapter 388-805 WAC; and

(d) Documentation of missed appointments.

(14) Medication records, if applicable;

(15) Laboratory reports, if applicable;

(16) Properly completed authorizations for release of information;

(17) Copies of all correspondence related to the patient, including reports of noncompliance;

(18) A copy of the continuing care plan signed and dated by the CDP and the patient; and

(19) The discharge summary.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-325, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-330 What are the requirements for reporting patient noncompliance?** The following standards define patient noncompliance behaviors and set minimum time lines for reporting these behaviors to the appropriate court. Chemical dependency service providers failing to report patient noncompliance with court ordered or deferred prosecution treatment requirements may be considered in violation of chapter 46.61 or 10.05 RCW reporting requirements and be subject to penalties specified in WAC 388-805-120, 388-805-125, and 388-805-130.

(1) For emergent noncompliance: The following noncompliance is considered emergent noncompliance and must be reported to the appropriate court within three working days from obtaining the information:

(a) Patient failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by patient self-report, identified third party report confirmed by the agency, or blood alcohol content or other laboratory test;

(b) Patient reports a subsequent alcohol/drug related arrest;

(c) Patient leaves program against program advice or is discharged for rule violation.

(2) For nonemergent noncompliance: The following noncompliance is considered nonemergent noncompliance and must be reported to the appropriate court as required by subsection (3) and (4) of this section:

(a) Patient has unexcused absences or failure to report. Agencies must report all patient unexcused absences, including failure to attend self-help groups. Report failure of patient

to provide agency with documentation of attendance at self-help groups if under a deferred prosecution order or required by the treatment plan. In providing this report, include the agency's recommendation for action.

(b) Patient failure to make acceptable progress in any part of the treatment plan. Report details of the patient's non-compliance behavior along with a recommendation for action.

(3) If a court accepts monthly progress reports, non-emergent noncompliance may be reported in monthly progress reports, which must be mailed to the court within ten working days from the end of each reporting period.

(4) If a court does not wish to receive monthly reports and only requests notification of noncompliance or other significant changes in patient status, the reports should be transmitted as soon as possible, but in no event longer than ten working days from the date of the noncompliance.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-330, filed 11/21/00, effective 1/1/01.]

## SECTION VIII—OUTCOMES EVALUATION

**WAC 388-805-350 What are the requirements for outcomes evaluation?** Each service provider must develop and implement policies and procedures for outcomes evaluation, to monitor and evaluate outcomes for the purpose of program improvement. Outcomes evaluation includes:

(1) A program description of:

(a) Measurable program objectives in the areas of effectiveness, efficiency, and patient satisfaction;

(b) Baseline measurement of program objectives; and measurement of outcomes at least two of the following times:

(i) During treatment, or

(ii) At discharge, or

(iii) After treatment.

(2) Use of the results.

(3) Measurement of a representative sample of patients served by the treatment provider.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-350, filed 11/21/00, effective 1/1/01.]

## SECTION IX—PROGRAM SERVICE STANDARDS

**WAC 388-805-400 What are the requirements for detoxification providers?** Detoxification services include acute and subacute services. To be certified to offer detoxification services, a provider must:

(1) Meet WAC 388-805-001 through 388-805-350 requirements; and

(2) Meet relevant requirements of chapter 246-326 WAC.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-400, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-410 What are the requirements for detox staffing and services?** (1) The service provider must ensure staffing as follows:

[Title 388 WAC—p. 1032]

(a) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must assess, counsel, and attempt to motivate each patient for referral;

(b) Other staff as necessary to provide services needed by each patient;

(c) All personnel providing patient care, except licensed staff and CDPs, must complete a minimum of forty hours of documented training before assignment of patient care duties. The personnel training must include:

(i) Chemical dependency;

(ii) HIV/AIDS and hepatitis B education;

(iii) TB prevention and control; and

(iv) Detox screening, admission, and signs of trauma.

(d) All personnel providing patient care must have current training in:

(i) Cardio-pulmonary resuscitation (CPR); and

(ii) First aid.

(2) The service provider must ensure detoxification services include:

(a) Screening of each person before admission by a person knowledgeable about alcoholism and other addictions and skilled in observation and eliciting information;

(b) A chemical dependency assessment, which must be attempted within forty-eight hours of a patient's admission;

(c) Counseling of each patient by a CDP, or CDP trainee under supervision of a CDP, at least once:

(i) Regarding the patient's chemical dependency; and

(ii) Attempting to motivate each person to accept referral into a continuum of care for chemical dependency treatment.

(d) Sleeping arrangements that permit observation of patients;

(e) Separate sleeping rooms for youth and adults; and

(f) Referral of each patient to other appropriate treatment services.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-410, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-500 What are the requirements for residential providers?** To be certified to offer intensive inpatient, recovery, or long-term residential services, a provider must meet the requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-510 through 388-805-550 as applicable; and

(3) Chapter 246-326 WAC as required for department of health licensing.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-500, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-510 What are the requirements for residential providers admitting youth?** A residential service provider admitting youth must ensure:

(1) A youth will be admitted only with the written permission of a parent or legal guardian. In cases where the youth meets the requirements of child in need of services (CHINS) the youth may sign themselves into treatment.

(2) The youth must agree to, and both the youth and parent or legal guardian must sign the following when possible:

(a) Statement of patient rights and responsibilities;

(b) Treatment or behavioral contracts; and

- (c) Any consent or release form.
- (3) Youth chemical dependency treatment must include:
  - (a) Group meetings to promote personal growth; and
  - (b) Recreational, leisure, and other therapy and related activities.
- (4) A certified teacher or tutor must provide each youth one or more hours per day, five days each week, of supervised academic tutoring or instruction when the youth is unable to attend school for an estimated period of four weeks or more. The provider must:
  - (a) Document the patient's most recent academic placement and achievement level; and
  - (b) Obtain schoolwork, where applicable, from the patient's home school or provide schoolwork and assignments consistent with the person's academic level and functioning.
- (5) Adult staff must lead or supervise seven or more hours of structured recreation each week.
- (6) Staff must conduct room checks frequently and regularly when patients are in their rooms.
- (7) A person fifteen years of age or younger must not room with a person eighteen years of age or older.
- (8) Sufficient numbers of adult staff, whose primary task is supervision of patients, must be trained and available at all times to ensure appropriate supervision, patient safety, and compliance with WAC 388-805-520.
- (9) In co-ed treatment services, there must be at least one adult staff person of each gender present or on call at all times.
- (10) There must be at least one chemical dependency professional (CDP) for every ten youth patients.
- (11) Staff must document attempts to notify the parent or legal guardian within two hours of any change in the status of a youth.
- (12) For routine discharge, each youth must be discharged to the care of the youth's legal custodian.
- (13) For emergency discharge and when the custodian is not available, the provider must contact the appropriate authority.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-510, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-520 What are the requirements for behavior management?** (1) Upon application for a youth's admission, a service provider must:

- (a) Advise the youth's parent and other referring persons of the programmatic and physical plant capabilities and constraints in regard to providing treatment with or without a youth's consent;
  - (b) Obtain the parent's or other referring person's agreement to participate in the treatment process as appropriate and possible; and
  - (c) Obtain the parent's or other referring person's agreement to return and take custody of the youth as necessary and appropriate on discharge or transfer.
- (2) The administrator must ensure policies and procedures are written and implemented which detail least to increasingly restrictive practices used by the provider to stabilize and protect youth who are a danger to self or others, including:

- (a) Obtaining signed behavioral contracts from the youth, at admission and updated as necessary;
  - (b) Acknowledging positive behavior and fostering dignity and self respect;
  - (c) Supporting self-control and the rights of others;
  - (d) Increased individual counseling;
  - (e) Increased staff monitoring;
  - (f) Verbal de-escalation;
  - (g) Use of unlocked room for containment or seclusion;
  - (h) Use of restraints; and
  - (i) Emergency procedures, including notification of the parent, guardian or other referring person, and, when appropriate, law enforcement.
- (3) The provider must ensure staff is trained in safe and therapeutic techniques for dealing with a youth's behavioral and emotional crises, including:
- (a) Verbal de-escalation;
  - (b) Crisis intervention;
  - (c) Anger management;
  - (d) Suicide assessment and intervention;
  - (e) Conflict management and problem solving skills;
  - (f) Management of assaultive behavior;
  - (g) Proper use of restraint; and
  - (h) Emergency procedures.
- (4) To prevent a youth's unauthorized exit from the residential treatment site, the provider may have:
- (a) An unlocked room for containment or seclusion;
  - (b) A secure perimeter, such as a nonscalable fence with locked gates; and
  - (c) Locked windows and exterior doors.
- (5) Providers using holding mechanisms in subsection (4) of this section must meet current Uniform Building Code requirements, which include fire safety and special egress control devices, such as alarms and automatic releases.
- (6) When less restrictive measures are not sufficient to de-escalate a behavioral crisis, clinical staff may contain or seclude a youth in a quiet unlocked room which has a window for observation and:
- (a) The clinical supervisor must be notified immediately of the staff person's use of a quiet room for a youth, and must determine its appropriateness;
  - (b) A chemical dependency professional (CDP) must consult with the youth immediately and at least every ten minutes, for counseling, assistance, and to maintain direct communication; and
  - (c) The clinical supervisor or designated alternate must evaluate the youth and determine the need for mental health consultation.
- (7) Youth who demonstrate continuing refusal to participate in treatment or continuing to exhibit behaviors that present health and safety risks to self, other patients, or staff may be discharged or transferred to more appropriate care after:
- (a) Interventions appropriate to the situation from those listed in subsection (2) of this section have been attempted without success;
  - (b) The person has been informed of the consequences and return options;

(c) The parents, guardian, or other referring person has been notified of the emergency and need to transfer or discharge the person; and

(d) Arrangements are made for the physical transfer of the person into the custody of the youth's parent, guardian, or other appropriate person or program.

(8) Involved staff must document the circumstances surrounding each incident requiring intervention in the youth's record and include:

- (a) The precipitating circumstances;
- (b) Measures taken to resolve the incident;
- (c) Final resolution; and
- (d) Record of notification of appropriate others.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-520, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-530 What are the requirements for intensive inpatient services?** (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

- (a) Complete the initial treatment plan within five days of admission;
- (b) Conduct at least one face-to-face individual chemical dependency counseling session with each patient each week;
- (c) Provide a minimum of ten hours of chemical dependency counseling with each patient each week;
- (d) Document a treatment plan review, at least weekly, which updates patient status, progress toward goals, and PPC level of service; and
- (e) Refer each patient for ongoing treatment or support, as necessary, upon completion of treatment.

(2) The provider must ensure a minimum of twenty hours of treatment services for each patient each week; up to ten hours may be education.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-530, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-540 What are the requirements for recovery house services?** (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must provide a minimum of five hours of treatment, for each patient each week, consisting of:

- (a) Education regarding drug-free and sober living; and
  - (b) Individual or group counseling.
- (2) A CDP, or CDP trainee under supervision of a CDP, must update patient records at least monthly; and
- (3) Staff must assist patients with general reentry living skills and, for youth, continuation of educational or vocational training.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-540, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-550 What are the requirements for long-term treatment services?** Each chemical dependency service provider must ensure each patient receives:

(1) Education regarding alcohol, other drugs, and other addictions, at least two hours each week.

(2) Individual or group counseling by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP, a minimum of two hours each week.

- (3) Education on social and coping skills.
- (4) Social and recreational activities.
- (5) Assistance in seeking employment, when appropriate.
- (6) Patient record review and update at least monthly.
- (7) Assistance with re-entry living skills.
- (8) A living arrangement plan.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-550, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-600 What are the requirements for outpatient providers?** To be certified to provide intensive or other outpatient services, a chemical dependency service provider must meet the requirements of:

- (1) WAC 388-805-001 through 388-805-350;
- (2) WAC 388-805-610 through 388-805-630, as applicable; and
- (3) WAC 388-805-700 through 388-805-750, if offering opiate substitution treatment services.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-600, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-610 What are the requirements for intensive outpatient treatment services?** (1) Patients admitted to intensive outpatient treatment under a deferred prosecution order pursuant to chapter 10.05 RCW, must complete intensive treatment as described in subsection (2) of this section. Any exceptions to this requirement must be approved, in writing, by the court having jurisdiction in the case.

(2) Each chemical dependency service provider must ensure intensive outpatient services are designed to deliver:

- (a) A minimum of seventy-two hours of treatment services within a maximum of twelve weeks,
- (b) The first four weeks of treatment must consist of:
  - (i) At least three sessions each week;
  - (ii) Each group session must last at least one hour; and
  - (iii) Each session must be on separate days of the week.
- (c) Individual chemical dependency counseling sessions with each patient every twenty hours of treatment, or more if clinically indicated;

(d) Education totaling not more than fifty percent of the treatment services regarding alcohol, other drugs, relapse prevention, HIV/AIDS, hepatitis B and TB prevention, and other air/blood-borne pathogens;

(e) Self-help group attendance in addition to the seventy-two hours;

(f) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must conduct and document a review of each patient's treatment plan every twenty hours of treatment, to assess adequacy and attainment of goals, using PPC;

(g) Upon completion of intensive outpatient treatment, a CDP, or a CDP trainee under the supervision of a CDP, must refer each patient for ongoing treatment or support, as necessary, using PPC.



(3) Patients not under deferred prosecution orders, including youth patients, may be admitted to levels of care as determined appropriate using PPC.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-610, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-620 What are the requirements for outpatient services?** A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

(1) Complete admission assessments within ten calendar days of admission, or by the second visit, unless participation in this outpatient treatment service is part of the same provider's continuum of care.

(2) Conduct group or individual chemical dependency counseling sessions for each patient, each month, according to an individual treatment plan.

(3) Assess and document the adequacy of each patient's treatment and attainment of goals:

(a) Once a month for the first three months; and

(b) Quarterly thereafter or sooner if required by other laws.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-620, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-630 What are the requirements for outpatient services in a school setting?** Any certified chemical dependency service provider may offer school-based services by:

(1) Meeting WAC 388-805-640 requirements; and

(2) Ensuring counseling is provided by a chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-630, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-640 What are the requirements for providing off-site chemical dependency treatment services?** (1) If a certified service provider wishes to offer treatment services, for which the provider is certified, at a site where clients are located primarily for purposes other than chemical dependency treatment, the administrator must:

(a) Ensure off-site treatment services will be provided:

(i) In a private, confidential setting that is discrete from other services provided within the off-site location; and

(ii) By a chemical dependency professional (CDP) or CDP trainee under supervision of a CDP;

(b) Revise agency policy and procedures manuals to include:

(i) A description of how confidentiality will be maintained at each off-site location, including how confidential information and patient records will be transported between the certified facility and the off-site location;

(ii) A description of how services will be offered in a manner that promotes patient and staff member safety; and

(iii) Relevant administrative, personnel, and clinical practices.

(c) Maintain a current list of all locations where off-site services are provided including the name, address (except patient in-home services), primary purpose of the off-site

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location, level of services provided, and date off-site services began at the off-site location.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-640, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-700 What are the requirements for opiate substitution treatment providers?** An opiate substitution treatment provider must meet requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-610 and 388-805-620; and

(3) WAC 388-805-700 through 388-805-750.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-700, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-710 What are the requirements for opiate substitution medical management?** (1) A program physician must provide oversight for determination of opiate physical addiction for each patient before admission unless the patient is exempted by the Federal Food and Drug Administration, and:

(a) Be available for consultation when an opiate physical addiction determination is conducted by anyone other than the program physician; and

(b) Conduct the opiate physical addiction determination for all youth patients.

(2) A physical examination must be conducted on each patient:

(a) By a program physician or other medical practitioner; and

(b) Within twenty-one days of admission.

(3) Following the patient's initial dose of opiate substitution treatment, the physician must establish adequacy of dose, considering:

(a) Signs and symptoms of withdrawal;

(b) Patient comfort; and

(c) Side effects from over medication.

(4) At the appropriate time, a program physician must approve an individual detoxification schedule for each patient being detoxified.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-710, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-720 What are the requirements for urinalysis in opiate substitution treatment?** (1) The provider must obtain a urine sample from each patient for urinalysis:

(a) At least once each month; and

(b) Randomly, without notice to the patient.

(2) Staff must observe the collection of each urine sample and use proper chain of custody techniques when handling each sample;

(3) When a patient refuses to provide a urine sample or initial the log of sample numbers, staff must consider the urine positive; and

(4) Staff must document a positive urine and discuss the findings with the patient in a counseling session within seven days of receiving the results of the test.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-720, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-730 What are the requirements for opiate substitution treatment dispensaries?** (1) Each opiate substitution treatment provider must comply with applicable portions of 21 CFR, Part 1301 requirements, as now or later amended.

(2) The administrator must ensure written policies and procedures to verify the identity of patients.

(3) Dispensary staff must maintain a file with a photograph of each patient. Dispensary staff must ensure pictures are updated when:

(a) The patient's physical appearance changes significantly; or

(b) Every two years, whichever comes first.

(4) In addition to notifying the Food and Drug Administration, the administrator must immediately notify the department and the state board of pharmacy of any theft or significant loss of a controlled substance.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-730, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-740 What are the requirements for opiate substitution treatment counseling?** (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must provide individual or group counseling sessions once each:

(a) Week, for the first ninety days, for a new patient or a patient readmitted more than ninety days since the person's most recent discharge from opiate substitution treatment;

(b) Week, for the first month, for a patient readmitted within ninety days of the most recent discharge from opiate substitution treatment; and

(c) Month, for a patient transferring from another opiate substitution treatment agency where the patient stayed for ninety or more days.

(2) A CDP, or a CDP trainee under supervision of a CDP, must conduct and document a continuing care review with each patient to review progress, discuss facts, and determine the need for continuing opiate substitution treatment:

(a) Between six and seven months after admission; and

(b) Once every six months thereafter.

(3) A CDP, or a CDP trainee under supervision of a CDP, must provide counseling in a location that is physically separate from other activities.

(4) The administrator must ensure at least one full-time CDP, or a CDP trainee under supervision of a CDP, for each fifty patients:

(a) A CDP with one or more CDP trainees may be assigned as primary counselor for up to seventy-five patients, including those assigned to the CDP trainee; and

(b) A CDP trainee may be assigned up to thirty-five patients.

(5) A pregnant woman and any other patient who requests, must receive at least one-half hour of counseling and education each month on:

(a) Matters relating to pregnancy and street drugs;

(b) Pregnancy spacing and planning; and

(c) The effects of opiate substitution treatment on the woman and fetus, when opiate substitution treatment occurs during pregnancy.

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(6) Staff must provide at least one-half hour of counseling on family planning with each patient through either individual or group counseling.

(7) The administrator must ensure there is one staff member who has training in family planning, prenatal health care, and parenting skills.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-740, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-750 What are the requirements for opiate substitution treatment take-home medications?** (1) An opiate substitution treatment provider may authorize take-home medications for a patient when:

(a) The medication is for a Sunday or legal holiday, as identified under RCW 1.16.050; or

(b) Travel to the facility presents a safety risk for patients or staff due to inclement weather.

(2) A service provider may permit take-home medications on other days for a stabilized patient who:

(a) Has received opiate substitution treatment medication for a minimum of ninety days; and

(b) Had negative urines for the last sixty days.

(3) The provider must meet 21 CFR, Part 291 requirements.

(4) The provider may arrange for opiate substitution treatment medication to be administered by licensed staff or self-administered by a pregnant woman receiving treatment at a certified residential treatment agency when:

(a) The woman had been receiving treatment medication for ninety or more days; and

(b) The woman's use of treatment medication can be supervised.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-750, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-800 What are the requirements for free-standing ADATSA assessment providers and services?** (1) A certified ADATSA assessment provider must conduct an ADATSA assessment for each eligible patient and be governed by the requirements under:

(a) WAC 388-805-001 through 388-805-310;

(b) WAC 388-805-020 and 388-805-325 (1), (2), (3), (5), (10), (16), (17), 388-805-330; and 388-805-350; and

(c) Chapter 388-800 WAC.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-800, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-810 What are the requirements for DUI assessment providers?** (1) If located in a district or municipal probation department, each DUI service provider must meet the requirements of:

(a) WAC 388-805-001 through 388-805-135,

(b) WAC 388-805-145 (4), (5), and (6);

(c) WAC 388-805-150, the administrative manual, subsections (4), (7) through (11), (13), and (14);

(d) WAC 388-805-155, facilities, subsections (1)(b), (c), (d), and (2)(b);

(e) WAC 388-805-200 (1), (4), and (5);

- (f) WAC 388-805-205 (1), (2), (3)(a) through (e), (4), (6), (7), and (8);
- (g) WAC 388-805-220, 388-805-225, and 388-805-230;
- (h) WAC 388-805-260, volunteers;
- (i) WAC 388-805-300, clinical manual, subsections (1), (2), (3), (7), (14), (18), and (19)(e);
- (j) WAC 388-805-305, patients' rights;
- (k) WAC 388-805-310, assessments;
- (l) WAC 388-805-320, patient record system, subsections (3)(a) through (f), and (4);
- (m) WAC 388-805-325, record content, subsections (1), (2), (3), (5), (8), (10), (12), (16), and (17); and
- (n) WAC 388-805-350, outcomes evaluation;
- (o) WAC 388-805-815, DUI assessment services.

(2) If located in another certified chemical dependency treatment facility, the DUI service provider must meet the requirements of:

- (a) WAC 388-805-001 through 388-805-260; 388-805-305 and 388-805-310;
- (b) WAC 388-805-300, 388-805-320, 388-805-325 as noted in subsection (1) of this section, 388-805-350; and
- (c) WAC 388-805-815.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-810, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-815 What are the requirements for DUI assessment services?** (1) The administrator must limit clients to persons who have been arrested for a violation of driving while under the influence of intoxicating liquor or other drugs or in physical control of a vehicle as defined under chapter 46.61 RCW;

(2) A chemical dependency professional (CDP), or a CDP trainee under the supervision of a CDP, or a probation assessment officer must conduct each client assessment and ensure the assessment includes, in addition to the requirements under WAC 388-805-310:

- (a) Evaluation of the client's blood alcohol level and other drug levels at the time of arrest, if available; and
- (b) Assessment of the client's self-reported driving record and the abstract of the client's legal driving record.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-815, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-820 What are the requirements for alcohol and other drug information school?** (1) Alcohol and other drug information school providers must be governed under:

- (a) WAC 388-805-001 through 388-805-135; and
- (b) This section.
- (2) The provider must:
  - (a) Inform each student of fees at the time of enrollment; and
  - (b) Ensure adequate and comfortable seating in well-lit and ventilated rooms.
- (3) A certified information school instructor must teach the course and:

- (a) Advise each student there is no assumption the student is an alcoholic or drug addict, and this is not a therapy session;
- (b) Discuss the class rules;

- (c) Review the course objectives;
- (d) Follow curriculum contained in "Alcohol and Other Drugs Information School Training Curriculum," published in 1991, or later amended;
- (e) Ensure not less than eight and not more than fifteen hours of class room instruction;
- (f) Administer the post-test from the above reference to each enrolled student after the course is completed;
- (g) Ensure individual client records include:
  - (i) Intake form;
  - (ii) Hours and date or dates in attendance;
  - (iii) Source of referral;
  - (iv) Copies of all reports, letters, certificates, and other correspondence;
  - (v) A record of any referrals made; and
  - (vi) A copy of the scored post-test.
- (h) Complete and submit reports required by the courts and the department of licensing, in a timely manner.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-820, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-830 What are the requirements for information and crisis services?** (1) Information and crisis service providers must be governed under:

- (a) WAC 388-805-001 through 388-805-135; and
- (b) This section.
- (2) The information and crisis service administrator must:
  - (a) Ensure a chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, is available or on staff;
  - (b) Maintain a current directory of certified chemical dependency service providers in the state;
  - (c) Maintain a current list of local resources for legal, employment, education, interpreter, and social and health services;
  - (d) Have services available twenty-four hours a day, seven days a week;
  - (e) Ensure all staff completes forty hours of training that covers the following areas before assigning unsupervised duties:
    - (i) Chemical dependency crisis intervention techniques;
    - (ii) Alcoholism and drug abuse; and
    - (iii) Prevention and control of TB and bloodborne pathogens.

(f) Have policies and procedures for provision of emergency services, by phone or in person, to a person incapacitated by alcohol or other drugs, or to the person's family, such as:

- (i) General assessments;
- (ii) Interviews for diagnostic or therapeutic purposes;
- (iii) Crisis counseling; and
- (iv) Referral.
- (g) Maintain records of each patient contact, including:
  - (i) The presenting problem;
  - (ii) The outcome;
  - (iii) A record of any referral made;
  - (iv) The signature of the person handling the case; and
  - (v) The name, age, sex, and race of the patient.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-830, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-840 What are the requirements for emergency service patrol?** (1) The emergency service patrol provider must ensure staff providing the service:

(a) Have proof of a valid Washington state driver's license;

(b) Possess annually updated verification of first aid and cardiopulmonary resuscitation training;

(c) Have completed forty hours of training in chemical dependency crisis intervention techniques, and alcoholism and drug abuse, to improve skills in handling crisis situations; and

(d) Have training on communicable diseases, including:

(i) TB prevention and control; and

(ii) Bloodborne pathogens such as HIV/AIDS and hepatitis.

(2) Emergency service patrol staff must:

(a) Respond to calls from police, merchants, and other persons for assistance with an intoxicated person in a public place;

(b) Patrol assigned areas and give assistance to a person intoxicated in a public place; and

(c) Conduct a preliminary assessment of a person's condition relating to the state of inebriation and presence of a physical condition needing medical attention:

(i) When a person is intoxicated, but subdued and willing, transport the person home, to a certified treatment provider, or a health care facility;

(ii) When a person is incapacitated, unconscious, or has threatened or inflicted harm on another person, staff must make reasonable efforts to:

(A) Take the person into protective custody; and

(B) Transport the person to an appropriate treatment or health care facility.

(3) Emergency service patrol staff must maintain a log including:

(a) The time and origin of each call received for assistance;

(b) The time of arrival at the scene;

(c) The location of the person at the time of the assist;

(d) The name and sex of the person transported;

(e) The destination of the transport and time of arrival; and

(f) In case of nonpickup of a person, a notation must be made about why the pickup did not occur.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-840, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-850 What are the requirements for treatment alternatives to street crime (TASC) providers and services?** (1) A certified TASC provider must provide referral and case management services to each eligible patient and meet the requirements of:

(a) WAC 388-805-001 through 388-805-210;

(b) WAC 388-805-240, students;

(c) WAC 388-805-260, volunteers;

[Title 388 WAC—p. 1038]

(d) WAC 388-805-300, clinical manual, subsections (1) through (7), (13) through (18), and (19)(a), (b), (d), (e), and (f);

(e) WAC 388-805-305, patients' rights, subsections (1) through (3), and (5) through (6);

(f) WAC 388-805-310, assessments, subsections (1) through (7);

(g) WAC 388-805-315, treatment, continuing care, transfer, and discharge plans, subsections (1), (2)(a), (c), (d), (e), and (f), (5), and (7) through (9);

(i) A CDP, or a CDP trainee under supervision of a CDP, must substitute referral and case management plans for treatment plan requirements in WAC 388-805-315 (1) and (2)(a)(d);

(ii) A CDP, or a CDP trainee under supervision of a CDP, must coordinate the referral of patients with the appropriate treatment provider for each identified problem, ensure they receive adequate treatment, and add new problems to the case management plan as they are identified;

(iii) A CDP, or a CDP trainee under supervision of a CDP, must coordinate the continuing care plan of the patient with appropriate treatment providers; and,

(iv) When transferring a patient to another treatment provider, a TASC provider will substitute a summary of the patient's progress toward each referral and case management goal.

(h) WAC 388-805-320, patient record system;

(i) WAC 388-805-325, patient record content, subsections (1) through (3), (5) through (10), and (12) through (19);

(j) WAC 388-805-330, reporting patient noncompliance; and

(k) WAC 388-805-350, outcomes evaluation.

(2) A CDP, or a CDP trainee under supervision of a CDP, must assess and document the adequacy of each client's referral and case management plan and attainment of goals once each month.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-850, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-900 What are the requirements for outpatient child care when a parent is in treatment?** A certified outpatient chemical dependency service provider may offer child care services when the provider:

(1) Notifies the department of the provider's intent to offer child care services.

(2) Submits a plan indicating numbers of children to be served and physical space available for the child care service which meets WAC 388-805-155 requirements.

(3) Demonstrates capability of meeting WAC 388-805-905 through 388-805-935 requirements.

(4) Has an approval letter from the department to provide child care services.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-900, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-905 What are the requirements for outpatient child care admission and health history?** (1) A chemical dependency service provider must have and implement written policies and procedures to ensure:

(a) A parent serves as the responsible caregiver; and

(2003 Ed.)

(b) Each child admitted is free of serious medical conditions and not in need of nursing care.

(2) The provider must have a file for each child which includes a health history of each child, obtained on admission, including:

- (a) Name and phone number of the child's physician;
- (b) Date of last physical examination;
- (c) Statement of allergies and reactions, if any;
- (d) Notation of special health problems;
- (e) Immunization status; and
- (f) Notation of medications currently being taken.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-905, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-910 What are the requirements for outpatient child care policies?** The administrator must ensure implementation of childcare policies which include:

- (1) Encouragement of each parent to obtain health care for each child when necessary.
- (2) What to do in case of a medical emergency.
- (3) Protection from child abuse, neglect, and exploitation.
- (4) Reporting of child abuse and neglect.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-910, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-915 What are the requirements for an outpatient child care activity program?** The person designated responsible for the child care program must:

- (1) Address the developmental, cultural, and individual needs of each child served.
- (2) Offer a variety of activity choices.
- (3) Offer each child daily opportunities for small and large muscle activities.
- (4) Implement a planned program of activities, as evidenced by a current, written activity schedule.
- (5) Provide a variety of easily accessible, culturally and developmentally appropriate learning and play materials.
- (6) Promote a nurturing, respectful, supportive, and responsive environment.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-915, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-920 What are the requirements for outpatient child care behavior management and discipline?** (1) The provider and the person responsible for child care must ensure behavior management and disciplinary practices promote:

(a) Each child's developmentally appropriate social behavior, self-control, and respect for the rights of others; and

(b) Fair, reasonable, and consistent practices related to a child's behavior.

(2) The following practices are prohibited by any person:

(a) Corporal punishment, including biting, jerking, shaking, spanking, slapping, hitting, striking, or kicking a child, or other means of inflicting physical pain or causing bodily harm;

(2003 Ed.)

(b) Use of a physical restraint method injurious to a child;

(c) Use of a mechanical restraint, locked time-out room or closet;

(d) Withholding of food; and

(e) Use of derogatory terms.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-920, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-925 What are the requirements for outpatient child care diaper changing?** The administrator must ensure diaper changing policies and procedures are approved by the person developing health care policies and include:

(1) A designated place for diaper changing that is:

- (a) Separate from food preparation areas;
- (b) Adjacent to a handwashing sink;
- (c) Sanitized between use for different children;
- (d) Impervious to moisture; and
- (e) Safe, with safety rails or straps.

(2) Appropriateness of changing diapers in the child's bed.

(3) Posting of diaper changing procedures accessible to staff and parents.

(4) Removal of soiled disposable diapers from the premises daily.

(5) Removal of soiled reusable diapers according to a commercial diaper service schedule.

(6) Handwashing procedures.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-925, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-930 What are the requirements for outpatient child care food service?** The service provider must have policies that address:

(1) Feeding schedules for infants and children.

(2) Safe and sanitary formula preparation and storage.

(3) Storage and handling of bottles and nipples in a sanitary manner, separate from diaper-changing areas.

(4) Identification of prepared bottles with each child's name and date of preparation.

(5) Promotion of a safe and nurturing method for child feeding including:

(a) Holding infants in a semi-sitting position unless against medical advice or the child is able to sit in a high chair;

(b) Interacting with the infant; and

(c) Not propping bottles.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-930, filed 11/21/00, effective 1/1/01.]

**WAC 388-805-935 What are the staffing requirements for outpatient child care services?** (1) The service provider must designate a person responsible for the child care program who:

(a) Meets relevant personnel requirements under WAC 388-805-200 and 388-805-205;

(b) Is eighteen years of age or older; and

[Title 388 WAC—p. 1039]

(c) Is capable of implementing WAC 388-805-905 through 388-805-930.

(2) The service provider must maintain staffing ratios as follows:

(a) One adult for up to and including four infants through eleven months of age;

(b) One adult for up to and including five children twelve through twenty-nine months of age;

(c) One adult for every ten children thirty months through five years of age; and

(d) One adult for every fifteen children five years of age or older.

(3) When there are children of mixed ages, the service provider must maintain the ratio prescribed for the youngest child in the mixed group.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-935, filed 11/21/00, effective 1/1/01.]

### Chapter 388-810 WAC

#### ADMINISTRATION OF COUNTY CHEMICAL DEPENDENCY PREVENTION, TREATMENT, AND SUPPORT PROGRAM (Formerly chapter 440-25 WAC)

#### WAC

388-810-005	What is the purpose of this chapter?
388-810-010	What definitions apply to this chapter?
388-810-020	What are the qualifications to be a county chemical dependency program coordinator?
388-810-030	What are the qualifications to be a county-designated chemical dependency specialist?
388-810-040	Who determines the service priorities for the county chemical dependency prevention, treatment, and support program?
388-810-050	How are available funds allocated for the county chemical dependency program?
388-810-060	How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program?
388-810-070	How will funds be made available to the county?
388-810-080	May a county subcontract for chemical dependency prevention, treatment, and support services?
388-810-090	How does a county request an exemption?

**WAC 388-810-005 What is the purpose of this chapter?** The purpose of this chapter is to describe the planning, contracting, and provision of chemical dependency prevention, treatment, and support services through counties (see chapter 70.96A RCW).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-005, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-010 What definitions apply to this chapter?**

"County" means each county or two or more counties acting jointly.

"County chemical dependency program coordinator" means a person appointed by the county legislative authority as the chief executive officer responsible for carrying out the duties under chapter 70.96A RCW.

"County chemical dependency prevention, treatment, and support program" means services and activities funded by the department through a negotiated contract between a county and the department.

[Title 388 WAC—p. 1040]

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

"Designated chemical dependency specialist" means a person designated by the county chemical dependency program coordinator to perform the involuntary commitment duties under chapter 70.96A RCW.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-010, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-020 What are the qualifications to be a county chemical dependency program coordinator?** A county chemical dependency program coordinator must have training and experience in:

(1) Chemical dependency prevention, intervention, and treatment strategies used in combating chemical dependency; and

(2) Administration of social and/or human services programs, sufficient to perform the following duties:

(a) Providing general supervision over the county chemical dependency prevention, treatment, and support program;

(b) Preparing plans and applications for funds to support the county chemical dependency prevention, treatment, and support program;

(c) Monitoring the delivery of services to assure conformance with plans and contracts;

(d) Providing staff support to the county alcoholism and other drug addiction board;

(e) Selecting the county designated chemical dependency specialist(s) to perform the intervention, involuntary detention and commitment duties as described under RCW 70.96A.120 and 70.96A.140; and

(f) Advising DSHS, county courts, law enforcement agencies, hospitals, chemical dependency programs, and other local health care and service agencies in the county as to who has been designated as the chemical dependency specialist(s).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-020, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-030 What are the qualifications to be a county-designated chemical dependency specialist?** A county-designated chemical dependency specialist must:

(1) Be certified as a chemical dependency professional (CDP) by the department of health under chapter 18.205 RCW, or meet or exceed the requirements to be eligible to be certified as a CDP as described in chapter 246-811 WAC;

(2) Demonstrate knowledge of the laws regarding the involuntary commitment of chemically dependent adolescents and adults; and

(3) Demonstrate knowledge and skills in differential assessment of mentally ill and chemically dependant clients.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-030, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-040 Who determines the service priorities for the county chemical dependency prevention, treatment, and support program?** (1) DSHS determines the service priorities for services funded by the department.

(2003 Ed.)



(c) Is capable of implementing WAC 388-805-905 through 388-805-930.

(2) The service provider must maintain staffing ratios as follows:

(a) One adult for up to and including four infants through eleven months of age;

(b) One adult for up to and including five children twelve through twenty-nine months of age;

(c) One adult for every ten children thirty months through five years of age; and

(d) One adult for every fifteen children five years of age or older.

(3) When there are children of mixed ages, the service provider must maintain the ratio prescribed for the youngest child in the mixed group.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-935, filed 11/21/00, effective 1/1/01.]

### Chapter 388-810 WAC

#### ADMINISTRATION OF COUNTY CHEMICAL DEPENDENCY PREVENTION, TREATMENT, AND SUPPORT PROGRAM (Formerly chapter 440-25 WAC)

#### WAC

388-810-005	What is the purpose of this chapter?
388-810-010	What definitions apply to this chapter?
388-810-020	What are the qualifications to be a county chemical dependency program coordinator?
388-810-030	What are the qualifications to be a county-designated chemical dependency specialist?
388-810-040	Who determines the service priorities for the county chemical dependency prevention, treatment, and support program?
388-810-050	How are available funds allocated for the county chemical dependency program?
388-810-060	How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program?
388-810-070	How will funds be made available to the county?
388-810-080	May a county subcontract for chemical dependency prevention, treatment, and support services?
388-810-090	How does a county request an exemption?

**WAC 388-810-005 What is the purpose of this chapter?** The purpose of this chapter is to describe the planning, contracting, and provision of chemical dependency prevention, treatment, and support services through counties (see chapter 70.96A RCW).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-005, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-010 What definitions apply to this chapter?**

"County" means each county or two or more counties acting jointly.

"County chemical dependency program coordinator" means a person appointed by the county legislative authority as the chief executive officer responsible for carrying out the duties under chapter 70.96A RCW.

"County chemical dependency prevention, treatment, and support program" means services and activities funded by the department through a negotiated contract between a county and the department.

[Title 388 WAC—p. 1040]

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

"Designated chemical dependency specialist" means a person designated by the county chemical dependency program coordinator to perform the involuntary commitment duties under chapter 70.96A RCW.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-010, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-020 What are the qualifications to be a county chemical dependency program coordinator?** A county chemical dependency program coordinator must have training and experience in:

(1) Chemical dependency prevention, intervention, and treatment strategies used in combating chemical dependency; and

(2) Administration of social and/or human services programs, sufficient to perform the following duties:

(a) Providing general supervision over the county chemical dependency prevention, treatment, and support program;

(b) Preparing plans and applications for funds to support the county chemical dependency prevention, treatment, and support program;

(c) Monitoring the delivery of services to assure conformance with plans and contracts;

(d) Providing staff support to the county alcoholism and other drug addiction board;

(e) Selecting the county designated chemical dependency specialist(s) to perform the intervention, involuntary detention and commitment duties as described under RCW 70.96A.120 and 70.96A.140; and

(f) Advising DSHS, county courts, law enforcement agencies, hospitals, chemical dependency programs, and other local health care and service agencies in the county as to who has been designated as the chemical dependency specialist(s).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-020, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-030 What are the qualifications to be a county-designated chemical dependency specialist?** A county-designated chemical dependency specialist must:

(1) Be certified as a chemical dependency professional (CDP) by the department of health under chapter 18.205 RCW, or meet or exceed the requirements to be eligible to be certified as a CDP as described in chapter 246-811 WAC;

(2) Demonstrate knowledge of the laws regarding the involuntary commitment of chemically dependent adolescents and adults; and

(3) Demonstrate knowledge and skills in differential assessment of mentally ill and chemically dependant clients.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-030, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-040 Who determines the service priorities for the county chemical dependency prevention, treatment, and support program?** (1) DSHS determines the service priorities for services funded by the department.

(2003 Ed.)

(2) DSHS must inform the county of the service priorities during the contract negotiation process.

(3) Counties must follow DSHS's service priorities when delivering chemical dependency program services supported by department funds.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-040, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-050 How are available funds allocated for the county chemical dependency program?** (1) For the purposes of this section, "county" means the legal subdivision of the state, regardless of any agreement between two counties.

(2) The department shall allocate the funds available to the counties through funding formulas jointly developed with representatives of the counties, to carry out the intent of the federal and state legislated appropriations including any budget provisos.

(3) For information on current funding formulas, contact: Chief Financial Officer, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, Washington 98504-5330, Telephone: (360) 438-8088.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-050, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-060 How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program?** A county may not use more than ten percent of the chemical dependency prevention, treatment, and support program funds managed by the county for administering the program.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-060, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-070 How will funds be made available to the county?** (1) DSHS and each county negotiates and executes a county contract before the department reimburses the county for chemical dependency prevention, treatment, and support program services.

(2) DSHS may authorize the county to continue providing services according to a previous county contract and reimburse at the average level of the previous contract, in order to continue services until the department executes a new contract.

(3) DSHS may make advance payments to a county, if the payments facilitate sound program management.

(4) DSHS may require fiscal and program reports.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-070, filed 9/20/99, effective 10/21/99.]

**WAC 388-810-080 May a county subcontract for chemical dependency prevention, treatment, and support services?** A county may subcontract for services specified in the contract.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-080, filed 9/20/99, effective 10/21/99.]

(2003 Ed.)

**WAC 388-810-090 How does a county request an exemption?** (1) A county may request an exemption to these rules by sending a written request to the department.

(2) DSHS may grant an exemption if the department's assessment of the exemption request:

(a) Ensures the exemption does not undermine the legislative intent of chapter 70.96A RCW; and

(b) Shows that granting the exemption does not adversely affect the quality of the services, supervision, health, and safety of department customers.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-090, filed 9/20/99, effective 10/21/99.]

## Chapter 388-818 WAC

### DEAF AND HARD OF HEARING SERVICES

(Formerly chapter 388-43 WAC)

#### WAC

388-818-001	Scope.
388-818-002	Regional centers.
388-818-003	Services.
388-818-005	Definitions.
388-818-010	Eligibility requirements.
388-818-020	Approval of application for initial device or request for replacement device.
388-818-030	Denial of initial application or request for replacement device.
388-818-040	Application renewal process.
388-818-050	Notice of approval or denial.
388-818-060	Review by department.
388-818-070	Distribution.
388-818-080	Training.
388-818-090	Ownership and liability.
388-818-110	Telecommunications relay service.
388-818-130	Uses for returned equipment.

**WAC 388-818-001 Scope.** (1) The office of deaf and hard of hearing services (ODHHS) within the department of social and health services (DSHS):

(a) Provides DSHS information relating to deaf, hard of hearing, and/or deaf-blind;

(b) Provides DSHS technical assistance regarding deafness;

(c) Provides DSHS training and workshops on deafness; and

(d) Assists DSHS in securing sign language interpreters services for DSHS deaf clients.

(2) ODHHS maintains and oversees the telecommunication access services (TDD relay and distribution program), and serves as administrator responsible for the DSHS advisory committee on deafness.

[99-20-022, recodified as § 388-818-001, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-001, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-002 Regional centers.** The office of deaf and hard of hearing services (ODHHS) shall contract with regional centers for the deaf and hard of hearing.

[99-20-022, recodified as § 388-818-002, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-002, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-003 Services.** (1) Within the available funds, contractors shall provide quality human services for a person who is deaf or hard of hearing.

(2) Within available funds, and as specified by contract, the department shall ensure the Washington regional service centers provide:

- (a) Information services relating to deafness services;
- (b) Coordination among private and public agencies, the office of deaf and hard of hearing services (ODHHS), regions, and the deaf community;
- (c) Training and consultative services to public and private agencies;
- (d) Advocacy for a deaf or hard of hearing client;
- (e) Assistance to a deaf or hard of hearing client in applying for and securing programs and services from DSHS;
- (f) Assistance and perform other duties relating to deafness as required by the contract; and
- (g) Share information among local deaf and hard of hearing organizations.

[99-20-022, recodified as § 388-818-003, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-003, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-005 Definitions.** The following definitions shall apply in this chapter, unless the context otherwise requires:

(1) "Amplifier" means an electrical device for use with a telephone which amplifies the sounds being received during a telephone call or a telephone with built-in amplification.

(2) "Applicant" means a person who applies for a teletypewriter (hereinafter TTY), amplifier, telebraille, large visual display, or signal device.

(3) "Audiologist" means a person who has a masters or doctoral degree in audiology and a certificate of clinical competence in audiology from the American Speech, Hearing, and Language Association.

(4) "Deaf" means a condition of severe or complete absence of auditory sensitivity where the primary effective receptive communication mode is visual or tactile, or both.

(5) "Deaf-blind" means a hearing loss and a visual impairment that require use of a TTY to communicate effectively on the telephone, and may require a specific telecommunications device for a person with limited sight, as certified under WAC 388-43-010.

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

(7) "Distribution center" means a facility under contract to DSHS services including but not limited to:

- (a) Providing literature about TAS programs;
- (b) Providing space for qualified trainers to instruct recipients in the use of telecommunications equipment;
- (c) Point of contact for persons to communicate with ODHHS or TAS.

(8) "Federal poverty level guidelines" means the poverty level established by P.L. 97-35 § 52 (codified at 42 USC § 9747), § 673(2) (codified at 42 USC § 99202(2)) as amended; and the Poverty Income Guideline updated annually in the Federal Register.

(9) "Hard of hearing" means a condition of some absence of auditory sensitivity with residual hearing which may be

sufficient to process linguistic information through audition with or without amplification under favorable listening conditions, or a condition of other auditory handicapping conditions.

(10) "Hearing disabled" means a hearing loss that requires use of either a TTY, telebraille, large visual display or an amplifier to communicate effectively on the telephone, and may require the use of a signal device to indicate when the telephone is ringing, as certified under WAC 388-43-010.

(11) "ODHHS" means the office of deaf and hard of hearing services, department of social and health services.

(12) "Official application date" means the date the department received the completed telecommunications equipment application form.

(13) "Qualified trainer" means a person knowledgeable about the appropriate use of TTYs, amplifiers, telebrailles, and/or signal devices, capable of instructing recipients with differing hearing and vision disabilities.

(14) "Recipient" means a person who or organization which has received a state-issued TTY, amplifier, telebraille, large visual display, or signal device.

(15) "School age" means a child five years to seventeen years of age.

(16) "Signal device" means an electronic device that alerts a hearing impaired or deaf-blind recipient of an incoming telephone call.

(17) "Speech disabled" means a speech disability that requires the use of a TTY to communicate effectively on the telephone.

(18) "TAS" means the telecommunications access service, governed by the office of deaf and hard of hearing services, department of social and health services.

(19) "Telebraille" means an electrical device for use with a telephone and TTY that utilizes a braille display to receive messages.

(20) "Telecommunications equipment/device" means amplifier, TTY, telebraille, large visual display, and signaling devices.

(21) "Telecommunications relay center" means a facility authorized by DSHS to provide telecommunications relay services.

(22) "Telecommunications relay service (TRS)" means a telephone service through facilities equipped with specialized equipment and staffed by communications assistants who relay conversations between people who use TTYs and people who use the general telephone network.

(23) "Teletypewriter (TTY)" means an electrical device for use with a telephone that utilizes a keyboard, acoustic coupler, and display screen to transmit and receive messages. Also known as "TDD" (telecommunications device for the deaf) or "TT" (text telephone).

[99-20-022, recodified as § 388-818-005, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-005, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-010 Eligibility requirements.** (1) An eligible applicant shall:

- (a) Be hearing or speech disabled or deaf-blind; and
- (b) Be a resident of Washington state; and

(c) Be at least school age as defined under WAC 388-43-005(15); or

(d) Be the parent/guardian applying on behalf of a child four years of age or younger who has been certified in writing, as specified under subsection (2)(a) through (f) of this section; and

(e) Meet total annual family income and family size requirements as set forth under section 020 of this chapter.

(2) An eligible applicant shall be certified in writing as hearing disabled, speech disabled, or deaf-blind by one of the following:

(a) A person licensed to practice medicine in the state of Washington;

(b) An audiologist in Washington as specified under WAC 388-43-005;

(c) A vocational rehabilitation counselor in a local division of vocational rehabilitation office;

(d) A deaf specialist or coordinator at one of the community service centers for the deaf and hard of hearing in the state;

(e) A deaf-blind specialist or coordinator at Helen Keller regional office, Washington deaf-blind service center, or an eye specialist; or

(f) A certified speech pathologist practicing in the state of Washington.

(3) TAS may require additional documentation to determine if the applicant meets the eligibility requirements under sections 010 and 020 of this chapter.

(4) At the time an applicant applies for equipment, the applicant shall provide the department information on family income and family size.

(5) At the time an applicant applies for equipment, the department shall notify the applicant of the legal consequences if the applicant provides false information.

(6) The department shall ensure an eligible organization meets the following criteria:

(a) The organization must provide a copy of the certificate of incorporation as a nonprofit organization and its bylaws, to indicate that the intent of the organization is to represent the hearing or speech disabled or deaf-blind persons statewide;

(b) The organization must have represented hearing or speech disabled or deaf-blind persons statewide in the last three years; and

(c) The organization must have a telephone number which is either listed or available through statewide publicity for the hearing disabled.

[99-20-022, recodified as § 388-818-010, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-010, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-010, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-020 Approval of application for initial device or request for replacement device.** (1) An applicant shall fill out:

(a) An application form; and

(b) A declaration of income statement.

(2) If the department determines an applicant is eligible, TAS shall approve the application except as provided under WAC 388-43-030 (1)(a) or (b).

(3) An eligible applicant's reported total family income and family size described under this subsection shall determine the applicant's level of financial responsibility in obtaining the equipment:

(a) The department shall determine client participation by a sliding scale based on zero percent to two hundred percent of the most recent federal poverty level; and

(b) The department shall ensure the sliding scale is adjusted yearly following the new federal poverty level publication.

(4) A recipient of equipment shall own the equipment, with the exception of a telebraille and tactile signalling device, if the department distributed the equipment before May 15, 1993. When a telecommunications device distributed before May 15, 1993 breaks after warranty has expired, the recipient shall renew the equipment application as an original application as described under this chapter.

(5) The department shall provide an eligible recipient initial or replacement equipment based on the availability of equipment and/or funds.

(6)(a) "DEC" means a deductible employee contribution;

(b) "Dependent" means a relative who depends on the family income for at least half of the relative's support;

(c) "Family size" means a person or a person and the person's spouse, if not legally separated, and the person's dependents;

(d) "S corporation" means a domestic corporation with one class of stock having thirty-five or less shareholders who are United States citizens;

(e) "SEP" means a simplified employee pension.

(7) Income includes, but is not limited to:

(a) Earned income, such as wages and tips;

(b) Unearned income, such as interest, dividends, and pensions;

(c) Family's share of income from S corporations, partnerships, estates, and trusts;

(d) Gains from the sale or exchange (including barter) of real estate, securities, coins, gold, silver, gems, or other property;

(e) Gain from the sale or exchange of the family's main home;

(f) Accumulation distributions from trusts;

(g) Original issue discount, distribution from SEPs and DECs;

(h) Amounts received in place of wages from accident and health plans if the employer paid for the policy;

(i) Bartering income;

(j) Tier 2 and supplemental annuities under the Railroad Retirement Act;

(k) Life insurance proceeds from a policy the family cashed in if the proceeds are more than the premiums paid;

(l) Endowments;

(m) Lump-sum distribution;

(n) Prizes and awards;

(o) Gambling winnings;

(p) Social Security;

(q) Capital gains;

## (r) Child support received.

[99-20-022, recodified as § 388-818-020, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-020, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-020, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-030 Denial of initial application or request for replacement device.** (1) Denial of initial application. TAS shall deny an original application for a TTY, amplifier, telebraille, large visual display, or signal device if an applicant:

(a) Does not meet the eligibility requirements of WAC 388-43-010; or

(b) Has already been issued a similar device from TAS.

(2) Denial of replacement request. TAS shall deny a request for replacement of a TTY, amplifier, telebraille, large visual display, or signal device if the recipient:

(a) Reported a family income of one hundred sixty-five percent and above on the federal poverty level; or

(b) Subjected a previously issued device, either through negligence or intent, to abuse, misuse, unauthorized repair, or other negligent or intentional conduct which resulted in damage to the equipment; or

(c) Failed to file with the police a report of stolen equipment within fifteen working days of discovering the theft; or

(d) Failed to file with the police or the fire department a report of fire having damaged the equipment within fifteen working days of the incident of the fire; or

(e) Lost the equipment; or

(f) Failed to obtain approval from the department before moving or traveling out-of-state with state-loaned equipment.

[99-20-022, recodified as § 388-818-030, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-030, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-040 Application renewal process.** (1)

An applicant may renew application for telecommunications equipment when two years have elapsed since the initial distribution or when the equipment breaks, whichever comes later.

(2) When either two years have elapsed since initial distribution or the equipment breaks, the applicant shall:

(a) Complete a new application including recent information on total annual family income and family size.

(b) Undergo the same procedures as first-time applicants.

[99-20-022, recodified as § 388-818-040, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-040, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-050 Notice of approval or denial.** (1)

Approved applications. When an original application has been approved, TAS shall inform the applicant in writing of:

(a) The official date the department received the applicant's completed application form;

(b) The time line by which a qualified trainer will contact the applicant.

(2) A qualified trainer shall notify the eligible applicant:

(a) That the applicant was approved to receive a TTY, amplifier, telebraille, large visual display, or signal device; and

(b) To arrange for training and distribution.

(3) Denied applications. If the department denies an original application, TAS shall inform the applicant in writing of:

(a) The official date the applicant's completed application form was received by the department;

(b) The reasons for the denial; and

(c) Any applicable procedures for appeal, as well as the circumstances under which the applicant may re-apply.

[99-20-022, recodified as § 388-818-050, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-050, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-060 Review by department.** (1) An applicant or recipient, whose application for an original or replacement device governed under this chapter has been denied, may request the department to review this decision. The applicant or recipient shall:

(a) Submit this request in writing to TAS specifying the basis for the request; and

(b) Ensure TAS receives this request within thirty days of the receipt of the denial notice.

(2) Within thirty days after TAS has received the request for review by ODHHS, the department shall inform the applicant or recipient in writing of the disposition of the request.

(3) If the applicant or recipient disagrees with the decision by the department, the applicant or recipient may appeal as described under chapters 10-08 and 388-08 WAC.

[99-20-022, recodified as § 388-818-060, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-060, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-070 Distribution.** (1) The department shall issue personal service contracts to qualified persons or agencies to act as qualified trainers. The department shall ensure reasonable accessibility to such training for a person with a hearing or speech disability or for a person who is deaf-blind.

(2) A qualified trainer shall have various responsibilities, which include, but are not limited to:

(a) Conducting individual and group training for the applicants in the use of the equipment;

(b) Conducting individual and group training for the applicants in the use of the telecommunications relay service;

(c) Requiring all recipients, legal guardians, or legal custodians to sign:

(i) A conditions of acceptance form for state-owned equipment; or

(ii) A statement of rights and responsibilities for client-owned equipment.

(d) Distributing TTYs, amplifiers, telebrailles, large visual displays, and signal devices to applicants; and

(e) Submitting monthly reports and billing as required by TAS.

(3) In the use of any devices distributed under this chapter, neither the TAS nor the contracted qualified trainers shall provide:

- (a) Replacement batteries for any telecommunications equipment;
- (b) Replacement paper for TTYs;
- (c) Replacement light bulbs for signal devices;
- (d) Payment of the recipient's telephone bill; or
- (e) Any other extraneous cost incurred by the recipient.

[99-20-022, recodified as § 388-818-070, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-070, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-080 Training.** (1) The qualified trainers shall provide training on proper equipment use and care to all recipients, legal guardians, or legal custodians.

(2) The qualified trainers shall be responsible for determining the training needs of the recipients and the time and length of training that would be most appropriate.

(3) The department shall not issue a device until an applicant has demonstrated ability to properly utilize all equipment issued to the applicant. The department may waive this requirement through a written release in which the applicant attests that the applicant has the ability to properly utilize all equipment issued to the applicant.

(4) If the applicant is seventeen years of age or younger, the applicant's legal guardian or legal custodian shall attend the training on appropriate equipment use and care.

[99-20-022, recodified as § 388-818-080, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-080, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-090 Ownership and liability.** (1) The department shall provide TTYs, amplifiers, telebrailles, large visual displays, and signal devices to a person eligible under subsection (1)(a), (b), and (c) of this section at no charge in addition to the basic exchange rate if:

(a) The person is eligible for participation in the Washington telephone assistance program under RCW 80.36.470;

(b) The person's annual family income is equal to or less than one hundred sixty-five percent of the federal poverty level; or

(c) The person is a child five years to seventeen years of age whose parent or guardian has a family income less than or equal to two hundred percent of the federal poverty level.

(2) After determining the person may be eligible to receive the telecommunications equipment at no charge, the department shall:

(a) Loan the equipment as needed by the applicant; and

(b) Ensure the applicant understands that the equipment remains the sole property of the state of Washington.

(3) A recipient, the recipient's legal guardian, or the recipient's legal custodian shall return a state-loaned TTY and/or other device to the TAS or appropriate distribution center when the recipient:

(a) Moves from a permanent Washington residence to a location outside of Washington;

(b) Does not have need of the state-loaned telecommunications device; or

(c) Has been notified by TAS to return the device.

(4) A recipient, the recipient's legal guardian, or the recipient's legal custodian shall be liable for any damage to or loss of any device issued under this chapter.

(2003 Ed.)

(5) TAS may deny a replacement request if a previously issued device:

(a) Was neglected, abused, misused, or abused through unintentional conduct causing damage;

(b) Was not reported as stolen or burned to either police or fire department within fifteen working days; or

(c) Was lost.

(6) TAS shall establish policies for the sale or salvage of any device returned and not appropriate for reassignment.

(7) A person shall not remove a state-owned TTY, amplifier, telebraille, large visual display, or other signal device from the state of Washington for a period longer than ninety days without the written permission of TAS.

(8) TAS may grant permission to remove a state-owned TTY, amplifier, telebraille, large visual display, or signal device from the state for more than ninety days after determining it is in the best interest of the recipient and the department.

(9) A person eligible under subsection (1)(b) of this section with a family income greater than one hundred sixty-five percent and less than or equal to two hundred percent of the federal poverty level shall be assessed a charge for the cost of TTYs, amplifiers, telebrailles, large visual displays, and signal devices based on a sliding scale of charges established under WAC 388-43-020 (2)(a) and (b).

(10) The department shall determine all TTYs, amplifiers, telebrailles, large displays, and signal devices under chapter 304, Laws of 1987, for which the recipient paid all or part of the equipment's cost to be the sole property of the recipient. The department shall determine the level of financial responsibility toward the purchase of the equipment by the federal poverty level guidelines as described under WAC 388-43-020 (2)(a) and (b).

(11) The department shall provide an eligible recipient a two-year warranty on equipment valued at four hundred dollars or more.

(12) Limiting the number of TTYs per household. The department shall consider that the telecommunications equipment needs of all household members have been met when one TTY has been issued to that household, unless exceptional circumstances are defined and approved by the department.

(13) The department shall receive payment before an eligible recipient receives a TTY, amplifier, telebraille, large visual display, or a signal device.

(14) A recipient shall sign and agree to warranty requirements on a TTY, telebraille, or large visual display at the time the recipient purchases this equipment.

(15) A recipient shall not receive a financial refund for the return of a TTY, amplifier, telebraille, large visual display, or signal device unless:

(a) The equipment is returned to the TAS office within thirty days after it was received by the client; and

(b) The equipment is clean, in good condition and in its original packaging.

(16) The department shall charge a person, eligible under subsection (1)(b) of this section whose income exceeds two hundred percent of the federal poverty level, the entire cost to the department of purchasing the equipment provided to that person.



(17) The department may waive part or all of the charges assessed under sections 010 and 020 if the department finds that:

(a) The eligible person requires telebraille equipment or other equipment of similar cost; or

(b) The charges normally assessed for the equipment under this subsection would create an exceptional or undue hardship on the eligible person.

(18) The department may determine certification of family income by the eligible person, the person's guardian, or head of household as sufficient to determine eligibility.

[99-20-022, recodified as § 388-818-090, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-090, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-110 Telecommunications relay service.** The department shall award contracts for the operation and maintenance of the statewide telecommunications relay service.

[99-20-022, recodified as § 388-818-110, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-110, filed 12/30/93, effective 1/30/94.]

**WAC 388-818-130 Uses for returned equipment.** (1) TAS shall issue, as available, the clean and working equipment, which has little or no warranty time left and has been returned to TAS by clients, free of charge to:

(a) Organizations serving hearing/speech disabled, deaf, and/or deaf-blind persons statewide; and

(b) Lending libraries of hospitals and/or hospice facilities.

(2) Organizations receiving used TAS equipment free of charge shall be thereafter responsible for equipment maintenance.

[99-20-022, recodified as § 388-818-130, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-130, filed 1/11/95, effective 2/11/95.]

**Chapter 388-820 WAC**

**COMMUNITY RESIDENTIAL SERVICES AND SUPPORT**

(Formerly chapter 275-26 WAC)

**WAC**

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388-820-560	What is an individual instruction and support plan (IISP) for clients?		
388-820-570	Who may participate in developing the IISP for each client?	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.
388-820-580	Who oversees the IISP for each client?		
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388-820-610	May a service provider combine agency and client funds?		
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388-820-680	When must a service provider pay a client?		
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388-820-740	What training is required before staff are qualified to perform delegated tasks?	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.
388-820-750	Do nursing assistants need to comply with department of health requirements?		
388-820-760	Who is authorized to provide consent for a client's receiving health care?	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.
388-820-770	What rights do nursing assistants have concerning the delegation of nursing care tasks?		
388-820-780	Are nursing assistants liable for errors while doing nursing care tasks?	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.
388-820-790	What happens if unqualified staff do a nursing task?		
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388-820-810	What happens when DSHS finds a service provider in violation of nurse delegation requirements?		
388-820-820	May a service provider have a chance to correct violations before being fined?	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.
388-820-830	May civil fines be imposed during technical assistance visits?		
388-820-840	How does DSHS impose a civil fine?		
388-820-850	When is payment due for a civil fine?		
388-820-860	May a service provider disagree with DSHS findings of a violation?	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.
388-820-870	May a service provider contest a civil fine?		
<b>DISPUTE RIGHTS</b>			
388-820-880	May an agency or service provider contest a DSHS decision?		
388-820-890	When does an administrative review conference occur?		
388-820-900	May an administrative review conference be conducted by telephone?	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.
388-820-910	What happens during the administrative review conference?		
388-820-920	May an agency or service provider contest the decision from the administrative review conference?	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.
<b>REQUESTS FOR EXCEPTIONS</b>			
388-820-930	Does DSHS make exceptions to the requirements in this chapter?		

**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,

**PURPOSE**

**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.]

## DEFINITIONS

**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.]

## RESIDENTIAL SERVICES: GENERAL REQUIREMENTS

### 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 388-820-040 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 388-820-050 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 388-820-060 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 388-820-070 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 388-820-080 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 388-820-090 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 388-820-100 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 388-820-110 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 388-820-120 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 388-820-130 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.]

## CERTIFICATION

**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.

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(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.

[Title 388 WAC—p. 1051]



[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 documentation supporting their position within fourteen calendar days after:

(a) The exit conference; or

[Title 388 WAC—p. 1052]

(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.]

#### ADMINISTRATIVE REQUIREMENTS: GENERAL

**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:

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- (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.

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(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;

[Title 388 WAC—p. 1053]

(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.]

[Title 388 WAC—p. 1054]

**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.]

### **ADMINISTRATIVE REQUIREMENTS: CLIENT RECORDS**

**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.

(2003 Ed.)

(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.]

(2003 Ed.)

**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.]

## EMERGENCIES

**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.]

## ABUSE AND NEGLECT REPORTING

**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.

[Title 388 WAC—p. 1055]

(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.]

### CLIENT SERVICES

**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

[Title 388 WAC—p. 1056]

(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

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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.]

### CLIENT SERVICE PLANS

**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.]

### CLIENT FUNDS

**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;

[Title 388 WAC—p. 1058]

(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;

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- (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.

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- (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.]

## CLIENT HEALTH SERVICES

**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

[Title 388 WAC—p. 1059]

(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.]

### CLIENT TRANSPORTATION

**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.]

### NURSE DELEGATION

**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.

[Title 388 WAC—p. 1060]

(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 registered 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.

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[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

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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.

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(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.]

### DISPUTE RIGHTS

**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.

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(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.]

### REQUESTS FOR EXCEPTIONS

**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

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**WAC 388-825-020 Definitions. "Abandonment"** means action or inaction by a person or entity with a duty to care for a vulnerable adult that leaves the vulnerable person

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without the means or ability to obtain necessary food, clothing, shelter, or health care.

**"Adolescent"** means a DDD eligible child age thirteen through seventeen years.

**"Attendant care"** means provision of physical and/or behavioral support to protect the safety and well being of a client.

**"Best interest"** includes, but is not limited to, client-centered benefits to:

- (1) Prevent regression or loss of skills already acquired;
- (2) Achieve or maintain economic self-support;
- (3) Achieve or maintain self-sufficiency;
- (4) Prevent or remedy neglect, abuse, or exploitation of individuals unable to protect their own interest;
- (5) Preserve or reunite families; and
- (6) Provide the least-restrictive setting that will meet the person's medical and personal needs.

**"Client or person"** means a person the division determines under RCW 71A.16.040 and WAC 388-825-030 eligible for division-funded services.

**"Community support services"** means one or more of the services listed in RCW 71A.12.040 including, but not limited to the following services: Architectural, case management, early childhood intervention, employment, counseling, family support, respite care, information and referral, health services and equipment, therapy services, and residential support.

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

**"Director"** means the director of the division of developmental disabilities.

**"Division or DDD"** means the division of developmental disabilities of the department of social and health services.

**"Emergency"** means a sudden, unexpected occurrence demanding immediate action.

**"Exemption"** means the department's approval of a written request for an exception to a rule in this chapter.

**"Family"** means individuals, of any age, living together in the same household and related by blood, marriage, adoption or as a result of sharing legal custody of a minor child.

**"Family resources coordinator"** means the person who is:

- (1) Recognized by the IDEA Part C lead agency; and
- (2) Responsible for:
  - (a) Providing family resources coordination;
  - (b) Coordinating services across agencies; and
  - (c) Serving as a single contact to help families receiving assistance and services for their eligible children who are under three years of age.

**"ICF/MR"** means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide services to the mentally retarded or persons with related conditions.

**"ICF/MR Eligible"** for admission to an ICF/MR means a person is determined by DDD as needing active treatment as defined in CFR 483.440. Active treatment requires:

- (1) Twenty-four hour supervision; and
- (2) Continuous training and physical assistance in order to function on a daily basis due to deficits in the following



areas: Toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication.

**"Individual"** means a person applying for services from the division.

**"Individual alternative living"** means provision of community-based individualized client training, assistance and/or ongoing support to enable a client to live as independently as possible with minimal services.

**"Individual supportive living service"** (also known as companion home) means provision of twenty-four hour residential support in a nonlicensed home for one adult person with developmental disabilities.

**"Intelligence quotient score"** means a full scale score on the Wechsler, or the intelligence quotient score on the Stanford-Binet or the Leiter International Performance Scale.

**"Medicaid personal care"** is the provision of medically necessary personal care tasks as defined in chapter 388-15 WAC.

**"Nonresidential programs"** means programs including, but not limited to, county-funded habilitation services.

**"Nursing facility eligible"** means a person is assessed by DDD as meeting the requirements for admission to a licensed nursing home as defined in WAC 388-71-0700 (3) through (5). The person must require twenty-four hour care provided by or under the supervision of a licensed nurse.

**"Other resources"** means resources that may be available to the client, including but not limited to:

- (1) Private insurance;
- (2) Medicaid;
- (3) Indian health care;
- (4) Public school services through the office of the superintendent of public instruction; and
- (5) Services through the department of health.

**"Part C"** means early intervention for children from birth through thirty-five months of age as defined in the Individuals with Disabilities Education Act (IDEA), Part C and 34 CFR, Part 303 and Washington's federally approved grant.

**"Residential habilitation center"** or **"RHC"** means a state-operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities.

**"RHC capacity"** means the maximum number of eligible persons that can reside in a residential habilitation center without exceeding its 1997 legislated budgeted capacity.

**"Residential programs"** means provision of support for persons in community living situations. Residential programs include DDD certified community residential services and support, both facility-based such as, licensed group homes, and non-facility based, i.e., supportive living, intensive tenant support, and state-operated living alternatives (SOLA). Other residential programs include individual alternative living, intensive individual supportive living services, adult family homes, adult residential care services, nursing homes, and children's foster homes.

**"Respite care"** means temporary residential services provided to a person and/or the person's family on an emergency or planned basis.

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

**"Vacancy"** means an opening at a RHC, which when filled, would not require the RHC to exceed its 1997 biannually budgeted capacity, minus:

- (1) Twenty-six beds designated for respite care use; and
- (2) Any downsizing related to negotiations with the Department of Justice regarding community placements.

**"Vulnerable adult"** means a person who has a developmental disability as defined under RCW 71A.10.020.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-020, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, amended and recodified as § 388-825-020, filed 11/9/99, effective 12/10/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-020, filed 2/1/99, effective 3/4/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-020, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-27-020, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-020, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-020, filed 2/28/89; 84-15-058 (Order 1214), § 275-27-020, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-020, filed 3/16/78; Order 1143, § 275-27-020, filed 8/11/76.]

**WAC 388-825-025 Exemptions.** (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 388-825-020 provided an:

(a) Assessment of the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

(3) Exemption requests are not subject to appeal.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-025, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-023, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-023, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-023, filed 8/9/91, effective 9/9/91.]

**WAC 388-825-030 Eligibility for services.** (1) A developmental disability is a condition which meets all of the following:

(a) A condition defined as mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition as described under WAC 388-825-030;

(b) Originates before the individual reaches eighteen years of age;

(c) Is expected to continue indefinitely; and

(d) Results in a substantial handicap.

(2) Mental retardation is a condition resulting in significantly subaverage general intellectual functioning as evidenced by:

(a) A diagnosis of mental retardation documented by a licensed psychologist or certified school psychologist; and

(b) A substantial handicap when the individual has an intelligence quotient score of more than two standard devia-

tions below the mean using the Stanford-Binet, Wechsler, or Leiter International Performance Scale; and

- (c) An intelligence quotient score which is not:
  - (i) Expected to improve with treatment, instruction, or skill acquisition above the established level; or
  - (ii) Attributable to mental illness or other psychiatric condition; and

(d) Meeting the requirements of developmental disability under subsection (1)(b) and (c) of this section.

(3) Cerebral palsy is a condition evidenced by:

(a) A diagnosis of cerebral palsy by a licensed physician; and

(b) A substantial handicap when, after forty-eight months of age:

(i) An individual needs direct physical assistance in two or more of the following activities:

- (A) Eating;
- (B) Dressing;
- (C) Bathing;
- (D) Toileting; or
- (E) Mobility; or

(ii) An individual meets the requirements under subsection (6)(b) of this section; and

(c) Meeting the requirements under subsection (1)(b) and (c) of this section.

(4) Epilepsy is a condition evidenced by:

(a) A diagnosis of epilepsy by a board-eligible neurologist, including documentation the condition is chronic; and

(b) The presence of partially controlled or uncontrolled seizures; and

(c) A substantial handicap when the individual:

(i)(A) Requires the presence of another individual to monitor the individual's medication, and is certified by a physician to be at risk of serious brain damage/trauma without direct physical assistance from another individual; or

(B) In the case of individuals eighteen years of age or older only, requires the presence of another individual to monitor the individual's medication, and is unable to monitor the individual's own medication resulting in risk of medication toxicity or serious dosage side effects threatening the individual's life; or

(ii) Meets the requirements under subsection (6)(b) of this section; and

(d) Meeting the requirements under subsection (1)(b) and (c) of this section.

(5) Autism is a condition evidenced by:

(a) A specific diagnosis, by a board-eligible psychiatrist or licensed clinical psychologist, of autistic disorder, a particular diagnostic subgroup of the general diagnostic category pervasive developmental disorders; and

(b) A substantial handicap shown by:

(i) The presence of significant deficits of social and communication skills and marked restriction of activities of daily living, as determined by one or more of the following persons with at least one year's experience working with autistic individuals:

- (A) Licensed psychologists;
- (B) Psychiatrists;
- (C) Social workers;
- (D) Certified communication disorder specialists;

(E) Registered occupational therapists;

(F) Case managers;

(G) Certificated educators; and

(H) Others; or

(ii) Meeting the requirements under subsection (6)(b) of this section; and

(c) Meeting the requirements under subsection (1)(b) and (c) of this section.

(6) Another neurological or other condition closely related to mental retardation, or requiring treatment similar to that required for individuals with mental retardation is a condition evidenced by:

(a)(i) Impairment of the central nervous system as diagnosed by a licensed physician; and

(ii) A substantial handicap when, after forty-eight months of age, an individual needs direct physical assistance with two or more of the following activities:

- (A) Eating;
- (B) Dressing;
- (C) Bathing;
- (D) Toileting; or
- (E) Mobility; and

(iii) An intelligence quotient score of at least one and one-half standard deviations below the mean, using the Wechsler Intelligence Scale, the Stanford-Binet, or the Leiter International Performance Scale; and

(iv) Meeting the requirements under subsection (1)(b) and (c) of this section; or

(b) A condition evidenced by:

(i) An intelligence quotient score at least one and one-half standard deviations below the mean, using the Wechsler Intelligence Scale, the Stanford-Binet, or the Leiter International Performance Scale; or

(ii) If the individual's intelligence score is higher than one and one-half standard deviations below the mean, then current or previous eligibility for participation in special education, under WAC 392-172-114 through 392-172-150, shall be demonstrated. Such participation shall not currently or at eighteen years of age be solely due to one or more of the following:

- (A) Psychiatric impairment;
- (B) Serious emotional/behavioral disturbance; or
- (C) Orthopedic impairment; and

(iii) A substantial handicap when a standard score of more than two standard deviations below the mean in each of four domains of the adaptive behavior section of the Inventory for Client and Agency Planning (ICAP) is obtained, the domains identified as:

- (A) Motor skills;
- (B) Social and communication skills;
- (C) Personal living skills;
- (D) Community living skills; and

(iv) The ICAP is administered at least every twenty-four months; and

(v) Is not attributable to mental illness, personality and behavioral disorders, or other psychiatric conditions; and

(vi) Meets the requirements under subsection (1)(b) and (c) of this section; or

(c) A child under six years of age at risk of developmental disability, as measured by developmental assessment tools

and administered by qualified professionals, showing a substantial handicap as evidenced by one of the following:

(i) A delay of at least twenty-five percent of the chronological age in one or more developmental areas between birth and twenty-four months of age; or

(ii) A delay of at least twenty-five percent of the chronological age in two or more developmental areas between twenty-five and forty-eight months of age; or

(iii) A delay of at least twenty-five percent of the chronological age in three or more developmental areas between forty-nine and seventy-two months of age; and

(iv) Such eligibility shall be subject to review at any time, but at least at thirty-six months of age and at least seventy-two months of age;

(v) Developmental areas as described in subsection (6)(c) of this section are:

(A) Fine or gross motor skills;

(B) Self-help skills;

(C) Expressive and receptive communication skills, including American sign language skills;

(D) Social skills; and

(E) Cognitive, academic, or problem-solving skills.

(vi) Qualified professionals, as described in subsection (6)(c) of this section, include, but are not limited to, the following professionals with at least one year's experience and training in the field of child development and preferably in the area of developmental disabilities:

(A) Licensed physicians;

(B) Licensed psychologists;

(C) Certified communication disorder specialists;

(D) Registered occupational therapists;

(E) Licensed physical therapists;

(F) Case managers;

(G) Registered public health nurses; and

(H) Educators.

(vii) Any standardized developmental assessment tool may be used if the tool:

(I) Is reasonably reliable and valid by professional standards; and

(II) Demonstrates the information required to make a determination of the developmental delay; or

(d) A child under six years of age having a diagnosis of Down Syndrome.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-030, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.10.020. 92-04-004 (Order 3319), § 275-27-026, filed 1/23/92, effective 2/23/92. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-026, filed 2/28/89.]

#### **WAC 388-825-035 Determination of eligibility. (1)**

The department shall determine an individual eligible for services upon application if the individual meets developmental disability criteria as defined under WAC 388-825-030.

(2) The department may require appropriate documents substantiating the presence of a developmental disability.

(3) When the department uses or requires the Wechsler Intelligence Test for the purposes of this chapter, the department may consider any standardized Wechsler Intelligence

Test as a valid measure of intelligence, assuming a full scale score can be obtained.

(4) If, in the opinion of the testing psychologist, an individual is not able to complete all of the subtests necessary to achieve a full scale score on the Wechsler, the department shall make a professional judgment about the person's intellectual functioning, based upon the information available.

(5) When an applicant has a significant hearing impairment, the department may use or require the Leiter International Performance Scale to determine the individual's intelligence quotient for the purposes of WAC 388-825-030.

(6) When an applicant has a significant vision impairment, the department may use or require the Wechsler verbal intelligence quotient score as the intelligence quotient score for the purposes of WAC 388-825-030.

(7) When an Inventory for Client and Agency Planning (ICAP) is required by the department to demonstrate a substantial handicap, the department shall provide or arrange for the administration of the ICAP.

(8) The department shall determine an applicant's eligibility for services within ten working days of receipt of the completed application and supporting documents.

(9) Any documentation the department requires shall be subject to departmental review. The department may also review client eligibility at any time.

(10) The secretary or designee may authorize eligibility under subsection (1) of this section under the following conditions:

(a) To register a child under eighteen years of age who is eligible for medically intensive home care services, under the department's Title XIX Model 50 waiver program; or

(b) To eliminate the department's requirement for documentation of disability prior to eighteen years of age when:

(i) The applicant is otherwise eligible under WAC 388-825-030; and

(ii) The department and applicant are unable to obtain any documentation of disability originating prior to eighteen years of age; and

(iii) The department has determined the applicant's condition occurred prior to eighteen years of age.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-035, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-030, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-030, filed 7/18/84; Order 1143, § 275-27-030, filed 8/11/76.]

#### **WAC 388-825-040 Application for services. (1)**

Individuals applying for division services shall file an application with one of the division field services offices in the form and manner required by the director.

(2) An individual, advocate, parent, or guardian of such an individual may file an application for services.

(3) DDD shall inform all applicants about the complete spectrum of service options provided by the division, including the existence and availability of residential habilitation centers and community support services.

[99-19-104, recodified as § 388-825-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-040, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-040, filed 7/18/84. Statutory

Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-040, filed 3/16/78; Order 1143, § 275-27-040, filed 8/11/76.]

**WAC 388-825-045 Determination for necessary services.** (1) Within sixty days from the date of the division's decision that a person is eligible for division funded services, the appropriate division field services office shall evaluate the person's needs to determine which services, if any, are necessary to serve the client's best interest. DDD shall explain to the person/family their available service options. In addition, DDD shall do what is reasonable to:

(a) Provide choice of service options within available funding that assists people to remain in their homes and communities;

(b) Plan and develop community support services that take into consideration the unique needs of the individual and family.

(2) After the evaluation is completed, and if appropriate, the division will develop an individual service plan pursuant to WAC 388-825-050.

(3) Determination of necessary services is not a guarantee of service authorization or delivery. Service authorization and delivery of services are pursuant to WAC 388-825-055.

(4) The department will develop an outreach program to ensure that eligible persons are aware of all of the services provided by DDD, including community support services and residential habilitation centers.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-045, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-050, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-050, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-050, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-050, filed 3/16/78; Order 1143, § 275-27-050, filed 8/11/76.]

**WAC 388-825-050 Individual service plan.** (1) The division may develop a written individual service plan (ISP) or other planning documents for each person determined eligible for division and department services within ninety days of the eligibility date. Interim services may be provided if necessary.

(2) An ISP shall be based on an assessment of a person's needs and will specify the services adjudged to be in the best interests of the person and meet the person's habilitation needs. The ISP shall be in the form and manner specified by the director.

(3) A person, the parent if a person is seventeen years of age or younger, or the person's guardian, or an advocate, or the service provider may request review or modification of the service plan at any time based on changed circumstances.

(4) The department's implementation of specific provisions of the plan shall require the development, review, and may require significant modifications of the ISP and shall include, to the maximum extent possible:

- (a) Appropriate division staff;
- (b) The person;
- (c) The person's parent or guardian;
- (d) Advocate; and

(e) Representatives of the agency or facility which is, or will be, primarily responsible for the implementation of specific provisions of the plan.

(5) An ISP shall be a planning document, and shall not be an authorization for services. An ISP shall not guarantee the authorization or delivery of services. The authorization of such services is described under WAC 388-825-055.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-050, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-060, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-060, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-060, filed 3/16/78; Order 1143, § 275-27-060, filed 8/11/76.]

**WAC 388-825-055 Authorization of services.** (1) The division's field services section shall be responsible for authorizing services agreed to by the person/family including, but not limited to:

(a) Placement to and from residential habilitation centers;

(b) Community residential services;

(c) Family support services; and

(d) Nonresidential programs.

(2) The division's authorization of services shall be based on the availability of services and funding.

(3) The division will include the following persons when determining authorized services:

(a) The person;

(b) The person's parent or guardian and may include:

(i) The person's advocate; or

(ii) Other responsible parties.

(4) Per RCW 71A.16.010 the division shall offer adults the choice of admittance to a residential habilitation center if all of the following conditions exist:

(a) An RHC vacancy is available;

(b) Funding, specifically designated for this purpose in the state operating budget, is available for alternative community support services;

(c) The person or their family is requesting residential services;

(d) The person meets ICF/MR or nursing facility eligibility for the available RHC vacancy;

(e) The person is the most in need of residential services as determined by DDD after reviewing all persons determined eligible for ICF/MR or nursing facility level of care. DDD will make this selection based on the following criteria:

(i) The person is age eighteen or older;

(ii) The person's/family's health and safety is in jeopardy due to the lack of necessary residential support and supervision:

(A) Priority is given to eligible persons/families currently without necessary residential supports;

(B) Other eligible persons will be considered based on their risk of losing residential supports due to unstable or deteriorating circumstances.

(f) The person's alternative DDD funded community support services would cost seventy percent or more of the

average RHC rate, assuming a minimum household size of three persons.

(5) If RHC capacity is not being used for permanent residents, the division will make these vacancies available for respite care or any other services the department determines are needed and allowable within the rules governing the use of federal funds.

(a) Admission of a child or adolescent to an RHC for respite care requires the written approval of the division director or designee.

(b) Respite care exceeding thirty days in a calendar year is subject to subsection (6) of this section.

(6) The division shall not make an emergency or temporary admission of a person to a residential habilitation center for thirty-one days or more without the written approval of the division director or the director's designee if the admission is not a choice provided under subsection (4) of this section.

(a) Children twelve years of age and younger shall not be admitted to an RHC.

(b) Admission of an adolescent to an RHC can only occur if:

(i) DDD determines that foster placement services cannot meet the emergency needs of the child/family; and

(ii) A voluntary placement plan is in place with DDD with the goal of community placement or family reunification; and

(iii) Progress towards placement planning is reported to the division director at least every ninety days.

(7) The division shall authorize county-funded services only when the:

(a) Service is included in a department contract; and

(b) Person is at least twenty-one years of age and graduated from school during their twenty-first year; or

(c) Person is twenty-two years of age or older; or

(d) Person is two years of age or younger and eligible for early intervention services.

(8) The department shall require a person to participate in defraying the cost of services provided when mandated by state or federal regulation or statute.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-055, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-230, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-230, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-230, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-230, filed 7/18/84. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-27-230, filed 3/1/82. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-230, filed 3/16/78; Order 1143, § 275-27-230, filed 8/11/76.]

**WAC 388-825-065 Financial services.** The division's field services may include services to protect the financial interests of developmentally disabled individuals.

[99-19-104, recodified as § 388-825-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-240, filed 7/18/84; Order 1143, § 275-27-240, filed 8/11/76.]

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**WAC 388-825-080 Guardianship services.** If it appears an eligible individual requires a guardian, the division's field services may assure initiation of and/or assist in guardianship proceedings.

[99-19-104, recodified as § 388-825-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-250, filed 7/18/84; Order 1143, § 275-27-250, filed 8/11/76.]

**WAC 388-825-100 Notification.** (1) The department shall notify the client or applicant, the parent when the client or applicant is a minor, and the guardian when the client or applicant is an adult, of the following decisions:

(a) Denial or termination of eligibility set forth in WAC 388-825-100;

(b) Development or modification of the individual service plan set forth in WAC 388-825-050;

(c) Authorization, denial, reduction, or termination of services set forth in WAC 388-825-100; and

(d) Admission or readmission to, or discharge from, a residential habilitation center.

(2) The notice shall set forth appeal rights pursuant to WAC 388-825-120 and a statement that the client's case manager can be contacted for an explanation of the reasons for the action.

(3)(a) The department shall provide notice of a denial or partial authorization of a family support services request and a statement of reason for denial or partial authorization, or reduction to the person or persons described in subsection (1) of this section. The department shall send such notice no later than five working days before the end of the month previous to the month for which service was requested;

(b) The department shall make available an administrative review of a decision to deny or partially authorize services upon receipt of a written request by a person or persons described in subsection (1) of this section to the administrator of the region in which the client is living. The regional office must receive a request for administrative review by the last working day of the month;

(c) The client shall state in the written request why the client or client's family believes their service priority designation is not correct;

(d) Upon receipt of request for administrative review, the regional administrator or designee shall review the request and the client file; and

(e) The department shall send the results of the administrative review to the client and/or family within the first five working days of the service month for which the client is being denied or receiving a partial authorization for services.

(4) The department shall provide at least thirty days' advance notice of action to terminate a client's eligibility, terminate or reduce a client's service, or discharge a client from a residential habilitation center to the community. Transfer or removal of a client from a service set forth in WAC 388-825-120 (5)(f) is governed by that section, and reduction of family support funding during the service authorization period is covered by subsection (3)(a) of this section.

(5) All parties affected by such department decision shall be consulted, whenever possible, during the decision process by the responsible field services regional office in person and/or by telephone.

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(6) The division shall ensure notification to the school district in which a school-aged child is to be placed when a placement decision is reached.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-100, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-400, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-400, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-400, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-400, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-400, filed 3/16/78; Order 1143, § 275-27-400, filed 8/11/76.]

**WAC 388-825-120 Adjudicative proceeding.** (1) A client, former client, or applicant acting on the applicant's own behalf or through an authorized representative has the right to an adjudicative proceeding to contest the following department actions:

- (a) Denial or termination of eligibility set forth in WAC 388-825-100;
- (b) Development or modification of the individual service plan set forth in WAC 388-825-050;
- (c) Authorization, denial, reduction, or termination of services set forth in WAC 388-825-100;
- (d) Admission or readmission to, or discharge from, a residential habilitation center;
- (e) A claim the client, former client, or applicant owes an overpayment debt;
- (f) A decision of the secretary under RCW 71A.10.060 or 71A.10.070;
- (g) A decision to change a client's placement from one category of residential services to a different category of residential services.

(2) Adjudicative proceedings are governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 71A.10.050, the rules in this chapter, and by chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter shall govern.

(3) The applicant's application for an adjudicative proceeding shall be in writing and filed with the DSHS office of appeals within twenty-eight days of receipt of the decision the appellant wishes to contest.

(4) The department shall not implement the following actions while an adjudicative proceeding is pending:

- (a) Termination of eligibility;
- (b) Reduction or termination of service, except when the action to reduce or terminate the service is based on the availability of funding and/or service; or
- (c) Removal or transfer of a client from a service, except when a condition in subsection (5)(f) of this section is present.

(5) The department shall implement the following actions while an adjudicative proceeding is pending:

- (a) Denial of eligibility;
- (b) Development or modification of an individual service plan;
- (c) Denial of service;
- (d) Reduction or termination of service when the action to reduce or terminate the service is based on the availability of funding or service;

(2003 Ed.)

(e) After notification of an administrative law judge's (or review judge) ruling that the appellant has caused an unreasonable delay in the proceedings; or

(f) Removal or transfer of a client from a service when:

- (i) An immediate threat to the client's life or health is present;
- (ii) The client's service provider is no longer able to provide services due to:
  - (A) Termination of the provider's contract;
  - (B) Decertification of the provider;
  - (C) Nonrenewal of provider's contract;
  - (D) Revocation of provider's license; or
  - (E) Emergency license suspension.
- (iii) The client, the parent when the client is a minor, or the guardian when the client is an adult, approves the decision.

(6) When the appellant files an application to contest a decision to return a resident of a state residential school to the community, the procedures specified in RCW 71A.10.050(2) shall govern the proceeding. These procedures include:

- (a) A placement decision shall not be implemented during any period during which an appeal can be taken or while an appeal is pending and undecided unless the:
  - (i) Client's or the client's representative gives written consent; or
  - (ii) Administrative law judge (or review judge) after notice to the parties rules the appellant has caused an unreasonable delay in the proceedings.
- (b) The burden of proof is on the department; and
- (c) The burden of proof is whether the specific placement proposed by the department is in the best interests of the resident.

(7) The initial order shall be made within sixty days of the department's receipt of the application for an adjudicative proceeding. When a party files a petition for administrative review, the review order shall be made within sixty days of the department's receipt of the petition. The decision-rendering time is extended by as many days as the proceeding is continued on motion by, or with the assent of, the appellant.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-120, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-500, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-27-500, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-500, filed 8/29/86. Statutory Authority: RCW 72.33.161. 84-15-038 (Order 2122), § 275-27-500, filed 7/13/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-500, filed 3/16/78; Order 1143, § 275-27-500, filed 8/11/76.]

**WAC 388-825-170 Community alternatives program (CAP).** Purpose—Legal basis.

(1) The purpose of this program is to authorize certain home and community-based services for persons with developmental disabilities to provide an alternative to care in an institution for the mentally retarded (IMR).

(2) Community alternatives program (CAP) is a Medicaid program authorized by P.L. 97-35 Section 2176 as approved by the secretary of the U.S. Department of Health and Human Services.

[Title 388 WAC—p. 1069]



[99-19-104, recodified as § 388-825-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-800, filed 3/14/84.]

**WAC 388-825-180 Eligible persons.** (1) To be eligible to apply for community alternatives program (CAP) services, the individual must:

(a) Meet the criteria for the division of developmental disabilities (DDD) eligibility.

(b) Meet the criteria for disability as established in the Social Security Act.

(c) Have an income of less than three hundred percent of the federal Supplemental Security Income (SSI) benefit amount.

(d) Need an IMR level of care as determined by a DDD nursing care consultant.

(i) Require twenty-four hour care and require services that cannot be provided by a family member, and

(ii) Have a documented need for habilitation services and training.

(2) Participation in CAP is by choice of the otherwise IMR-eligible person.

[99-19-104, recodified as § 388-825-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-810, filed 3/14/84.]

**WAC 388-825-190 Community alternatives program (CAP)—Services.** (1) The department may authorize the following services under 42 CFR Part 435 as specified in the ISP:

(a) Case management services, including intake, eligibility determination, assessment of need, service coordination, service authorization, placement and case monitoring;

(b) Habilitation services, including instruction, support, and supervision in developing a person's physical skills, personal care, social and community integration skills;

(c) Family support for an eligible person needing support and supervision which the person's family cannot provide; and

(d) Other community-based services.

(2) The department cost of a person's services under CAP shall not exceed one hundred percent of the cost of care in an ICF/MR.

(3) The division shall review CAP eligibility under 42 CFR Part 435 on forms specified by the division director.

[99-19-104, recodified as § 388-825-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-820, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-820, filed 3/14/84.]

**WAC 388-825-200 What is the purpose of the family support opportunity program?** The purpose of the family support opportunity program is to:

(1) Strengthen family functioning through use of the program elements;

(2) Provide a wide range of supports that will assist and stabilize families;

(3) Encourage individuals and local communities to provide support for the persons with developmental disabilities that live with families;

[Title 388 WAC—p. 1070]

(4) Complement other public and private resources in providing supports;

(5) Recognize the ability of communities to participate in a variety of ways;

(6) Allow families to make use of all program elements according to the individual and family needs; and

(7) Provide assistance to as many families as possible.

[99-19-104, recodified as § 388-825-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-180, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-205 Who is eligible to participate in the family support opportunity program?** (1) All individuals living with their families determined to be developmentally disabled according to WAC 388-825-035 are eligible to participate in the program if their family requires assistance in meeting their needs. However, the program will fund or provide support services only as funding is available.

(2) Persons currently receiving services under WAC 388-825-030, Family support services, may volunteer to participate in the program.

(3) Families will receive program services based on the date of application.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-205, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-185, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-210 What basic services can my family receive from the family support opportunity program?** A number of basic services are available. Some services have their own eligibility requirements. Specific services are:

(1) **Case management services:** Your family will benefit from case management services. The family and the case manager will develop a family support plan which includes needs assessment, referral, service coordination, service authorization, case monitoring and coordination for community guide services.

(2) **Community guide services:** Once your case manager assesses your family situation, you will be offered access to the services of a community guide. The community guide will assist your family in using the natural and informal community supports relevant to the age of your family member with developmental disabilities and the specific needs of your family. Community guide services will support your family and help develop connections to your community.

(3) **Short-term intervention services:** Your family may be eligible for up to eleven hundred dollars in short-term intervention funding if necessary services are not otherwise available. This funding is not intended to cover basic subsistence such as food or shelter costs. Short-term intervention funding is available only for those specialized costs directly related to and resulting from your child's disability.

(4) **Personal care services:** Medicaid personal care can provide your family with long-term in-home personal assistance. (See WAC 388-15-202 and 388-15-203.) In home personal assistance may be available through Medicaid personal care or through a state-funded alternative.

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(5) **Community alternatives program (CAP) waiver:** If eligible, your family may participate in the CAP waiver program. The CAP waiver gives eligible clients the opportunity to participate in the federal Medicaid program and DDD the opportunity to obtain federal funds for community based services. (See WAC 388-825-170, 388-825-180 and 388-825-190.)

(6) **Early intervention services:** These services are for your children (from birth through thirty-five months old) and include early childhood programs, birth through two public school programs, children with special health care needs programs, and Part C services (IDEA).

(7) **Emergency services:** Your family can request emergency funds to be used to respond to a single incident, situation or short term crisis such as care giver hospitalization, absence, or incapacity. Your request must be made through your case manager and include an explanation of how you plan to resolve the emergency situation. Your request will be reviewed by the regional administrator or designee. If approved, you will receive emergency services for a limited time period, not to exceed two months.

(8) **Serious need services:** Your family may request serious need funds to take care of needs not met by other basic services, including short-term intervention services, personal care services or use of a community guide. Serious need funds are short or long-term funds used to provide additional support to allow the individual with disabilities to continue living at home.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-210, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-190, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-220 What is the purpose of community guide services?** (1) Community guide services are available to support your family and help you become well connected to resources or supports in your community. After an assessment, your case manager will give you information about a community guide, whose services can be used, if desired by the family.

(2) This guide will assist your family in using the natural and informal community supports relevant to the age of your child with developmental disabilities and your family's specific needs.

[99-19-104, recodified as § 388-825-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-191, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-222 Who can become a community guide?** To be a guide, a person must demonstrate his/her connections to the informal structures of their community. The department may contract with an individual, agency or organization. Guides must be knowledgeable about resources in their community and comfortable assisting families and persons with developmental disabilities. DDD will provide appropriate training for community guides within available resources.

(2003 Ed.)

[99-19-104, recodified as § 388-825-222, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-192, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-224 Does my family have a choice in selecting its community guide?** Your family will be offered a choice of community guides that best meets the needs of your family. At your family's discretion, your family resources coordinator may serve as your community guide if your developmentally disabled child is thirty-five months of age or younger.

[99-19-104, recodified as § 388-825-224, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-193, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-226 Can the family support opportunity program help my family obtain financial assistance for community guide services?** The program will authorize up to two hundred 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 388-825-230 Specifically how can short-term intervention funds be used?** Short-term intervention funds can be used to purchase a wide range of services and supports, such as:

- (1) Respite care, including community activities providing respite, attendant care or nursing care;
- (2) Training such as parenting classes and supports such as disability related support groups;
- (3) The purchase, rental, loan or refurbishment of specialized equipment, adaptive equipment or supplies not covered by other resources, including Medicaid. Specific examples are mobility devices such as walkers and wheelchairs, communication devices and medical supplies. Diapers may be approved only for those three years of age and older.

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(4) Environmental modifications including home damage repairs caused by the client and home modifications made necessary because of a family member's disability;

(5) Occupational therapy, physical therapy, communication therapy, behavior management, visual and auditory services, or counseling needed by developmentally disabled individuals but not covered by another resource such as public schools and child development services funding;

(6) Medical/dental services not covered by any other resource. These services may include the payment of insurance premiums and deductibles but are limited to the portion of the premium or deduction that applies to the client.

(7) Nursing services, not covered by another resource, that cannot be provided by an unlicensed care giver but can only be rendered by a registered or licensed practical nurse. Examples of such services are ventilation, catheterization, and insulin shots;

(8) Special formulas or specially prepared foods necessary because of the client's disability;

(9) Parent/family counseling for grief and loss issues, genetic counseling or behavior management;

(10) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(11) Specialized utility costs including extraordinary utility costs resulting from the client's disability or medical condition;

(12) If another resource is not available, transportation costs, including gas, ferry or transit cost, so a client can receive essential services and maintain appointments; per diem costs may be reimbursed for medical appointments; and

(13) Other services approved by a DDD regional administrator or designee, according to established department guidelines.

[99-19-104, recodified as § 388-825-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-196, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-232 How can serious need funds help my family?** Your family may need extraordinary support for children or adults with developmental disabilities living in your home in addition to the basic family support services. The purpose of serious need funds is to help you get that support when you need it. If funding is available, it may be short or long-term in nature and can be used for services such as additional personal care, respite care, behavior management and licensed nursing care.

[99-19-104, recodified as § 388-825-232, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-197, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-234 How can my family qualify for serious need funds?** Your family may qualify for serious need funds if the following conditions are met:

(1) The basic program services outlined in WAC 388-825-210 (community guide, personal care services, short-term intervention services, etc.) are currently being used by your family or they have been exhausted;

(2) You and your case manager have examined other resources like the medically intensive home care program; private insurance, local mental health programs and pro-

[Title 388 WAC—p. 1072]

grams available through the public schools and have found them either unavailable, inappropriate or insufficient for your needs; and

(3) The support is crucial for the child or adult with developmental disabilities to continue living in your home.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-234, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-234, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-198, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-236 How does my family request serious need funds?** You must contact your case manager who will submit a written request to the appropriate DDD regional administrator. The request must:

- (1) Indicate the type of services your family needs;
- (2) Explain why those services can only be obtained through the use of serious need funds;
- (3) Outline the changes you anticipate in your family situation if the requested services are not received;
- (4) Estimate the length of time your family will need the requested services; and
- (5) Propose funding review dates.

[99-19-104, recodified as § 388-825-236, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-199, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-238 What amount of serious need funding is available to my family?** (1) The maximum amount of funding available is four hundred 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 388-825-240 Who determines what family support services my family can receive?** Your family and your case manager determine what services your family needs. The department has final approval over service authorization.

[99-19-104, recodified as § 388-825-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-202, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-242 What department restrictions apply to family support payments?** (1) All family support service payments must be authorized by the department.

(2) The department may contract directly with:

- (a) A service provider, or

(b) A parent for the reimbursement of goods or services purchased by the parent, or

(c) An agency to purchase goods and services on behalf of a client.

(3) The department's authorization period will start when you agree to be in this program. The period will last one year and may be renewed if you continue to need services.

[99-19-104, recodified as § 388-825-242, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-204, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-244 What are regional family support advisory councils?** (1) Each division of developmental disabilities regional administrator must appoint a family support advisory council which may serve as a subcommittee of the regional advisory council. The membership of the family support advisory council must include at least one parent representative and at least one case manager.

(2) The purpose of these family support advisory councils is to advise the regional administrator regarding:

- (a) Family support issues;
  - (b) Guidelines for approving or denying short term intervention requests;
  - (c) Community needs; and
  - (d) Recommendations for community service grants.
- (3) Family support advisory councils must meet at least twice a year.

[99-19-104, recodified as § 388-825-244, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-211, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-246 What are community service grants?** (1) Community service grants are funded by the division of developmental disabilities family support program to promote community oriented projects that benefit families. Community service grants may fund long-term or short-term projects that benefit children and/or adults.

Agencies or individuals may apply for funding. The department will announce the availability of funding.

(2) To qualify for funding, a proposed project must address one or more of the following topics:

- (a) Provider support and development;
- (b) Parent helping parent; or
- (c) Community resource development for inclusion of all.

(3) Goals for community service projects are as follows:

- (a) Enable families to use generic resources;
- (b) Reflect geographic, cultural and other local differences;
- (c) Support families in a variety of noncrisis-oriented ways;
- (d) Prioritize support for unserved families;
- (e) Address the diverse needs of Native Americans, communities of color and limited or non-English speaking groups;
- (f) Be family focused;
- (g) Increase inclusion of persons with developmental disabilities;
- (h) Benefit families who have children or adults eligible for services from DDD; and

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(i) Promote community collaboration, joint funding, planning and decision making.

(4) Decisions to approve or reject community service grant requests are made by DDD regional administrators considering the recommendations of their regional family support advisory councils. The DDD director has the discretion to award community service grants that have statewide significance.

(5) DDD may sponsor two family support conferences in different areas of the state each year. The purpose of these conferences is to discuss areas addressed by community service grants and other issues of importance to families.

[99-19-104, recodified as § 388-825-246, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-212, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-248 Who is covered under these rules?** These sections (WAC 388-825-200 through 388-825-242) apply to persons enrolled in family support after June 1996. Those enrolled before June 1996 are covered under WAC 388-825-252 through 288-825-256.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-248, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-248, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-213, filed 2/1/99, effective 3/4/99.]

**WAC 388-825-250 Continuity of family support services.** (1) It is the policy of the department to recognize the dependence of individuals currently receiving family support services at a given level of services, and to avoid disruption of those services at that given level when possible.

(2) In order for the department to maximize the continuity of service while remaining within appropriated funds for family support services, when appropriated funds for family support services do not permit serving new applicants or increasing services to current recipients without reducing services to existing clients, the department may deny requests for new or increased services based on the lack of funds pursuant to WAC 388-825-055.

(3) These requests may be denied even if the service need levels, as described in WAC 388-825-030, of new applicants or current recipients are of a higher priority than those currently receiving services.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-250, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-250, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.040. 92-13-024 (Order 3394), § 275-27-219, filed 6/9/92, effective 7/10/92.]

**WAC 388-825-252 Family support services.** (1) The purpose of the family support program is to:

(a) Reduce or eliminate the need for out-of-home residential placement of a client where the in-home placement is in the client's best interest;

(b) Allow a client to live in the most independent setting possible; and

(c) Have access to services best suited to a client's needs.

(2) The department's family support services shall include, the following services:

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(a) Respite care, including the use of community activities which provide respite;

(b) Attendant care;

(c) Nursing services provided by a registered nurse or licensed practical nurse, that cannot be provided by an unlicensed caregiver, including but not limited to, ventilation, catheterization, insulin injections, etc., when not covered by another resource;

(d) Therapeutic services, provided these therapeutic services are not covered by another resource such as medicaid, private insurance, public schools, or child development services funding, including:

(i) Physical therapy;

(ii) Occupational therapy;

(iii) Behavior management therapy; and

(iv) Communication therapy; or

(v) Counseling for the client relating to a disability.

(3) Up to nine hundred dollars of the service need level amount in WAC 388-825-252 may be used during a one year period for flexible use as follows. The requested service must be necessary as a result of the disability of the client.

(a) Training and supports including parenting classes and disability related support groups;

(b) Specialized equipment and supplies including the purchase, rental, loan or refurbishment of specialized equipment or adaptive equipment not covered by another resource including Medicaid. Mobility devices such as walkers and wheelchairs are included, as well as communication devices and medical supplies such as diapers for those more than three years of age;

(c) Environmental modification including home repairs for damages, and modifications to the home needed because of the disability of the client;

(d) Medical/dental services not covered by any other resource. This may include the payment of insurance premiums and deductibles and is limited to the premiums and deductibles of the client;

(e) Special formulas or specially prepared foods needed because of the disability of the client;

(f) Parent/family counseling dealing with a diagnosis, grief and loss issues, genetic counseling and behavior management;

(g) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(h) Specialized utility costs including extraordinary supplemental utility costs related to the client's disability or medical condition;

(i) Transportation costs for gas or tickets (ferry fare, transit cost) for a client to get to essential services and appointments, if another resource is not available;

(j) Other services approved by the DDD regional administrator or designee that will replace or reduce ongoing departmental expenditures and will reduce the risk of out-of-home placement. Exemption requests under this section are not subject to appeal.

(4) Recommendations will be made to the regional administrator by a review committee. The regional administrator will approve or disapprove the request and will communicate reasons for denial to the committee.

(5) Payment for services specified in subsection (3), except (3)(a) and (h), shall cover only the portion of cost attributable to the client.

(6) Requests must be received by DDD no later than midway through the service authorization period unless circumstances exist justifying an emergency.

(7) A plan shall be developed jointly by the family and the department for each service authorization period. The department may choose whether to contract directly with the vendor, to authorize purchase by another agency, or may reimburse the parent of the client.

(8) Emergency Services. Emergency funds may be requested for use in response to a single incident or situation or short term crisis such as care giver hospitalization, absence, or incapacity. The request shall include anticipated resolution of the situation. Funds shall be provided for a limited period not to exceed two months. All requests are to be reviewed and approved or denied by the regional administrator or designee.

(9) A departmental service authorization shall state the type, amount, and period (duration) of service. Each department authorization shall constitute a new service for a new period.

(10) If the client becomes eligible and begins to receive Medicaid Personal Care services as defined in WAC 388-15-202 through 388-15-203, the family support funding will be reduced at the beginning of the next month of service. The family will receive notice of the reconfiguration of services at least five working days before the beginning of the month.

(11) If requested family support services are not authorized, such actions shall be deemed a denial of services.

(12) Family support services may be authorized below the amount requested by the family for the period. When, during the authorized service period, family support services are reduced or terminated below the amount specified in service authorizations, the department shall deem such actions as a reduction or termination of services.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-252, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-252, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-220, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-220, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-220, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-220, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-220, filed 8/29/86.]

**WAC 388-825-254 Service need level rates.** (1) The department shall base periodic service authorizations on:

(a) Requests for family support services described in WAC 388-825-252(2) of this section;

(b) Service need levels as described in WAC 388-825-252(3) of this chapter. Service need level lid amounts are as follows:

(i) Clients designated for service need level one (WAC 388-825-256) may receive up to one thousand 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.]

**WAC 388-825-256 Service need levels.** (1) The department shall use service need levels to determine periodic family support service authorizations.

(2) The department shall determine service need levels in order of priority for funding as follows:

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(a) Service need level 1: Client is at immediate risk of out-of-home placement without the provision of family support services. The client needs intensive residential support to assist the client's family to care for the family's child or adult requiring nursing services, attendant care, or support due to difficult behaviors. A client shall:

(i) Have received, over the past three months, at least ten days or eighty hours of service; or

(ii) Requires at least ten days or eighty hours per month of service to prevent immediate out-of-home placement, based upon an assessment conducted by the department;

(b) Service need level 2: Client is at high risk of out-of-home placement without the provision of family support services and has one or more of the following documented in writing:

(i) The client:

(A) Currently receives adult protective services or division of children and family services as an active:

(I) Child protective service client;

(II) Child welfare service client; or

(III) Family reconciliation service client.

(B) Has returned home from foster care or group care placement within the last six months;

(C) Has a serious medical problem requiring close and ongoing monitoring and/or specialized treatment, such as:

(I) Apnea monitor;

(II) Tracheotomy;

(III) Heart monitor;

(IV) Ventilator;

(V) Constant monitoring due to continuous seizures;

(VI) Immediate life-saving intervention due to life threatening seizures;

(VII) Short bowel syndrome; or

(VIII) Brittle bone syndrome.

(D) Has a dual diagnosis based on current mental health DSM Axis I diagnosis;

(E) Has an extreme behavioral challenge resulting in health and safety issues for self and/or others which:

(I) Resulted in serious physical injury to self or others within the last year;

(II) For a client who is two years of age or older, requires constant monitoring when awake for personal safety reasons; or

(III) Is of imminent danger to self or others as determined by a psychiatrist, psychologist, or other qualified professional.

(F) Is ten years of age or older or weighs forty pounds or more, requires lifting, and needs direct physical assistance in three or more of the following areas:

(I) Bathing;

(II) Toileting;

(III) Feeding;

(IV) Mobility; or

(V) Dressing.

(ii) The caregiver:

(A) Is a division of developmental disabilities client;

(B) Has a physical or medical problem that interferes with providing care; or

(C) Has serious mental health or substance abuse problems and:



- (I) Is receiving counseling for these problems; or
- (II) Has received or applied for counseling within the past six months.

(c) Service need level 3: The family is at risk of significant deterioration which could result in an out-of-home placement of the client without provision of family support services due to the following:

(i) The client requires direct physical assistance, above what is typical for such client's age, in three or more of the following areas:

- (A) Bathing;
- (B) Toileting;
- (C) Feeding;
- (D) Mobility; or
- (E) Dressing.

(ii) The client has current behavioral episodes resulting in:

- (A) Physical injury to the client or others;
- (B) Substantial damage to property; and/or
- (C) Chronic sleep pattern disturbances or chronic continuous screaming behavior.

(iii) The client has medical problems requiring substantial extra care; and/or

- (iv) The family is:
  - (A) Experiencing acute and/or chronic stress;
  - (B) Has acute or chronic physical limitations; or
  - (C) Has acute or chronic mental or emotional limitations.

(d) Service need level 4: Family needs temporary or ongoing services in order to:

(i) Receive support to relieve and/or prevent stress of caregiver/family; or

(ii) Enhance the current functioning of the family.

(3) The department, through regional review committees, shall determine service need level of the client's service request by reviewing information received from the client, family, and other sources about:

(a) Whether client is an active recipient of services from the division of children and family services or adult protective services;

(b) Whether indicators of risk of out-of-home placement exist, and the imminence of such an event. The department's assessment of such risk may include:

- (i) Review of family's requests for placement;
- (ii) History of family's involvement with children's protective services or adult protective services;
- (iii) Client's current adjustment;
- (iv) Parental history of psychiatric hospitalization;
- (v) Clinical assessment of family's condition; and
- (vi) Statements from other professionals.

(c) Caregiver conditions, such as acute and/or chronic:

- (i) Stress;
- (ii) Physical limitations; and
- (iii) Mental and/or emotional impairments.

(d) Client's need for intense medical, physical, or behavioral support;

(e) Family's ability to use typical community resources;

(f) Availability of private, local, state, or federal resources to help meet the need for family support;

(g) Severity and chronicity of family or client problems; and

(h) Degree to which family support services will:

- (i) Ameliorate or alleviate such problems; and
- (ii) Reduce the risk of out-of-home placement.

[99-19-104, recodified as § 388-825-256, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW 97-13-051, § 275-27-223, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-223, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-223, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-223, filed 2/5/88.]

**WAC 388-825-260 What are qualifications for individual service providers?** The following rules establish qualifications for:

(1) Persons whom DDD pays to provide services to individuals with developmental disabilities including children; and

(2) Agencies contracted to provide services in the home of the DDD client.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-260, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-262 What services do individuals provide for persons with developmental disabilities?** Individual providers contract directly with DDD to provide services such as respite care, Medicaid personal care, attendant care, individual alternative living and companion home services.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-262, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-264 If I want to provide services to persons with developmental disabilities, what do I do?** You must contact your local DDD office and ask for a contract application package.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-264, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-266 If I want to provide respite care in my home, what is required?** All out-of-home respite care funded through DDD must take place in a DSHS licensed home unless you meet criteria listed in the "exemption" section below (WAC 388-825-270). You must have a child foster care, family day care, or adult family home license.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-266, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-268 What is required for agencies wanting to provide care in the home of a person with developmental disabilities?** Agencies must be a home care agency or a home health agency licensed through the department of health. If a DDD-certified residential agency wishes to provide Medicaid personal care or respite care in the client's home, the agency must have home care agency certification or a home health license.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-268, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-270 Are there exceptions to the licensing requirement?** Relatives of a specified degree are exempt

from the licensing requirement and may provide out-of-home respite in their home. Relatives of specified degree include parents, grandparents, brother, sister, stepparent, stepbrother, stepsister, uncle, aunt, first cousin, niece or nephew (WAC 388-15-202).

In addition, RCW 70.128.010 defines adult family home as "more than one, not more than six unrelated adults." If the person requiring out-of-home respite or attendant care is an adult, care may be provided in the nonrelative provider's home without an adult family home license when:

- (1) Care is provided for no more than one unrelated person at a time; and
- (2) The person or his/her legal guardian signs a statement saying they have seen the home where care will be provided and think it is an appropriate place for the care of the adult. If the person does not have a legal guardian, the parent or other relative with whom the person resides may sign a statement.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-270, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-270, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-272 What are the minimum requirements to become an individual provider?** (1) Be at least eighteen years of age;

(2) Successfully pass a criminal history background check;

(3) Not be the spouse of the client receiving services or the natural/step/adoptive parent of a child age seventeen or younger;

(4) Have no findings of fact or conclusions of law or agreed orders related to abuse, neglect, financial exploitation or abandonment of a minor or vulnerable adult, as defined in RCW 74.39A.050(8);

(5) Have not had a child foster care, day care, adult family home or other license issued by the department of social and health services (DSHS) revoked, denied, suspended or terminated for noncompliance with state and federal regulations. Any existing contracts you hold with DDD will be terminated for cause if such an action exists;

(6) Be able to prove you can work in the United States, provide your social security card and official picture identification or by providing other approved documentation of eligibility to work;

(7) Speak in the language of the person served or have a viable means of communication, such as translation services;

(8) Provide three satisfactory references, unless you are a relative or a Medicaid personal care provider. References are checked prior to the issuance of the initial contract; and

(9) At DDD discretion, a waiver of references may be granted under the following conditions:

(a) The service provider is recruited to provide service exclusively to a specific person;

(b) A request to waive references is submitted in writing by the person, his or her parents, or legal guardian.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-272, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-276 What are required skills and abilities for this job?** You must be able to:

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(1) Adequately maintain records of services performed and payments received;

(2) Read and understand the person's service plan. Translation services may be used if needed;

(3) Be kind and caring to the DSHS client for whom services are authorized.

(4) Identify problem situations and take the necessary action;

(5) Respond to emergencies without direct supervision;

(6) Understand the way your employer wants you to do things and carry out instructions;

(7) Work independently;

(8) Be dependable and responsible;

(9) Know when and how to contact the client's representative and the client's case manager;

(10) Participate in any quality assurance reviews required by DSHS.

(11) If you are working with an adult client of DSHS as an individual alternative living, attendant care or individual supportive living provider, you must also:

(a) Be knowledgeable about the person's preferences regarding the care provided;

(b) Know the resources in the community the person prefers to use and enable the person to use them;

(c) Know who the person's friends are and enable the person to see those friends; and

(d) Enable the person to keep in touch with his/her family as preferred by the person.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-276, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-278 Are there any educational requirements for individual providers?** Training is mandated only for Medicaid personal care providers of adults (WAC 388-15-196). DSHS retains the authority to require training of any provider.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-278, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-278, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-280 What are the requirements for an individual supportive living service (also known as a companion home) contract?** (1) General knowledge of acceptable standards of performance, including the necessity to be dependable, report punctually, maintain flexibility and to demonstrate kindness and caring to any DSHS client for whom services are authorized.

(2) Twenty hours of training approved by DDD must be completed during the first year of the contract; ten hours must be completed during the second year and all subsequent years.

(3) A clean, safe and healthful environment must be available for the client, including:

(a) A telephone the client can use;

(b) A flashlight or other nonelectrical light source in working condition;

(c) Basic first aid supplies;

(d) An evacuation plan;

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- (e) A safe storage area for flammable and combustible materials;
- (f) Unblocked exits;
- (g) Accessibility by customary forms of ingress and egress for space used for residential purposes; and
- (h) Smoke alarms in the residence.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-280, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-282 What is "abandonment of a vulnerable adult"?** State law makes it a crime to abandon a vulnerable adult. "Abandon" means leaving a person without the means or ability to obtain any of the basic necessities of life. If you wish to "quit" or terminate your employment, you must give at least two weeks written notice to your employer, their representative (if applicable) and the DDD case manager. You will be expected to continue working until the termination date unless otherwise determined by DSHS.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-282, filed 11/9/99, effective 12/10/99.]

**WAC 388-825-284 Are providers expected to report abuse?** You are expected to report any abuse or suspected abuse immediately to child protective services, adult protective services or local law enforcement and make a follow-up call to the person's case manager.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-284, filed 11/9/99, effective 12/10/99.]

## Chapter 388-826 WAC

### VOLUNTARY PLACEMENT PROGRAM

#### WAC

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- 388-826-0120 What happens if a parent disagrees with a decision made by DDD?
- 388-826-0125 Does DDD make exceptions to the requirements in this chapter?

**WAC 388-826-0001 What is the purpose of the voluntary placement program?** The purpose of the voluntary placement program is to:

(1) Support the optimal growth and development of the child or youth in out-of-home placement. The sole reason for the out-of-home placement is the child's developmental disability. Services are offered by DSHS/DDD through a voluntary placement agreement. Parents retain custody of their child or youth.

(2) Support the child and family with a shared parenting arrangement through the use of licensed foster care providers.

(3) Complement other public and private resources in providing supports to the child and family.

(4) Encourage the relationship between the child and parents, even when the child or youth is not living in their own home.

(5) These rules are adopted under the authority of RCW 74.13.350.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0001, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0005 Definitions. "Best interest"** includes, but is not limited to:

(1) Prevent regression or loss of skills already acquired;

(2) Achieve or maintain self-sufficiency;

(3) Provide the least restrictive setting that will meet the child's/youth's medical, social, developmental and personal needs;

(4) Benefits the medical, personal, social and developmental needs of the child/youth;

(5) Maintains family relationships.

**"Child or youth"** means an individual who is eligible for division services per RCW 71A.16.040 and chapter 388-825 WAC, is less than eighteen years of age and who is in the custody of a parent by blood, adoption or legal guardianship.

**"Client or person"** means an individual is eligible for division services per RCW 71A.16.040 and WAC 388-825-030.

**"Community support services"** means one or more of the services listed in RCW 71A.12.040 including, but not limited to the following services: Architectural, social work, early childhood intervention, employment, family counseling, respite care, information and referral, health services, legal services, therapy services, residential services and support, transportation services, and vocational services.

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

**"Director"** means the director of the division of developmental disabilities.

**"DDD"** means the division of developmental disabilities of the department of social and health services.

**"Emergency"** means a sudden, unexpected occurrence demanding immediate action.

**"Exemption"** means the department's approval of a written request for an exception to a rule in this chapter.

**"Family"** means individuals of any age, living together in the same household related by blood, marriage, adoption or as a result of sharing legal custody of a minor child.

**"Foster care provider"** means the individual person licensed by the DSHS, children's administration, division of licensed resources (DLR) (chapter 388-148 WAC) to provide foster care in the person's home; or a group care agency licensed by DLR to provide foster care for an individual in a group facility or staffed residential setting.

**"In the voluntary placement program the legal status of the child"** means that the child is in legal custody of the biological or adoptive parent(s) or legal and custodial guardian.

**"The judicial determination and review"** means a process that occurs in court and its purpose is to affirm that out-of-home placement is in the best interest of the child. The parent is notified of the court date and may appear in court with the child's DDD social worker.

**"Out-of-home placement"** means a DLR licensed home, a licensed group care facility or another licensed setting.

**"Parent"** means the individual who is the biological or adoptive person or legal custodial guardian who has legal responsibility for and physical custody of the child.

**"Shared parenting"** means biological or adoptive parents or legal guardians and foster care providers share responsibilities. Responsibilities are for the physical and emotional care, education and medical well-being of child/youth who meets DDD eligibility criteria and who is in a voluntary out of home placement as is described in the shared parenting agreement.

**"Shared parenting plan"** means a written plan among the parent, a foster care provider and DDD, with the expectation of sharing responsibilities for care of a child/youth, including exchanging information on a routine basis about medical, education, daily routines and special situations in the life of the child/youth.

**"Voluntary out-of-home placement"** for a child who is eligible for DDD services means:

- (1) When a parent and the division of developmental disabilities (DDD) agree that it is in the best interest of the child to reside out of the home of the parents;
- (2) The placement is solely due to the child's disability;
- (3) There are no unresolved issues of abuse and neglect;
- (4) When the parent or custodial and legal guardian and division sign a voluntary placement agreement; and
- (5) When a child lives more than fifty percent of her/his life in a licensed setting that is other than in the parents' home. The setting may be a licensed foster family home,

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group care facility, or staffed residential home as licensed under chapter 74.15 RCW.

**"Voluntary placement agreement,"** as used in this section, means a written agreement between the department and a child's parent or legal guardian authorizing the department to place the child in a licensed facility.

**"Written request for out-of-home placement"** means a written request signed by the custodial parent requesting out-of-home placement for the child or youth under eighteen years of age.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0005, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0010 Who is eligible for the voluntary placement program?** Children who:

- (1) Are determined eligible for DDD services under RCW 71A.16.040;
- (2) Are under eighteen years of age when the request for services through VPP is made;
- (3) Have no unresolved issues of abuse or neglect pending with DSHS children's administration;
- (4) Are in the legal and physical custody of their parent or legal guardian; and
- (5) The request is made solely due to the child's disability RCW 74.13.350 and parents have used all other appropriate services for their child through DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0010, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0015 Who else may be eligible to participate in the voluntary placement program?** Within available resources:

- (1) Children or youth who are eligible for DDD services per RCW 71A.16.040, may transfer from children's administration, as long as they are under eighteen years of age, in a stable guardianship, and have no unresolved issues of abuse or neglect pending with children's administration.
- (2) Youth who turn eighteen while in the VPP and reside in a DLR licensed setting, may continue to participate in VPP until age twenty-one as long as her/his placement remains in tact and does not disrupt and she/he remains in school until graduation or reaches age twenty-one, whichever comes first (see WAC 388-826-0115).

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0015, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0020 How does the family, whose child is a client of DDD request access to the VPP?** Parents must make a written request for voluntary out-of-home placement services (DSHS 10-277) for their child to their DDD case resource manager. The request is considered when the following criteria are met:

- (1) The child is under eighteen years of age;
- (2) The placement is due solely to the child's disability;
- (3) The family is currently using some DDD services or is on the list for services;
- (4) There are available funds for the VPP;
- (5) There are no issues of abuse and neglect; and

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(6) The custodial parent and the division of developmental disabilities (DDD) agree that it is in the best interest of the child to reside outside of the parent's home.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0020, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0025 What is the process for a child or youth who transfers from children's administration to get into the VPP?** (1) At the regional level, a staffing occurs. It involves DDD and DCFS social workers and supervisors, and any other agency representatives who have knowledge of the child or youth's issues.

(2) At the staffing the participants discuss the criteria outlined in WAC 388-826-0010 and 388-826-0015.

(3) Within available resources and when appropriate criteria are met, social workers determine the appropriateness of the transfer of the child's case from one administration to the other.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0025, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0030 How is a decision made for out-of-home placement?** A parent makes a written request for out-of-home placement, to her/his child's case manager. Prior to a decision for out-of-home placement, a staffing is held. The purpose of the staffing is to determine whether all other available and appropriate services have been used or could be used by the family. The parents, the DDD case manager, the DDD social worker, and/or resource developer and where appropriate, DCFS social worker may participate in staffings.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0030, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0035 How is a decision made regarding participation in the voluntary placement program?**

(1) A decision regarding participation in VPP is based on the premise that all available DDD services to the child and family have been used and that out-of-home placement is in the best interest of the child and that the placement is due solely to the child's disability;

(2) There are funds available in VPP;

(3) Through a staffing, the family's DDD case resource manager, VPP supervisor and VPP social worker, and any other person who can provide useful information, discuss the services used, and share information and resources regarding the needs of the family and child;

(4) DDD and the parents must be in agreement about the need for out-of-home placement and that the request fits the criteria for the program. When both parties are in agreement, a written voluntary placement agreement is signed by the parent and DDD representative:

(a) If there are no funds available, parents may sign a request for out-of-home placement (DSHS 10-277);

(b) When it is determined that the request is appropriate, the child or youth is eligible for out-of-home placement, there are available funds and there is a placement, the agreement is signed and the child's file is transferred to a DDD social worker in the voluntary placement program;

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(c) If there are funds available, the consideration for out-of-home placement continues. The name of the child/youth is placed on the VPP data base for consideration of placement outside the home.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0035, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0040 What is a voluntary placement agreement?** It is a mutually voluntary and written document between the parent and the department. It must be signed by the child's parent and the DSHS/DDD representative to be in effect. An agreement regarding a Native American child is not valid unless executed in writing before the court and filed with the court as provided in RCW 13.34.130. Any party to the voluntary placement agreement may terminate the agreement at any time. When one party ends the agreement, per the VPA, the voluntary agreement is ended.

The agreement authorizes DSHS/DDD to facilitate a placement for the child who is under eighteen years of age in a licensed facility. Under the term of the agreement, the parent retains legal custody. DSHS/DDD is responsible for the child's placement and care. The agreement shall at a minimum specify the legal status of the child and the rights and obligations of the parent or legal guardian, the child, and the department while the child is in placement.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0040, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0045 What happens after a voluntary placement agreement is signed, what are the legal issues and who is responsible?** When the DDD social worker facilitates the placement of a child in a licensed out-of-home care arrangement, under a DDD voluntary placement agreement, the department has the responsibility for the child's placement and care. The department shall:

(1) In conjunction with the parents, develop an individual services plan for the child no later than sixty days from the date that the department assumes responsibility for the child's placement and care;

(2) Develop a shared parenting plan with foster care providers and parents;

(3) Obtain a judicial determination, within one hundred eighty days of placement, in accordance with RCW 13.34.030 and 13.34.270 that the placement is in the best interest of the child;

(4) Attend the permanency planning hearing reviews where a review of the child's out-of-home placement determines if it continues to be in the best interest of the child to continue the out-of-home placement;

(5) Make a face-to-face visit with the child and visit with the child in their licensed placement, every ninety days;

(6) Facilitate a judicial review at one hundred eighty days and annually thereafter, unless the child's placement ends before one hundred eighty days have elapsed;

(7) Provide for periodic administrative reviews of the child's case, unless a judicial review occurs every one hundred eighty days after initial placement.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0045, filed 10/31/02, effective 12/1/02.]

(2003 Ed.)

**WAC 388-826-0050 Is there an ongoing court process when the child is in out-of-home placement and how does the process work?** The ongoing court process involves the following activities:

(1) When a child is placed in a licensed out-of-home setting, within one hundred eighty days, the DDD social worker must file an order with the court that says the custodial and legal parent has signed a voluntary placement agreement with DDD and voluntarily requests placement of their child in out-of-home care;

(2) The child's DDD social worker prepares the necessary papers and files them with the court clerk; and

(3) Once a year, the DDD social worker prepares a report that must be presented to the court. It is called an order for continued placement and it describes in the words of the social worker, why the out-of-home placement continues to be in the best interest of the child.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0050, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0055 What basic services may a child receive from the voluntary placement program?** (1) Shared parenting between foster care providers and parents on daily routines;

(2) Medical coverage, under a medical coupon issued from the foster care medical unit (FCMU);

(3) Coordination with special education services in the local school district when the child meets eligibility criteria;

(4) Supervised special activities in the community when appropriate;

(5) Safe, developmentally appropriate care;

(6) Supervision by a DDD social worker who has responsibility for visiting the child/youth at a minimum, every ninety days;

(7) An individual services plan for the child within sixty days from the date that DSHS/DDD assumes responsibility for the child's placement and care;

(8) DDD social worker prepares documents for court, and pursuant to RCW 13.34.030 and 13.34.270 shares the documents at the court hearings in order to determine that the placement is in the best interest of the child;

(9) Social work services such as needs assessment, referral, service coordination and case monitoring;

(10) Early intervention services: DDD ensures coordination of services for children from birth through thirty-five months of age with early intervention and special education; and

(11) Medically intensive services under WAC 388-531-3000.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0055, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0060 Are there other services a child may receive in this program?** In-home supports may be available to support a child in the parent's home. Approval of in-home support services is based on available funds. The criteria to receive in-home supports when there are available funds are:

(2003 Ed.)

(1) Children whose current out of home placement disrupts and who are awaiting new out-of-home placements;

(2) Children whose names are on the data base and whose parents have signed a "request for out-of-home placement."

Service need level for in-home services are evaluated every six months and reviewed every ninety days thereafter. Any reduction in service or denial of services allows the child's family the right to appeal the decision under chapter 388-825 WAC.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0060, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0065 What can parents expect if they use in-home supports under this program?** Within available funds, the child may sometimes receive supports. Supports may be in the form of respite services, specialized behavioral support, and other services that are needed to support the child's continued living arrangement in the parent's home. A person meeting provider qualifications may provide the supports to the child in the home, through a contract with DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0065, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0070 What is the responsibility of the department for the child who is in out-of-home care?** When DDD facilitates an out-of-home placement, DDD is responsible for:

(1) A voluntary placement agreement according to this section;

(2) Monitoring of the child's placement and care;

(3) A permanency plan of care for the child;

(4) A plan that monitors the health, safety and appropriateness of the child's placement at a minimum every ninety days, making face-to-face visits at that time;

(5) The DDD social worker maintains any records as required by court oversight; and

(6) DDD social worker facilitates a needs assessment, individual service plan and a shared parenting plan.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0070, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0075 What are the responsibilities of the parents when their child receives services in the voluntary placement program?** Parents retain custody of their child at all times when the child is receiving services in the voluntary placement program. Parents responsibilities include, but are not limited to, the following:

(1) The right to make all major nonemergency decision about medical care, enlistment in military service, marriage and other important legal decisions for the person under eighteen years of age;

(2) Maintain ongoing and regular contact with the child;

(3) Agree to work cooperatively with their child's DDD social worker and other DSHS staff and persons caring for their child;

(4) Participate in decision making for their child;

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(5) Cooperate with DDD in selecting a representative payee for the child's Social Security benefits, received from the Social Security Administration, and which are used for basic maintenance while the child is in out-of-home care;

(6) Agree that if their child's out-of-home placement disrupts, their child will return to the parents physical care until a new placement is developed. The parent's signature on the voluntary placement agreement confirms their understanding of the responsibilities listed in the VPA.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0075, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0080 What are the expectations for parents when their child is in out-of-home care?** Parents are expected to be active in the "shared parenting" plan and continue to be involved in their child's life. The plan is a written agreement between the licensed foster parents or provider caring for the child and the child's parents. It includes:

- (1) Responsibilities of legal and foster parents or provider;
- (2) Plan for respite;
- (3) Emergency procedures;
- (4) Planned activities;
- (5) Expectations and special considerations; and
- (6) Involvement on a regular basis by the parent.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0080, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0085 Are other DDD services available for a child through the voluntary placement program?** When a parent signs a voluntary placement agreement and the child enters the VPP, the child will no longer be eligible for services from the family support opportunity program, or the Medicaid Personal Care program. A parent will not be able to obtain other DDD services when the parent's child is in the VPP. The DDD VPP services will be authorized and obtained through the VPP. Some services will be similar to other DDD services, but they will not be paid for out of any other program, as long as the child is receiving services in the VPP.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0085, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0090 What does a parent do with the child's Social Security benefits when the parent's child lives outside the parent's home?** (1) When a parent signs a DDD VPA, the DDD social worker shares with the parent a list of representative payee agencies. From the list, parents must select a representative payee for their child's SSI benefits.

(2) Each month, the child's SSI check will be sent to the representative payee. The portion of the check designated for "room and board," the amount that is allowed for basic maintenance while in foster care and when parents are not caring for their child in their own home, is sent to the licensed foster care provider for reimbursement for basic maintenance.

(3) The representative payee sets aside an amount from the child's SSI warrants designated as "client personal incidentals or CPI" and it is entered into a trust account for the

child or youth. It is made available for items that are of a direct benefit to the child. The representative payee monitors the account held in trust for the child and notifies the DDD social worker when the account is within three hundred dollars of the maximum reserve exemption allowance.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0090, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0095 Who pays for a child's care when a child is in out-of-home placement?** State funds, federal funds and the child's SSI, that is used for basic maintenance support the cost of the child's care while the child is in licensed out-of-home placement. The parent is encouraged to continue to support their child with typical activities, e.g., presents, clothing, special items, special outings. Licensed providers who care for the child in a licensed setting will be paid directly through a contract with DDD and according to an established rate structure, established within DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0095, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0100 What happens if the voluntary placement ends?** The child must be returned to the physical care of the child's legal parent unless the child has been taken into custody pursuant to RCW 13.34.050 or 26.44.050, placed in shelter care pursuant to RCW 13.34.060, or placed in foster care pursuant to RCW 13.34.130. The agreement as described in RCW 74.13.350, between DDD and legal parents is completely voluntary. Per RCW 74.13.350, any party may terminate the agreement at any time.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0100, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0105 When the child leaves the voluntary placement program for any reason, what DDD services are available to the child and family when voluntary placement ends?** Depending on availability of funds, the child and family may be eligible for other DDD programs and that would support the child.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0105, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0110 Will a child or youth continue to receive special education or early intervention services while in VPP?** (1) Early intervention services are available to a child, birth through thirty-five months when in VPP and when that child meets the early intervention eligibility criteria.

(2) When a child or youth meets eligibility criteria for special education programs, ages three to twenty-one years, the child or youth continues to receive special education services through their local public school district.

(3) Office of superintendent of public instruction is responsible for the special education program for the eligible children, ages three to twenty-one years, RCW 28A.155.220 allows that children and youth who meet eligibility criteria may remain in special education until graduation, if that occurs during the school year.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0110, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0115 What happens after a youth turns eighteen?** When a youth turns eighteen, and is considered an adult, while in the voluntary placement program, the youth may remain in the child foster home, in VPP, under the following circumstances:

(1) Youth remains in the education or vocational program in the local public school district in which he/she has been enrolled until graduation or age twenty-one, whichever is earlier, per WAC 392-172-030(2), RCW 74.13.031 (10) and (13), 28A.155.020, and 28A.155.030;

(2) The placement remains intact and does not disrupt;

(3) When needed, youth who turns eighteen can self-administer medication;

(4) Youth cannot remain in foster care, living in a child foster home, and in VPP, after eighteen years of age when:

(a) The child foster home placement disrupts;

(b) The youth leaves education or vocational program; or

(c) The youth who turns eighteen needs someone to administer medication.

Dependency guardianships end at age eighteen. If a youth has been in a legal guardianship, under chapter 11.88 RCW and if the reason for guardianship was the minority of the child the guardianship ends.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0115, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0120 What happens if a parent disagrees with a decision made by DDD?** If a parent disagrees with a decision made by DDD staff, the parent has the right to pursue the appeal process, as outlined in RCW 71A.10.050 and chapter 388-02 WAC.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0120, filed 10/31/02, effective 12/1/02.]

**WAC 388-826-0125 Does DDD make exceptions to the requirements in this chapter?** DDD may grant exceptions to the requirements specified in this chapter as long as the DDD director approves the request in writing within sixty days.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0125, filed 10/31/02, effective 12/1/02.]

**Chapter 388-830 WAC**

**DIVISION OF DEVELOPMENTAL DISABILITIES PROGRAM OPTION RULES**

(Formerly chapter 275-31 WAC)

**WAC**

388-830-005	Purpose.
388-830-010	Definitions.
388-830-015	Determination of eligibility.
388-830-020	Notification to potential applicants.
388-830-025	Application for services.
388-830-030	Individual service plan.
388-830-035	Implementation of necessary services.
388-830-040	Criteria for determining costs.
388-830-045	Method of rate determination.

(2003 Ed.)

**WAC 388-830-005 Purpose.** (1) In order for developmentally disabled individuals to live in the most independent settings possible, and in order for these individuals and families to have access to services best suited to their needs, the division of developmental disabilities may approve alternative service plans for individuals.

(2) Measurable outcomes producing a positive result for individuals will be demonstrated as a result of services provided under such alternative plans.

(3) Cost savings will be demonstrated when costs of services under alternative plans are compared with costs of services provided prior to alternative plans.

[99-19-104, recodified as § 388-830-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-005, filed 1/18/84.]

**WAC 388-830-010 Definitions.** (1) "Department" means the department of social and health services of the state of Washington.

(2) "Division" means the division of developmental disabilities of the department of social and health services.

(3) "Field services" means the section of the division providing case management services and resource management to division clients living in the community.

(4) "Individual" means the person for whom an alternative plan is being developed.

(5) "Individual habilitation plan" means an individual written plan of care prepared by an interdisciplinary team that sets measurable goals or objectives stated in terms of desirable behavior and that prescribes an integrated program of activities, experiences, or therapies necessary for the individual to reach those goals or objectives. The overall purpose of the plan is to help the individual function at the greatest physical, intellectual, social, or vocational level the individual can presently or potentially achieve.

(6) "Individual program plan" means an individual service plan or individual habilitation plan.

(7) "Individual service plan" means the written plan, specifying goals and objectives, developed by division staff, parent or parents and/or guardian, the individual, and others whose participation is relevant to identifying needs of the individual.

(8) "Less dependent program" means an alternative program which will provide increased numbers and variety of community contacts for the individual or will require fewer hours of staff supervision/support for the individual.

(9) "Provider" means the person or agency contracted by the department to provide training, support, or other services as designated in the alternative plan.

(10) "Secretary" means the secretary of the department of social and health services or such officer of the department as the secretary may designate to carry out administration of the provision of these rules.

[99-19-104, recodified as § 388-830-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-010, filed 1/18/84.]

**WAC 388-830-015 Determination of eligibility.** An individual shall be eligible for services under an alternative plan, provided that the division has determined the individual

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has a disability as defined in WAC 388-825-030 and the individual is receiving current services from the department.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-830-015, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-830-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-020, filed 1/18/84.]

**WAC 388-830-020 Notification to potential applicants.** (1) Field services shall, prior to March 15, 1984, contact by mail all individuals determined to have a disability as defined in WAC 388-825-030, along with the guardians and agencies entitled to custody of such disabled individuals and parents of disabled individuals who are minors. Thereafter, the aforementioned persons shall be advised once in each calendar year.

(2) Potential applicants shall be informed of the process by which they may develop an alternative plan for services.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-830-020, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-830-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-030, filed 1/18/84.]

**WAC 388-830-025 Application for services.** (1) In the case of a minor individual, an application can be made by the parent or parents, the guardian or limited guardian, or by the person or agency legally entitled to custody.

(2) In the case of an adult, an application can be made by the individual, by the guardian or limited guardian, or by the person or agency legally entitled to custody.

(3) Application will be made on the forms supplied by the department and the applicant will state the following:

- (a) The outline of services proposed;
- (b) Service providers for each service;
- (c) Tasks necessary to the delivery of each service and the person/organization responsible for each task;
- (d) All costs of services currently provided for the individual;
- (e) The cost of each service component proposed in the alternative plan;
- (f) Information explaining why the alternative plan is a less dependent program than the current program; and
- (g) Information explaining why the alternative plan is appropriate under the goals and objectives of the individual program plan.

(4) Applicants must be notified within ninety days after the alternative plan has been received by the department of the secretary's approval or denial of the plan.

(5) The notification of the department's decision is subject to appeal rights pursuant to WAC 388-825-100 and 388-825-120.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-830-025, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-830-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-040, filed 1/18/84.]

**WAC 388-830-030 Individual service plan.** The division shall ensure a current individual service plan is available for each individual prior to approval of application.

[99-19-104, recodified as § 388-830-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-050, filed 1/18/84.]

**WAC 388-830-035 Implementation of necessary services.** (1) Plans meeting all the criteria specified in WAC 388-825-050 shall be implemented as soon as reasonable, but not later than one hundred twenty days after the completion of the determination process.

(2) Approval and reasonableness may be reviewed for a new determination if the plan has not been implemented within one hundred twenty days.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-830-035, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-830-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-070, filed 1/18/84.]

**WAC 388-830-040 Criteria for determining costs.** (1) The term "all costs" includes, but is not limited to: Residential support, habilitation, medical care, income grants to the persons, support to assist their families or other caregivers, and nonrecurring start-up expenses. All residential costs will recognize capital investment, using federal or professional accounting conventions. The department will take the following costs into account:

(a) All costs paid by the department, including costs borne by the federal government. Income grants paid by the federal government directly to the person (or payee) will be considered.

(b) All costs of the current or proposed program.

(2) The department will estimate a monthly average cost based on a two-year prospective cost period.

(3) Where costs are paid or records kept for a group of individuals rather than for one individual in question, the department will primarily use average cost for that group, such as all individuals living at the particular group home or particular residential habilitation center, or all the persons supported by the particular day habilitation program. Exceptions will be considered for persons receiving substantial services above the services received by the typical person in the group.

(4) The analysis of the proposed alternative service plan should show that proposed services can be provided at eighty percent of the current service cost. Exceptions will be considered for persons needing substantial services.

[99-19-104, recodified as § 388-830-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-080, filed 1/18/84.]

**WAC 388-830-045 Method of rate determination.** Prevailing rates for comparable services will ordinarily be utilized in determining reimbursement for cost components of the alternative plan.

[99-19-104, recodified as § 388-830-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-090, filed 1/18/84.]

## Chapter 388-835 WAC

## ICF/MR PROGRAM AND REIMBURSEMENT SYSTEM

(Formerly chapter 275-38 WAC)

## WAC

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 388-835-0165 Is a superintendent required to give notice when they detain a resident?  
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 388-835-0195 What requirements apply to surety bonds or assigned funds used as security by a provider?  
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 388-835-0215 What are the requirements for participating in PCRRS?  
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 388-835-0230 Must a cost report be certified?  
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 388-835-0345 Can residents overdraw their trust account?  
 388-835-0350 Can a resident trust account be charged for Title XIX services?  
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 388-835-0385 How are trust fund monies refunded?  
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## ALLOWABLE AND UNALLOWABLE COSTS

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388-835-0415	Are the costs of meeting required standards allowable costs?	388-835-0645	Are management fees allowable costs?
388-835-0420	Are costs associated with related organizations allowable costs?	388-835-0650	Are all management fees allowable?
388-835-0425	Are start-up costs allowable costs?	388-835-0655	Are management fees involving a related organization allowable costs?
388-835-0430	Are organizational costs allowable costs?	388-835-0660	How do overhead and indirect costs relate to allowable costs?
388-835-0435	Are education and training costs allowable costs?	388-835-0665	Are travel and housing expenses of nonresident staff working at a provider's ICF/MR facility allowable costs?
388-835-0440	Are operating lease costs allowable costs?	388-835-0670	Are bonuses paid to a provider's employees allowable costs?
388-835-0445	Are rental expenses paid to related organizations allowable costs?	388-835-0675	Are fees paid to members of the board of directors or corporations allowable costs?
388-835-0450	What is allowable interest?	388-835-0680	How is the administration and operations rate component computed?
388-835-0455	Can a provider offset interest income against allowable costs?	388-835-0685	How is the property rate component computed?
388-835-0460	How does DSHS calculate total compensation for owners and relatives?	388-835-0690	Does DSHS pay a return on equity to providers?
388-835-0465	How does DSHS define owner or relative compensation?	388-835-0695	How is a return on equity calculated?
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388-835-0475	What requirements apply to capitalizing buildings, other real property items, components, improvements and leasehold improvements?	388-835-0705	Are return on equity calculations subject to field audits?
388-835-0480	How are the useful lives of leasehold improvements determined?	388-835-0710	How does DSHS use field audit results?
388-835-0485	What are depreciable assets?	388-835-0715	Does DSHS place upper limits on the reimbursement rates it pays providers?
388-835-0490	What are some examples of depreciable assets?	<b>SETTLEMENTS</b>	
388-835-0495	What is "minor equipment"?	388-835-0720	What general requirements apply to settlements between DSHS and providers?
388-835-0500	Is land a depreciable asset?	388-835-0725	What requirements apply to paying overpayments and underpayments?
388-835-0505	What costs are included in the capitalized cost of land?	388-835-0730	What if the amount of overpayment or underpayment is being disputed?
388-835-0510	What is the depreciation base of a tangible asset?	388-835-0735	What requirements apply to a provider's proposed preliminary settlement?
388-835-0515	Can an appraisal be used to establish historical cost?	388-835-0740	How must DSHS respond to a provider's proposed preliminary settlement?
388-835-0520	What is the depreciation base of a donated or inherited asset?	388-835-0745	What recourse does a provider have if DSHS rejects their proposed preliminary settlement?
388-835-0525	How is the useful life of a depreciable asset determined?	388-835-0750	What requirements apply to final settlements?
388-835-0530	What depreciation methods are approved by DSHS?	388-835-0755	Can a provider disagree with a final settlement report?
388-835-0535	What is depreciation expense?	388-835-0760	What if DSHS conducts an audit during the final settlement process?
388-835-0540	Can providers claim depreciation on assets that are abandoned, retired or disposed of in some other way?	388-835-0765	Why is a state facility settlement important?
<b>GAINS AND LOSSES ON RETIRED ASSETS</b>			
388-835-0545	How must providers account for gains and losses on the retirement of tangible assets?	388-835-0770	How is a state facility settlement calculated?
388-835-0550	How are gains and losses calculated when a tangible asset is retired?	388-835-0775	How is a state facility settlement implemented?
388-835-0555	How must providers account for gains and losses on retired assets that are replaced?	388-835-0780	Does DSHS have a responsibility to notify each provider regarding prospective reimbursement rates?
388-835-0560	How must providers account for gains and losses on retired assets that are not replaced?	388-835-0785	Can DSHS increase prospective reimbursement rates?
388-835-0565	How must providers account for gains and losses on retired assets if they terminate their contract with DSHS?	388-835-0790	How does a provider request a rate increase?
388-835-0570	Can DSHS recover reimbursements for depreciation expense?	388-835-0795	What requirements apply to providers who receive rate increases?
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388-835-0575	What requirements apply to calculating ICF/MR reimbursement rates?	388-835-0800	What if DSHS discovers that a prospective rate calculation was affected by an error or omission?
388-835-0580	What program services are not covered by DSHS prospective reimbursement rates?	388-835-0805	What if a provider discovers an error or omission that affected their cost report?
388-835-0585	What requirements apply to prospective reimbursement rates for new providers?	388-835-0810	What other requirements apply to rate adjustments resulting from errors or omissions?
388-835-0590	How are reimbursement rates calculated?	388-835-0815	What requirements apply to repayment of amounts owed due to errors or omissions?
388-835-0595	When does DSHS review a provider's annual cost report?	<b>PUBLIC REVIEW—PUBLIC DISCLOSURE</b>	
388-835-0600	What is the purpose of reviewing a provider's annual cost report?	388-835-0820	What role does the public play in setting prospective reimbursement rates?
388-835-0605	What is the scope of an annual cost report review?	388-835-0825	What is DSHS' public disclosure responsibility regarding rate setting methodology?
388-835-0610	Can DSHS accumulate cost report information and use it for department purposes?	<b>BILLING PROCEDURES AND PAYMENTS</b>	
388-835-0615	What are component rates and cost centers?	388-835-0830	How does a provider bill DSHS for services provided?
388-835-0620	What reimbursement requirements apply to resident care and habilitation cost centers?	388-835-0835	How does DSHS pay a provider?
388-835-0625	What requirements apply to administration, operations and property cost center rates?	388-835-0840	Can DSHS withhold provider payments?
388-835-0630	What is the food rate component?	388-835-0845	Can DSHS terminate Medicaid Title XIX payments to providers?
388-835-0635	Is there a limit to the allowable cost for administrative personnel?	388-835-0850	Who is responsible for collecting from residents any amounts they may own for their care?
		388-835-0855	What if a resident's circumstances change causing a provider to contribute more to the resident's care?

## RECEIVERSHIP

- 388-835-0860 What is the role of a receiver when an ICF/MR facility is placed in receivership? 388-835-035 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-0865 How does DSHS determine prospective reimbursement rates during receivership? 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.
- 388-835-0870 What if the court asks DSHS to recommend a receiver's compensation? 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.
- 388-835-0875 Can DSHS give emergency or transitional financial assistance to a receiver? 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.
- 388-835-0880 What happens when a receivership ends? 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.

## DISPUTE RESOLUTION

- 388-835-0885 What disputes between providers and DSHS can be resolved through the administrative review process? 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.
- 388-835-0890 What disputes cannot be resolved through the administrative review and fair hearing processes? 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.
- 388-835-0900 How does a provider request an administrative review? 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.
- 388-835-0905 What happens after a provider requests an administrative review? 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.
- 388-835-0910 What if a provider disagrees with the administrative review decision? 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.
- 388-835-0915 Can DSHS withhold an undisputed overpayment amount from a current ICF/MR payment? 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.
- 388-835-0920 Can DSHS withhold a disputed overpayment amount from a current ICF/MR payment? 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.

## COST OF CARE OF MENTALLY DEFICIENT PERSONS RESIDING IN STATE INSTITUTIONS

- 388-835-0925 What is the purpose of this section? 388-835-090 What is the payment for residential facilities set? 388-835-0935 How much of a resident's income is exempt from paying their care? 388-835-0940 What if the estate of a resident is able to pay all or a portion of their monthly cost? 388-835-0945 If a resident or guardian is served by DSHS with a NFR when is payment due? 388-835-0950 May a resident or guardian request a hearing if they disagree with the NFR? 388-835-0955 What information must be included in the request for a hearing?

## 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.



- 388-835-090 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.	388-835-280	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.
388-835-220	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.	388-835-285	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.
388-835-225	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.	388-835-290	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.
388-835-230	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.	388-835-295	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.
388-835-235	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.	388-835-300	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.
388-835-240	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.	388-835-305	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.
388-835-245	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.	388-835-310	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.
388-835-250	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.	388-835-315	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.
388-835-255	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.	388-835-320	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.
388-835-260	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.	388-835-325	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.
388-835-265	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.	388-835-330	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.
388-835-270	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.	388-835-335	Depreciable assets. [99-19-104, recodified as § 388-835-335, filed 9/20/99, effective 9/20/99. Statutory
388-835-275	Limit on costs to related organizations. [99-19-104, recodified as § 388-835-275, filed 9/20/99, effective		

- 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.

### PURPOSE

**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.]

### DEFINITIONS

**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.]

(2003 Ed.)

**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

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(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.]

### EXEMPTIONS

**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.]

### GENERAL REQUIREMENTS

**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 nursing 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.]

[Title 388 WAC—p. 1096]

**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.]

(2003 Ed.)

**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 re-determination 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.]

#### PLACEMENT—TRANSFER—RELOCATION— DISCHARGE

**WAC 388-835-0070 What requirements apply to the placement of individuals in an ICF/MR facility?** (1) Placing 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

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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 pre-transfer 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;

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(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 388-835-0100 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 388-835-0055 requires that DSHS give the resident and their guardian, next of kin, or responsible party thirty days notice, in writing, of its 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 its intent to transfer the resident.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0110, filed 7/25/02, effective 8/25/02. 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 its 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 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, § 388-835-0140, filed 4/20/01, effective 5/21/01.]

## DISCHARGE/READMISSION AND INCIDENT REPORTING

**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.

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[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0145, filed 4/20/01, effective 5/21/01.]

**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.]

## SOCIAL LEAVE FOR ICF/MR RESIDENTS

**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.]

## SUPERINTENDENT'S AUTHORITY TO DETAIN A RESIDENT

**WAC 388-835-0160 Can residential habilitation center (RHC) superintendents involuntarily detain residents?** (1) When an RHC resident decides to initiate a voluntary 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.]

[Title 388 WAC—p. 1099]



**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.]

### ICF/MR CONTRACTS

**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 388-835-0185.

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(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.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0180, filed 7/25/02, effective 8/25/02. 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 388-835-0200 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 sub-

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mits 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.]

## PROSPECTIVE COST RELATED REIMBURSEMENT SYSTEM

**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

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(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.]

### FILING COST REPORTS

**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

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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 388-835-0250 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.

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(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 statutes, 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 388-835-0335 must be filed with the amendment.

(4) Any adjustments to reimbursement rates resulting from an amended report will be made according to WAC 388-835-0885.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0265, filed 7/25/02, effective 8/25/02. 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.]

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**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 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.]

## MAINTAINING COST REPORT RECORDS

**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

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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.]

## FIELD AUDITS

**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.

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[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.]

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**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.]

## RESIDENT TRUST ACCOUNTS

**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.

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[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 388-835-0350 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.

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(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 bank's 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 per-

son 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 388-835-0380).

(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.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0395, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0395, filed 4/20/01, effective 5/21/01.]

## ALLOWABLE AND UNALLOWABLE COSTS

**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.

(2003 Ed.)

[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.

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(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 organization 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.

(2003 Ed.)

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0445, filed 4/20/01, effective 5/21/01.]

**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.]

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**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.]

### CAPITALIZED COSTS AND DEPRECIATION

**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;

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(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;

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- (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 388-835-0500 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.]

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**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.]

### **GAINS AND LOSSES ON RETIRED ASSETS**

**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 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 388-835-0550 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

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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.]

### **REIMBURSEMENT RATES**

**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 facil-

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ities 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, 388-835-0865, 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.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0575, filed 7/25/02, effective 8/25/02. 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

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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 388-835-0600 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

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(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 it 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, however, 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:

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(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 388-835-0650 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.]

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**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 388-835-0700 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.]

## SETTLEMENTS

**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 388-835-0955). After thirty days, if the preliminary settlement report has not been contested, it cannot be reviewed.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0745, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0745, filed 4/20/01, effective 5/21/01.]

**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 388-835-0955). After thirty days, if the final settlement report has not been contested, it cannot be reviewed.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0755, filed 7/25/02, effective 8/25/02. 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

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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.]

## ERRORS AND OMISSIONS

**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.]

**PUBLIC REVIEW—PUBLIC DISCLOSURE**

**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,

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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.]

**BILLING PROCEDURES AND PAYMENTS**

**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 388-835-0850 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

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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.]

## RECEIVERSHIP

**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.

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(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.]

## DISPUTE RESOLUTION

**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 388-835-0900 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.]

### **COST OF CARE OF MENTALLY DEFICIENT PERSONS RESIDING IN STATE INSTITUTIONS**

**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 treatment, 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.]

(2003 Ed.)

**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.]

### **Chapter 388-840 WAC**

#### **WORK PROGRAMS FOR RESIDENTS OF RESIDENTIAL HABILITATION CENTERS IN THE DIVISION OF DEVELOPMENTAL DISABILITIES**

(Formerly chapter 275-41 WAC)

#### **WAC**

388-840-005	Purpose.
388-840-010	Definition.
388-840-015	Establishment of new work programs.
388-840-020	Protection of residents.
388-840-025	Compensation for persons participating in work programs.

**WAC 388-840-005 Purpose.** The regulations provide guidelines for the operation of work programs at residential habilitation centers or for programs contracted on behalf of residents of residential habilitation centers within the division of developmental disabilities as required under RCW 43.20A.445.

[99-19-104, recodified as § 388-840-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-005, filed 8/9/91, effective 9/9/91.]

**WAC 388-840-010 Definition.** (1) "Compensate" means the resident's receipt of money for work done at a work program.

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

(3) "Division" means the developmental disabilities division of the department of social and health services.

(4) "Prevailing wage" means the amount paid to a non-disabled worker in a nearby industry or surrounding community for essentially the same type, quality, and quantity of work or work requiring comparable skills.

(5) "Residential habilitation center (RHC)" means a residential habilitation center operated by the developmental disabilities division.

(6) "Work program" means a directed vocational activity or series of related activities provided on a systematic, organized basis for developing and maintaining individual resi-

[Title 388 WAC—p. 1123]



dent work skills, and providing remuneration to resident employees. Work programs must result in:

- (a) Benefit to the economy of the facility; or
- (b) A contribution to the facility's maintenance; or
- (c) Produce articles or services for sale.

[99-19-104, recodified as § 388-840-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-010, filed 8/9/91, effective 9/9/91.]

**WAC 388-840-015 Establishment of new work programs.** The requirements of RCW 43.20A.445 shall be followed before the department establishes new residential habilitation center work programs.

[99-19-104, recodified as § 388-840-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-015, filed 8/9/91, effective 9/9/91.]

**WAC 388-840-020 Protection of residents.** (1) When a resident participates in a work program, the resident shall be employed in work and subjected to work conditions where reasonable precautions are taken to ensure the resident's health and safety.

(2) Resident work programs shall be consistent with the resident's individual habilitation plan objectives.

[99-19-104, recodified as § 388-840-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-020, filed 8/9/91, effective 9/9/91.]

**WAC 388-840-025 Compensation for persons participating in work programs.** (1) The department shall compensate a person participating in a work program at the prevailing minimum wage except when an appropriate certificate has been obtained by the RHC or contract program in accordance with current regulations and guidelines issued under the Fair Labor Standards Act (29 CFR Ch. V, 525 and 529) as amended.

(2) The department shall not be required to compensate a person participating in the shared domiciliary activities of maintaining the person's own immediate household or residence.

[99-19-104, recodified as § 388-840-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-025, filed 8/9/91, effective 9/9/91.]

**Chapter 388-850 WAC**

**COUNTY PLAN FOR DEVELOPMENTAL DISABILITIES**

(Formerly chapter 275-25 WAC)

**WAC**

388-850-010	Definitions.
388-850-015	Exemptions.
388-850-020	Plan development and submission.
388-850-025	Program operation—General provisions.
388-850-030	Appeal procedure.
388-850-035	Services—Developmental disabilities.
388-850-040	Rights—Health and safety assured.
388-850-045	Funding formula—Developmental disabilities.
388-850-050	Client rights—Notification of client.

**WAC 388-850-010 Definitions.** (1) All terms used in this chapter not defined herein shall have the same meaning as indicated in the act.

(2) "Act" means local funds for community services chapter 71.20 RCW, State services chapter 71A.12 RCW, and Local services chapter 71A.14 RCW as now existing or hereafter amended.

(3) "County" means each county or two or more counties acting jointly.

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

(5) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

(6) "Indian" shall mean any:

(a) Person enrolled in or eligible for enrollment in a recognized Indian tribe; any person determined to be or eligible to be found to be an Indian by the secretary of the interior; and any Eskimo, Aleut or other Alaskan native;

(b) Canadian Indian person who is a member of a treaty tribe, Metis community, or other nonstatus Indian community from Canada;

(c) Unenrolled Indian person considered an Indian by a federally or nonfederally recognized Indian tribe or by an urban Indian/Alaska community organization.

(7) "Plan" means the application a county submits to the secretary for review and approval under the act(s); or revision of an existing plan.

(8) "Population" means the most recent estimate of the aggregate number of persons located in the designated county as computed by the office of financial management.

(9) "Secretary" means the secretary of the department or such employee or such unit of the department as the secretary may designate.

[99-19-104, recodified as § 388-850-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234. 93-15-013 (Order 3591), § 275-25-010, filed 7/8/93, effective 8/8/93. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-010, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-010, filed 1/12/83; Order 1142, § 275-25-010, filed 8/12/76. Formerly chapters 275-12, 275-13 and 275-29 WAC.]

**WAC 388-850-015 Exemptions.** (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 388-850-010(5) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-850-015, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-850-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-015, filed 8/9/91, effective 9/9/91.]

**WAC 388-850-020 Plan development and submission.** (1) All dates in this section refer to the twenty-four-month period prior to the start of the state fiscal biennium.

(2) Before July 1, in the odd year of each biennium, the department shall negotiate with and submit to counties the biennial plan guidelines.

(3) Before July 1, the department shall submit to counties needs assessment data, and before December 31, updated needs assessment data in the odd year of each biennium.

(4) Before April 1, of the even year of each biennium, each county shall submit to the department a written plan for developmental disabilities services for the subsequent state fiscal biennium. The county's written plan shall be in the form and manner prescribed by the department in the written guidelines.

(5) Within sixty days of receipt of the county's written plan, the department shall acknowledge receipt, review the plan, and notify the county of errors and omissions in meeting minimum plan requirements.

(6) Within thirty days after receipt, each county shall submit a response to the department's review when errors and omissions have been identified within the review.

(7) Before December 15 of the even year of each biennium, the department shall announce the amount of funds included in the department's biennial budget request to each county. The department shall announce the actual amount of funds appropriated and available to each county as soon as possible after final passage of the Biennial Appropriations Act.

(8) Each county shall submit to the department a contract proposal within sixty days of the announcement by the department of the actual amount of funds appropriated and available.

(9) The department may modify deadlines for submission of county plans and responses to reviews or contract proposals when, in the department's judgment, the modification enables the county to improve the program or planning process.

(10) The department may authorize the county to continue providing services in accordance with the previous plan and contract, and reimburse at the average level of the previous contract, in order to continue services until the new contract is executed.

[99-19-104, recodified as § 388-850-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030 and 71A.16.020, 92-09-115 (Order 3373), § 275-25-020, filed 4/21/92, effective 5/21/92. Statutory Authority: RCW 69.54.040 and 71.24.190, 83-03-011 (Order 1936), § 275-25-020, filed 1/12/83. Statutory Authority: RCW 69.54.040, 78-08-086 (Order 1322), § 275-25-020, filed 7/28/78; Order 1142, § 275-25-020, filed 8/12/76.]

**WAC 388-850-025 Program operation—General provisions.** (1) The provisions of this section shall apply to all programs operated under authority of the acts.

(2) The county and all contractors and subcontractors must comply with all applicable law or rule governing the department's approval of payment of funds for the programs. Verification may be in the manner and to the extent requested by the secretary.

(3) State funds shall not be paid to a county for costs of services provided by the county or other person or organization who or which was not licensed, certified, and approved

as required by law or by rule whether or not the plan was approved by the secretary.

(4) The secretary may impose such reasonable fiscal and program reporting requirements as the secretary deems necessary for effective program management.

**(5) Funding.**

(a) The department and county shall negotiate and execute a contract before the department provides reimbursement for services under contract, except as provided under WAC 388-850-020(10).

(b) Payments to counties shall be made on the basis of vouchers submitted to the department for costs incurred under the contract. The department shall specify the form and content of the vouchers.

(c) The secretary may make advance payments to counties, where such payments would facilitate sound program management. The secretary shall withhold advance payments from counties failing to meet the requirements of WAC 388-850-020 until such requirements are met. Any county failing to meet the requirements of WAC 388-850-020 after advance payments have been made shall repay said advance payment within thirty days of notice by the department that the county is not in compliance.

(d) If the department receives evidence a county or subcontractor performing under the contract is:

- (i) Not in compliance with applicable state law or rule; or
- (ii) Not in substantial compliance with the contract; or

(iii) Unable or unwilling to provide such records or data as the secretary may require, then the secretary may withhold all or part of subsequent monthly disbursement to the county until such time as satisfactory evidence of corrective action is forthcoming. Such withholding or denial of funds shall be subject to appeal under the Administrative Procedure Act (chapter 34.05 RCW).

(6) **Subcontracting.** A county may subcontract for the performance of any of the services specified in the contract. The county's subcontracts shall include:

(a) A precise and definitive work statement including a description of the services provided;

(b) The subcontractor's specific agreement to abide by the acts and the rules;

(c) Specific authority for the secretary and the state auditor to inspect all records and other material the secretary deems pertinent to the subcontract; and agreements by the subcontractor that such records will be made available for inspection;

(d) Specific authority for the secretary to make periodic inspection of the subcontractor's program or premises in order to evaluate performance under the contract between the department and the county; and

(e) Specific agreement by the subcontractor to provide such program and fiscal data as the secretary may require.

(7) **Records: Maintenance.** Client records shall be maintained for every client for whom services are provided and shall document:

(a) Client demographic data;

(b) Diagnosis or problem statement;

(c) Treatment or service plan; and

(d) Treatment or services provided including medications prescribed.

**(8) Liability.**

(a) The promulgation of these rules or anything contained in these rules shall not be construed as affecting the relative status or civil rights or liabilities between:

- (i) The county and community agency; or
- (ii) Any other person, partnership, corporation, association, or other organization performing services under a contract or required herein and their employees, persons receiving services, or the public.

(b) The use or implied use herein of the word "duty" or "responsibility" or both shall not import or imply liability other than provided for by the statutes or general laws of the state of Washington, to any person for injuries due to negligence predicated upon failure to perform on the part of an applicant, or a board established under the acts, or an agency, or said agency's employees, or persons performing services on said agency's behalf.

(c) Failure to comply with any compulsory rules shall be cause for the department to refuse to provide the county and community agency funds under the contract.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-850-025, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-850-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-030, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-030, filed 1/12/83; Order 1142, § 275-25-030, filed 8/12/76.]

**WAC 388-850-030 Appeal procedure.** (1) Any agency making application to participate in a county program operated under authority of the act(s), which is dissatisfied with the disposition of its application, or the community board(s) as defined in the act(s) or the community social services board, which is dissatisfied with any aspect of the plan, may appeal for a hearing before the county governing body. The county governing body shall review the appeal and notify the agency or board of its disposition within thirty days after the appeal has been received.

(2) A county which is dissatisfied with the department's disposition of its plan may request an administrative review.

(3) All requests for administrative reviews shall:

- (a) Be made in writing to the appropriate program office within the department;
- (b) Specify the date of the decision being appealed;
- (c) Specify clearly the issue to be resolved by the review;
- (d) Be signed by, and include the address of the county or its representative;

(e) Be made within thirty days of notification of the decision which is being appealed.

(4) An administrative review and redetermination shall be provided by the department within thirty days of the submission of the request for review, with written confirmation of the findings and the reasons for the findings to be forwarded to the county as soon as possible.

(5) Any county dissatisfied with the finding of an administrative review or who chooses not to request an administrative review may initiate proceedings pursuant to the Administrative Procedure Act (chapter 34.05 RCW).

[99-19-104, recodified as § 388-850-030, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234.

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93-15-013 (Order 3591), § 275-25-040, filed 7/8/93, effective 8/8/93; Order 1142, § 275-25-040, filed 8/12/76.]

**WAC 388-850-035 Services—Developmental disabilities.** (1) A county may purchase and provide services listed under chapter 71A.14 RCW. The department shall pay a county for department authorized services provided to an eligible developmentally disabled person.

(2) A county may purchase or provide authorized services. Authorized services may include, but are not limited to:

- (a) Early childhood intervention services;
- (b) Employment services;
- (c) Community access services;
- (d) Residential services;
- (e) Individual evaluation;
- (f) Program evaluation;
- (g) County planning and administration; and
- (h) Consultation and staff development.

[99-19-104, recodified as § 388-850-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-520, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-25-520, filed 3/1/82. Statutory Authority: RCW 71.20.030, 71.20.050, and 71.20.070. 78-04-002 (Order 1278), § 275-25-520, filed 3/2/78; Order 1142, § 275-25-520, filed 8/12/76.]

**WAC 388-850-040 Rights—Health and safety assured.** A county, when contracting for specific services, must assure that client rights and client health and safety are protected.

[99-19-104, recodified as § 388-850-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-25-527, filed 3/1/82.]

**WAC 388-850-045 Funding formula—Developmental disabilities.** (1) For the purposes of this section, "county" shall mean the legal subdivision of the state, regardless of any agreement with another county to provide developmental disabilities services jointly.

(2) The allocation of funds to counties shall be based on the following criteria:

(a) Each county shall receive a base amount of funds. The amount shall be based on the prior biennial allocation, including any funds from budget provisos from the prior biennium, and subject to the availability of state and federal funds;

(b) The distribution of any additional funds provided by the legislature or other sources shall be based on a distribution formula which best meets the needs of the population to be served as follows:

(i) On a basis which takes into consideration minimum grant amounts, requirements of clients residing in an ICF/MR or clients on one of the division's Title XIX home and community-based waivers, and the general population of the county, and special education enrollment as well as the population eligible for county-funded developmental disabilities services;

(ii) On a basis that takes into consideration the population numbers of minority groups residing within the county;

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## Chapter 388-853 WAC

## COSTS OF CARE OF MENTALLY DEFICIENT PERSONS RESIDING IN STATE INSTITUTIONS

(Formerly chapter 275-20 WAC)

(iii) A biennial adjustment shall be made after these factors are considered; and

(iv) Countries not receiving any portion of additional funds pursuant to this formula shall not have their base allocation reduced due to application of this formula.

(c) Funding appropriated through legislative proviso, including vendor rate increases, shall be distributed to the population directed by the legislature utilizing a formula as directed by the legislature or using a formula specific to that population or distributed to identified people;

(d) The ability of the community to provide funds for the developmental disability program provided in chapter 71A.14 RCW may be considered with any or all of the above.

(3) A county may utilize seven or less percent of the county's allocated funds for county administrative expenses. A county may utilize more than seven percent for county administration with approval of the division director. A county electing to provide all services directly, in addition to county administration, is exempt from this requirement.

(4) The department may withhold five or less percent of allocated funds for new programs, for statewide priority programs, and for emergency needs.

[99-19-104, recodified as § 388-850-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.040, 92-13-032 (Order 3404), § 275-25-530, filed 6/10/92, effective 7/11/92. Statutory Authority: RCW 71A.14.030, 91-17-005 and 91-17-025 (Orders 3230 and 3230A), § 275-25-530, filed 8/9/91 and 8/14/91, effective 9/9/91 and 9/14/91. Statutory Authority: RCW 69.54.040 and 71.24.190, 83-03-011 (Order 1936), § 275-25-530, filed 1/12/83; Order 1142, § 275-25-530, filed 8/12/76.]

**WAC 388-850-050 Client rights—Notification of client.** (1) All agencies providing services under the act shall post a statement of client rights. Such statement shall inform the client of the client's right to:

- (a) Be treated with dignity;
- (b) Be protected from invasion of privacy;
- (c) Have information about him/her treated confidentially;
- (d) Actively participate in the development or modification of his/her treatment program;

(e) Be provided treatment in accordance with accepted quality-of-care standards and which is responsive to his/her best interests and particular needs;

(f) Review his/her treatment records with the therapist at least bimonthly: Provided, That information confidential to other individuals shall not be reviewed by the client;

(g) Be fully informed regarding fees to be charged and methods for payment.

(2) Clients shall be informed of their rights pursuant to WAC 388-865-0515 upon admission to inpatient service.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125, 02-16-014, § 388-850-050, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-850-050, filed 9/20/99, effective 9/20/99; Order 1142, § 275-25-755, filed 8/12/76.]

(2003 Ed.)

## WAC

388-853-010	Authority.
388-853-030	Schedule of per capita cost.
388-853-035	Exempt income.
388-853-080	Notice and finding of responsibility—Appeal procedure.

**WAC 388-853-010 Authority.** The following rules regarding costs of care of mentally/physically deficient persons are hereby adopted under the authority of chapter 72.01 RCW.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125, 02-16-014, § 388-853-010, filed 7/25/02, effective 8/25/02; 00-17-151, recodified as § 388-853-010, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.01.090, 78-03-029 (Order 1270), § 275-20-010, filed 2/17/78; Order 2, § 275-20-010, filed 2/23/68.]

**WAC 388-853-030 Schedule of per capita cost.** Resident charges will be established in accordance with the methodology promulgated under chapter 388-835 WAC.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125, 02-16-014, § 388-853-030, filed 7/25/02, effective 8/25/02; 00-17-151, recodified as § 388-853-030, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.33.660, 84-18-022 (Order 2144), § 275-20-030, filed 8/29/84. Statutory Authority: RCW 72.33.600, 83-18-028 (Order 2018), § 275-20-030, filed 8/31/83; 82-20-022 (Order 1885), § 275-20-030, filed 9/29/82; 81-17-025 (Order 1690), § 275-20-030, filed 8/12/81; 81-06-004 (Order 1611), § 275-20-030, filed 2/19/81; 80-12-011 (Order 1535), § 275-20-030, filed 8/25/80; 80-02-060 (Order 1480), § 275-20-030, filed 1/18/80; 79-08-044 (Order 1418), § 275-20-030, filed 7/19/79; 78-10-057 (Order 1341), § 275-20-030, filed 9/22/78. Statutory Authority: RCW 72.01.090, 78-03-029 (Order 1270), § 275-20-030, filed 2/17/78; Order 1191, § 275-20-030, filed 2/18/77; Order 1071, § 275-20-030, filed 12/2/75; Order 982, § 275-20-030, filed 11/14/74, effective 1/1/75; Order 903, § 275-20-030, filed 1/29/74; Order 808, § 275-20-030, filed 6/15/73, effective 8/1/73; Order 15, § 275-20-030, filed 5/11/71; Order 2, § 275-20-030, filed 2/23/68.]

**WAC 388-853-035 Exempt income.** Residents whose total resources are insufficient to pay the actual cost of care shall be entitled to a monthly exemption from income in the amount of twenty-five dollars or such amount as specified in chapter 388-835 WAC.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125, 02-16-014, § 388-853-035, filed 7/25/02, effective 8/25/02; 00-17-151, recodified as § 388-853-035, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.01.090, 78-03-029 (Order 1270), § 275-20-035, filed 2/17/78.]

**WAC 388-853-080 Notice and finding of responsibility—Appeal procedure.** (1) When the department determines that the estate of a resident of a state residential habilitation center is able to pay all or a portion of the monthly charges for care, support, and treatment, the department shall serve a notice and finding of responsibility (NFR) on the:

- (a) Guardian of the resident's estate; or
- (b) If a guardian has not been appointed, resident's spouse or parent or other person acting in a representative

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capacity and in possession of the resident's property, and the superintendent of the state school.

(2) When a resident is an adult and is not under a legal disability, the department shall personally serve the NFR on the resident.

(3) The NFR shall state the amount which the department determines the resident's estate is able to pay per month. The amount shall not exceed the monthly charges fixed under RCW 43.20B.420.

(4) The resident's or guardian's responsibility for payment to the department shall commence twenty-eight days after service of the NFR.

(5) The right to an adjudicative proceeding contesting the NFR is contained in RCW 43.20B.430.

(a) A financially responsible person wishing to contest the NFR shall, within twenty-eight days of receipt of the NFR:

(i) File a written application for an adjudicative proceeding showing proof of receipt with the Secretary, DSHS, Attn: Determination Officer, P.O. Box 9768, Olympia, WA 98504; and

(ii) Include in or with the application:

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

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

(C) A copy of the NFR being contested.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20B.430, this chapter, and chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-853-080, filed 7/25/02, effective 8/25/02; 00-17-151, recodified as § 388-853-080, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 71.05.560. 90-21-030 (Order 3083), § 275-20-080, filed 10/9/90, effective 11/9/90. Statutory Authority: RCW 34.05.220 (1)(a) and 43.20B.420. 90-04-074 (Order 2997), § 275-20-080, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 72.33.660. 79-08-044 (Order 1418), § 275-20-080, filed 7/19/79.]

### Chapter 388-855 WAC

#### LIABILITY FOR COSTS OF CARE AND HOSPITALIZATION OF THE MENTALLY ILL

(Formerly chapter 275-16 WAC)

#### WAC

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388-855-0030	Schedule of charges.
388-855-0035	Available assets of estate of patients and responsible relatives.
388-855-0045	Exempt income.
388-855-0055	Notice and finding of responsibility (NFR)—Appeal procedure.
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388-855-0075	Unusual and exceptional circumstances.
388-855-0085	Other pertinent factors.
388-855-0095	Failure to cooperate with department.
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**WAC 388-855-0010 Authority.** The following rules regarding hospitalization charges are hereby adopted under the authority of Title 71 RCW.

[Title 388 WAC—p. 1128]

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0010, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-010, filed 3/25/81. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-16-010, filed 2/17/78; Order 1, § 275-16-010, filed 2/23/68; Emergency Rules (part), filed 1/26/68, 10/24/67, and 8/2/67.]

**WAC 388-855-0015 Definitions. "Adjusted charges"** are those [charges levied upon] [amounts charged to] a patient who is or has been confined to a state hospital for the mentally ill, either by voluntary or involuntary admission, and their estates and responsible relatives, which are less than the actual cost of hospitalization as reflected in the schedule of charges herein and which has been established by the issuance of a notice of finding of responsibility.

**"Adjusted gross income"** is that gross income of the estate of the patient and responsible relatives less any deductions, contributions or payments mandated by law including, but not necessarily limited to, income tax and social security.

**"Dependent"** means any spouse, minor son or daughter, or permanently disabled son or daughter, of the patient living in the patient's household. If the patient is a minor, then the same definitions shall apply in determining the dependency of members of the parent's household. If a minor son or daughter is not living in the patient's household, that son or daughter shall not be considered a dependent unless the patient is in fact contributing more than fifty percent of that child's support in accordance with a court order or court-recognized agreement.

**"Department"** means the department of social and health services.

**"Determination officer"** is that duly appointed and qualified claims investigator who is delegated authority by the secretary to conduct or cause to have conducted an investigation of the financial condition of the estate of the patient and responsible relatives; to evaluate the results of such investigations; to make determinations of the ability to pay hospitalization charges from such investigations and evaluations; and to issue notices of findings of responsibility to the responsible parties.

**"Estate of patient and responsible relative"** means the total assets available to the patient and his responsible relatives to reimburse the department for hospitalization charges incurred by the patient in a state hospital for the mentally ill in accordance with these regulations.

**"Gross income"** means the total assets available to the estate of the patient and responsible relatives expressed in terms of their cash equivalent on a monthly basis. The total assets available to the estate of the patient and responsible relatives are converted to a monthly cash equivalent figure by dividing those assets by twelve months. Gross income includes all of the following calculated prior to any mandatory deductions; gross wages for service; net earnings from self-employment; and all other assets divided by twelve months.

**"Responsible relative"** includes the spouse of a patient, or the parent of a patient who is under eighteen years of age.

**"Secretary"** means the secretary of the department of social and health services.

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[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0015, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412], 81-08-020 (Order 1627), § 275-16-015, filed 3/25/81.]

**Reviser's note:** RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

**WAC 388-855-0030 Schedule of charges.** Under RCW 43.20B.325, the department shall base hospitalization charges for patients in state hospitals on the actual operating costs of such hospitals. The department shall require patient's hospitalization charges due and payable on or before the tenth day of each calendar month for services rendered to department patients during the preceding month. A schedule of each hospital's charge rates will be computed under this section based on actual operating costs of the hospital for the previous year. The schedule will be prepared by the secretary's designee, from financial and statistical information contained in hospital records. The schedule will be updated at least annually. All changes under this section shall be prepared in advance of the effective date. Each hospital will make available the schedule of current charge rates upon request.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0030, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.325, 94-16-048 (Order 3764), § 275-16-030, filed 7/27/94, effective 8/27/94; 93-22-031 (Order 3659), § 275-16-030, filed 10/27/93, effective 11/27/93; 92-17-007 (Order 3434), § 275-16-030, filed 8/6/92, effective 9/6/92; 92-09-118 (Order 3376), § 275-16-030, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 43.20B.335, 91-21-122 (Order 3267), § 275-16-030, filed 10/23/91, effective 11/23/91; 91-17-064 (Order 3235), § 275-16-030, filed 8/20/91, effective 9/20/91; 91-08-014 (Order 3155), § 275-16-030, filed 3/26/91, effective 4/26/91. Statutory Authority: RCW 43.20B.335 and 71.05.560. 90-18-004 (Order 3061), § 275-16-030, filed 8/23/90, effective 9/23/90. Statutory Authority: RCW 71.02.412, 89-22-128 (Order 2890), § 275-16-030, filed 11/1/89, effective 12/2/89. Statutory Authority: RCW 43.20B.335, 88-21-095 (Order 2715), § 275-16-030, filed 10/19/88. Statutory Authority: RCW 71.02.412, 87-19-026 (Order 2531), § 275-16-030, filed 9/10/87; 86-17-075 (Order 2414), § 275-16-030, filed 8/19/86; 85-17-038 (Order 2273), § 275-16-030, filed 8/15/85; 84-17-011 (Order 2131), § 275-16-030, filed 8/3/84; 83-18-029 (Order 2019), § 275-16-030, filed 8/31/83; 82-17-070 (Order 1866), § 275-16-030, filed 8/18/82; 80-06-087 (Order 1508), § 275-16-030, filed 5/28/80. Statutory Authority: RCW 72.01.090. 79-03-019 (Order 1372), § 275-16-030, filed 2/21/79; 78-03-029 (Order 1270), § 275-16-030, filed 2/17/78; Order 1190, § 275-16-030, filed 2/18/77; Order 1086, § 275-16-030, filed 1/15/76; Order 1002, § 275-16-030, filed 1/14/75; Order 947, § 275-16-030, filed 6/26/74; Order 812, § 275-16-030, filed 6/28/73; Order 14, § 275-16-030, filed 5/11/71; Order 6, § 275-16-030, filed 1/10/69; Order 1, § 275-16-030, filed 2/23/68; Emergency Rules (part), filed 1/26/68, 10/24/67, 8/2/67, and 7/28/67.]

**WAC 388-855-0035 Available assets of estate of patients and responsible relatives.** (1) The department will include, but not necessarily be limited to, in their determination of the assets of the estates of present and former patients of state hospitals for the mentally ill and their responsible relatives, cash, stocks, bonds, savings, security interests, insurance benefits, guardianship funds, trust funds, governmental benefits, pension benefits and personal property.

(2) Real property shall also be an available asset to the estate: Provided, That the patient's home shall not be considered an available asset if that property is owned by the estate and serves as the principal dwelling and actual residence of

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the patient, the patient's spouse, and/or minor children and disabled sons or daughters: Provided further, That if the home is not being used for residential purposes by the patient, the patient's spouse, and/or minor children and disabled sons or daughters, and in the opinion of two physicians, there is no reasonable expectancy that the patient will be able to return to the home during the remainder of his life, the home shall be considered an asset available to the estate.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0035, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412], 81-08-020 (Order 1627), § 275-16-035, filed 3/25/81.]

**WAC 388-855-0045 Exempt income.** Patients whose total resources are insufficient to pay for the actual cost of care shall be entitled to a monthly exemption from income in the amount of forty-one dollars and sixty-two cents or such amount as specified in WAC 388-478-0040.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0045, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 388-16-045 (codified as WAC 275-16-045), filed 2/17/78.]

**WAC 388-855-0055 Notice and finding of responsibility (NFR)—Appeal procedure.** (1) The determination officer's assessment of the ability and liability of a person or of the person's estate to pay hospitalization charges shall be issued in the form of a notice and finding of responsibility (NFR) as prescribed by RCW 43.20B.340.

(2) When the NFR is for full hospitalization charges as specified under WAC 388-855-0030, the department shall:

(a) Inform the financially responsible person of the current charges; and

(b) Periodically recompute the financially responsible person's charges.

(3) When the NFR is for adjusted charges, the department shall:

(a) Express the charges in a daily or monthly rate; and

(b) Set aside charges for ancillary services.

(4) The right to an adjudicative proceeding to contest the NFR is contained in RCW 43.20B.340.

(a) A financially responsible person wishing to contest the NFR shall, within twenty-eight days of receipt of the NFR:

(i) File a written application for an adjudicative proceeding showing proof of receipt with the Secretary, DSHS, Attn: Determination Officer, P.O. Box 9768, Olympia, WA 98504; and

(ii) Include in or with the application:

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

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

(C) A copy of the contested NFR.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20B.340, this chapter, and chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0055, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 71.05.560. 90-21-030 (Order 3083), § 275-16-



055, filed 10/9/90, effective 11/9/90. Statutory Authority: RCW 34.05.220 (1)(a) and 43.20B.335. 90-04-075 (Order 3001), § 275-16-055, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-055, filed 3/25/81.]

**WAC 388-855-0065 Determination of liability.** (1) In determining the ability of the estate of the patient and responsible relative to pay hospitalization charges, first priority shall be given to any third party benefits which might be available. The availability of third party benefits, such as medical insurance, health insurance, Medicare, Medicaid, CHAMPUS, CHAMPVA, shall be considered as an available asset of the estate and shall justify a finding for actual costs of hospitalization during such period as the coverage is in effect.

(2) In the absence of third party benefits, charges shall be based upon the available assets of the estate giving consideration to any unusual and exceptional circumstances and other pertinent factors. No financial determination of the ability of the estate to pay hospitalization charges shall conflict with the eligibility requirements for Medicaid for those patients who are eligible or potentially eligible for such benefits.

(3) The ability of the estate to pay adjusted charges will be determined by applying the following formula:

$$X = (Z-E)F$$

Where  $Z = (A-Y-N-R) \div D$

Z = available income per family member  
 X = adjusted charges (daily)  
 A = gross income  
 Y = mandatory deductions  
 N = allowance for unusual and exceptional circumstances  
 R = allowance for other pertinent factors  
 D = number of dependents  
 E = exempt income  
 F = a factor which converts the monthly figures to a daily rate (.0328767).

All calculations are expressed in monthly terms except the final adjusted charge which is converted to a daily rate. All final figures are rounded out to the nearest cent.

(4) The adjusted gross income (A-Y) is determined by first developing the gross income of the estate of the patient and the responsible relative. Gross income (A) includes not only gross wages for services rendered, and/or net earnings from self-employment, but all other available assets which have been divided by twelve months to convert them to a monthly cash equivalent figure. All mandatory deductions (Y), such as income tax and social security, are deducted from the gross income to arrive at the adjusted gross income.

(5) Approved allowances for unusual and exceptional circumstances (N) and for other pertinent factors (R) are then subtracted from the adjusted gross income.

(6) The available income (A-Y-N-R) is then divided by the number of dependents in the household of the patient (D) to determine the available income per family member.

(7) Exempt income (E) as defined in WAC 388-855-0045 is then subtracted from the available income per family member to arrive at the monthly adjusted charges.

(8) The monthly adjusted charges are multiplied by the factor of .0328767 which converts the monthly figure to a daily rate.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0065, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-065, filed 3/25/81.]

**WAC 388-855-0075 Unusual and exceptional circumstances.** Unusual and exceptional circumstances for these purposes will cover those expenses other than usual or common; rare and extraordinary; that are of a medical nature and *must* be supplied to the patient for his health, medical or physical well being. Such expenses do not include those expenses that are reimbursable from insurance benefits or can be reasonably obtained from welfare agencies, health maintenance organizations, free clinics, or other free private or governmental sources. The existence and necessity of such unusual and exceptional circumstances must be attested to in writing, by the institution superintendent, that those expenses resulting therefrom are an integral part of the patient's treatment plan and that allowance for such circumstances is necessary for the medical and/or mental well-being of the patient. Upon such written certification, the resources necessary to meet the unusual and exceptional circumstances will not be considered as an asset available to the estate of the patient and responsible relatives for these purposes: Provided, That any such attestation by the institution superintendent must conform with the eligibility criteria of Medicaid if the patient is eligible or potentially eligible for such benefits.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0075, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-075, filed 3/25/81.]

**WAC 388-855-0085 Other pertinent factors.** The determination officer may consider the following other pertinent factors in determining the ability of the estate of the patient and responsible relatives to pay.

(1) The determination officer may consider those factors related to the well-being, education and training, child support obligations set by court order or by administrative finding under chapter 74.20A RCW, and/or rehabilitation of the patient and the patient's immediate family, to whom the patient owes a duty of support. The patient and/or responsible relatives shall show the existence and the necessity for the pertinent factors as defined. Upon such a showing, the determination officer may consider such resources necessary to reasonably provide for such pertinent factors as assets not available to the estate of the patient and responsible relatives.

(2) Consistent with RCW 43.20B.335, the determination officer shall consider a judgment owed by the patient to any victim of an act that would have resulted in criminal conviction of the patient but for a finding of the patient's criminal insanity. A victim shall include an estate's personal representative who has obtained judgment for wrongful death against the criminally insane patient.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0085, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.335. 96-18-090, § 275-16-085, filed

9/4/96, effective 10/5/96. 81.02.412 [71.02.412]. Statutory Authority: RCW 81-08-020 (Order 1627), § 275-16-085, filed 3/25/81.]

**WAC 388-855-0095 Failure to cooperate with department.** Any patient, former patient, guardian, or other responsible party or parties who, after diligent effort by the department, has been shown to have failed to cooperate with the financial investigation by the department; or fails to comply with, or ignores, departmental correspondence; or supplies false or misleading information; or willfully conceals assets or potential assets; will be subject to a determination by the department that the estate of the patient and responsible relatives has the ability to pay full hospitalization charges: Provided, That no person adjudged incompetent by a court of this state at the time of said investigation shall be penalized by his or her actions: Provided further, That such a finding of liability to pay full hospitalization charges shall in no way diminish the responsible party's right to appeal such a finding of responsibility.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0095, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-095, filed 3/25/81.]

**WAC 388-855-0105 Petition for review.** (1) After a finding of responsibility becomes final in accordance with RCW 43.20B.340, the responsible party may petition for a review of such findings to the secretary. The petitioner must show a substantial change in the financial ability of the estate to pay the charges in a petition for review. The burden of proof of a change in financial ability rests with the petitioner.

(2) A petition for review shall be in writing and to the following address:

Secretary, DSHS  
Attn: Determination Officer  
P.O. Box 9768 MS HJ-21  
Olympia, WA 98504

(3) The determination officer, upon receipt of the petition for review, may conduct or cause to have conducted such investigation as may be necessary to verify the alleged changes in financial status or to determine any other facts which would bear upon the financial ability of the estate to pay.

(4) Based upon the review of the facts, the determination officer may modify or vacate the NFR under the provisions of RCW 43.20B.350.

(5) The NFR will not be modified or vacated, if such modification or vacation inflicts or causes the loss of Medicaid eligibility; jeopardizes the eligibility for other third-party benefits; or has the potential end result of diminishing or jeopardizing the recovery of hospitalization cost by the department without a clear showing of real benefit, financial or otherwise, to the patient and/or responsible relatives.

(6) Nothing herein is intended to preclude the reinvestment and/or review of the finding of responsibility by the department of its own volition.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0105, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.335. 90-23-071 (Order 3096), § 275-16-105, filed

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11/20/90, effective 12/21/90. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-105, filed 3/25/81.]

## Chapter 388-865 WAC

### COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

#### WAC

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#### SECTION ONE—COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

**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

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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 eligible 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 chapters 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.]

## SECTION TWO—REGIONAL SUPPORT NETWORKS

**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 chapters 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 chapters 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 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 chapters 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 chapters 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 non-forensic 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  $(M \times 40\%) + (U \times 35\%) + (P \times 25\%) \times F$ .

(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 chapters 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:

(2003 Ed.)

(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

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the requirements of chapters 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 chapters 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, chapters 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 chapters 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 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, § 388-865-0229, filed 5/31/01, effective 7/1/01.]

**WAC 388-865-0230 Community support services.** The regional support network must develop and coordinate

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age and culturally competent community support services that are consistent with chapters 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 71.24.025(14).

(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.

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[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 cur-

rent 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 contractor'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;

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(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.

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[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 consum-

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ers, 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

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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.]

### SECTION THREE—MENTAL HEALTH PREPAID HEALTH PLANS

**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

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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

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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 can 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.

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(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 execut-

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ing 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; noncov-

ered 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 pre-

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paid 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.]

#### SECTION FOUR—COMMUNITY SUPPORT SERVICE PROVIDERS

**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;

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(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

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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.]

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**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

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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;

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(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.]

(2003 Ed.)

**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.]

(2003 Ed.)

**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.

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[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 provider 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;

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(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.

(2003 Ed.)

(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 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;

(2003 Ed.)

(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.

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(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;

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(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.

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(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.]

## SECTION FIVE—INPATIENT EVALUATION AND TREATMENT FACILITIES

**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.

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(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 regula-

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tions 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 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 inpatient 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;

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(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.

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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

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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

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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.]

## SECTION SIX—DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION

**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 equiv-

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alent 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 - 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 RCW;

(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.

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(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 388-875 WAC

### CRIMINALLY INSANE PERSON COMMITTED TO THE CARE OF THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES—EVALUATION, PLACEMENT, CARE AND DISCHARGE

(Formerly chapter 275-59 WAC)

#### WAC

388-875-0010	Purpose.
388-875-0020	Definitions.
388-875-0030	Mental health division.
388-875-0040	Schedule of maximum payment for defendant expert or professional person.
388-875-0050	Time limitations and requirements.
388-875-0060	Individualized treatment.
388-875-0070	Transfer of a patient between state-operated facilities for persons with mental illness.
388-875-0080	Restoration procedure for a former involuntarily committed person's right to firearm possession.
388-875-0090	Conditional release.
388-875-0100	Retroactivity.
388-875-0110	Access to records by criminal justice agencies.

**WAC 388-875-0010 Purpose.** These regulations are adopted pursuant to and in accordance with chapter 117, Laws of 1973 1st ex. sess. They are adopted to provide procedures for the evaluation, placement, care and discharge of persons committed to the care of the department of social and health services, under the aforementioned Act, relating to the criminally insane.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0010, filed 12/6/00, effective 1/6/01; Order 846, § 275-59-010, filed 8/9/73.]

**WAC 388-875-0020 Definitions. "Department"** means the state department of social and health services.

**"Division"** means the mental health division, department of social and health services.

**"Evaluation"** means the initial procedure when a court requests the department to provide an opinion if a person charged with a crime is competent to stand trial or, if indicated and appropriate, if the person was suffering under a mental disease or defect excluding responsibility at the time of the commission of the crime.

**"Indigent"** means any person who is financially unable to obtain counsel or other necessary expert or professional services without causing substantial hardship to himself or his family.

**"Professional person"** means:

(1) A psychiatrist. This is defined as a person having a license as a physician and surgeon in this state, who has in addition, completed three years of graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association and who is certified or is eligible to be certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(2) A psychologist. This is defined as a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW.

(3) A social worker. This is defined as a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

**"Secretary"** means the secretary of the department of social and health services or his designee.

**"Superintendent"** means the person responsible for the functioning of a treatment facility.

**"Treatment facility"** means any facility operated or approved by the department of social and health services for the treatment of the criminally insane. Such definition shall not include any state correctional institution or facility.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0020, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-020, filed 3/1/79; Order 846, § 275-59-020, filed 8/9/73.]

**WAC 388-875-0030 Mental health division.** The secretary designates to the division the responsibility for:

(1) Evaluation and treatment of any person committed to the secretary for evaluation or treatment, under chapter 10.77 RCW;

(2) Assisting the court in obtaining nondepartmental experts or professional persons to participate in the evaluation or a hearing on behalf of the defendant and supervising the procedure whereby such professionals will be compensated, according to fee schedule if the person being evaluated or treated is an indigent;

(3) Assuring that any nondepartmental expert or professional person requesting compensation has maintained adequate evaluation and treatment records which justify compensation;

(4) Assisting the court by designation of experts or professional persons to examine the defendant and report to the court when the defendant is not committed to the secretary;

(5) Determination of what treatment facility shall have custody of persons committed to the secretary under chapter 10.77 RCW.

(6) If the court is advised by any party that the defendant may be developmentally disabled, at least one of the experts or professional persons appointed shall be a developmental disabilities professional.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0030, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-030, filed 3/1/79; Order 846, § 275-59-030, filed 8/9/73.]

**WAC 388-875-0040 Schedule of maximum payment for defendant expert or professional person.** Department payments to an expert or professional person for department services an indigent person receives shall not exceed:

- (1) One hundred dollars an hour for services; or
- (2) Eight hundred dollars total payment for services.

The department shall only approve an exception to this section ruling when the exception is approved, in writing, by the division director. The department shall only approve payment for one mental health examination per indigent person in each six month period.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0040, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 91-24-045 (Order 3298), § 275-59-041, filed 11/27/91, effective 1/1/92; 79-03-038 (Order 1373), § 275-59-041, filed 3/1/79.]

**WAC 388-875-0050 Time limitations and requirements.** If a person is committed to the secretary as criminally insane, commitment and treatment cannot exceed the maximum possible sentence for any offense charged. Therefore:

(1) The superintendent, if no superintendent then the division, with the assistance of the office of the attorney general where necessary shall determine at the time of commitment the maximum possible sentence for any offense charged, and thereby compute a maximum release date for every individual so committed.

(2) If the committed person has not been released by court order six months prior to the expiration of the maximum possible release date, the superintendent, if no superintendent, the division, shall notify the committing court and prosecuting attorney of its computation of maximum release date and the requirement that the person must be released on that date unless civil proceedings are instituted or the court determines that the computation of maximum release date is incorrect.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0050, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-050, filed 3/1/79; Order 846, § 275-59-050, filed 8/9/73.]

**WAC 388-875-0060 Individualized treatment.** (1) Whenever a person is committed to the secretary as criminally insane, the treatment facility to which the person is assigned shall, within fifteen days of admission to the facility, evaluate and diagnose the committed person for the purpose of devising an individualized treatment program.

(2) Every person, committed to the secretary as criminally insane, shall have an individualized treatment plan formulated by the treatment facility. This plan shall be developed by appropriate treatment team members and implemented as soon as possible but no later than fifteen days after the person's admission to the treatment facility as criminally insane. Each individualized treatment plan shall include, but not be limited to:

(a) A statement of the nature of the specific problems and specific needs of the patient;

(b) A statement of the physical setting necessary to achieve the purposes of commitment;

(c) A description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

(d) A statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

(e) A specification of staff responsibility and a description of proposed staff involvement with a patient in order to attain these treatment goals;

(f) Criteria for recommendation to the court for release.

(3) This individualized treatment plan shall be reviewed by the treatment facility periodically, at least every six months, and a copy of the plan shall be sent to the committing court.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0060, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-060, filed 3/1/79; Order 846, § 275-59-060, filed 8/9/73.]

**WAC 388-875-0070 Transfer of a patient between state-operated facilities for persons with mental illness.** In some instances, it is appropriate for the department to transfer a patient currently residing in a state facility to another state facility for ongoing treatment. The department shall accomplish the transfer with the utmost care given to the therapeutic needs of the patient. This section describes the procedures for handling a patient transfer between state facilities in a manner consistent with the best interest of the patient.

(1) The department may use the following criteria when determining the appropriateness of a patient transfer:

(a) The patient's family resides within the receiving facility's catchment area; or

(b) The patient's primary home of residence is in the receiving facility's catchment area; or

(c) A particular service or need of the patient is better met at the receiving facility; or

(d) Transfer to the receiving facility may facilitate community discharge due to the availability of community service in the receiving facility's catchment area; or

(e) The county, regional support network, or patient requests a transfer.

(2) Prior to any proposed transfer of a patient, the state facility shall comply with the following:

(a) The sending facility, at the request of the superintendent, shall in writing forward information necessary to make a decision on whether transfer is appropriate to the receiving facility's liaison and the regional support network liaison;

(b) The receiving facility's liaison and the regional support network liaison shall recommend appropriate action to the superintendent of the sending facility in writing within five calendar days of receipt of the request;

(c) If the receiving facility accepts the proposed patient transfer, the sending facility shall notify the patient, guardian, regional support network liaison, and attorney, if known, at least five days before the proposed patient transfer;

(d) The sending facility is responsible for all patient transfer arrangements, e.g., transportation, staff escort, etc., and shall coordinate the day and time of arrival with the receiving facility's liaison; and

(e) The sending facility shall arrange for the transfer of patient's medical record to the receiving facility.

(3) The sending state facility shall document the following in the patient's record:

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(a) Physician documentation of the medical suitability of the patient for transfer; and

(b) Social worker documentation regarding:

(i) Justification as to why the transfer is considered in the patient's best interests; and

(ii) The patient's wishes regarding transfer.

(4) The sending facility shall contact the prosecuting attorney's office of the committing county prior to the transfer.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0070, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.05.560 [71.05.560]. 91-22-044 (Order 3275), § 275-59-071, filed 10/31/91, effective 12/1/91. Statutory Authority: RCW 71.05.560. 88-23-021 (Order 2724), § 275-59-071, filed 11/7/88.]

**WAC 388-875-0080 Restoration procedure for a former involuntarily committed person's right to firearm possession.** (1) The department and mental health professionals implementing chapter 10.77 RCW shall recognize and affirm that a person is entitled to the immediate restoration of the right to firearm possession, as described under RCW 9.41.040 (6)(c), when the person no longer requires treatment or medication for a condition related to the commitment.

(2) Mental health professionals implementing the provisions of chapter 71.05 RCW shall provide to the court of competent jurisdiction such relevant information concerning the commitment and release from commitment as the court may request in the course of reaching a decision on the restoration of the person's right to firearm possession. (See RCW 9.41.097.)

(3) A person who has been barred from firearm possession under RCW 9.41.040(6) and who wishes to exercise this right, may petition the court which ordered involuntary treatment or, the superior court of the county in which the person resides for restoration of the right to possess firearms. At a minimum, such petition shall include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the order of final discharge entered by the committing court.

(4) A petitioner shall show that the petitioner no longer requires treatment or medication for a condition related to the commitment.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0080, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 9.41.040(6). 94-06-025 (Order 3709), § 275-59-072, filed 2/23/94, effective 3/26/94.]

**WAC 388-875-0090 Conditional release.** (1) Any person committed to the secretary as criminally insane may make application to the secretary for conditional release.

(2) The secretary designates the superintendent of the treatment facility, if no superintendent, then the director of the division, as the person to receive and act on such application for conditional release.

(3) The person making application for conditional release shall not, under any circumstances, be released until there is a court hearing on the application and recommenda-

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tions and a court order authorizing conditional release has been issued.

(4) If conditional release is denied by the court the person making the applications may reapply after a period of six months from the date of denial.

(5) If the court grants conditional release and places the person making application under the supervision of a department employee, that supervising department employee shall make monthly reports, unless indicated otherwise by the court, concerning the conditionally released person's progress and compliance with the terms and conditions of conditional release. Such reports shall be forwarded to the committing court, the division, the prosecuting attorney, and the treatment facility in which the person was most recently housed.

(6) The following persons are designated to exercise power and authority of the secretary contained in RCW 10.77.190:

- (a) The director or designee of the division;
- (b) The probation and parole office, if any, supervising the conditionally released person; and
- (c) The treatment facility supervising the conditionally released person or from which the person was conditionally released.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0090, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-080, filed 3/1/79; Order 846, § 275-59-080, filed 8/9/73.]

**WAC 388-875-0100 Retroactivity.** (1) This chapter shall apply to persons committed to the secretary or the department, under prior rules and regulations, as incompetent to stand trial or as being criminally insane and therefore requires that these individuals be provided:

- (a) An individualized treatment plan;
- (b) An evaluation to be forwarded to the committing court;
- (c) Applicability of time limitations and requirements provided herein;
- (d) A maximum release date; and
- (e) An opportunity to apply for conditional release.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0100, filed 12/6/00, effective 1/6/01; Order 846, § 275-59-090, filed 8/9/73.]

**WAC 388-875-0110 Access to records by criminal justice agencies.** Upon written request, criminal justice agencies shall have access to the following documents developed pursuant to the procedures set forth in chapter 10.77 RCW. the most recent forensic:

- (1) Psychiatric assessment;
- (2) Release summary; and
- (3) Pre-trial report of the examination, either inpatient or outpatient.

Other relevant information may be provided by agreement between the requesting criminal justice agency and the treatment facility, subject to federal and state confidentiality provisions.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, § 388-875-0110, filed 12/6/00, effective 1/6/01.]

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## Chapter 388-880 WAC

### SEXUAL PREDATOR PROGRAM—SPECIAL COMMITMENT—ESCORTED LEAVE (Formerly chapter 275-155)

#### WAC

388-880-005	Special commitment of sexually violent predators— Legal basis.
388-880-007	Purpose.
388-880-010	Definitions.
388-880-020	Authorization for indefinite commitment to the sexual predator program.
388-880-030	Sexual predator program initial evaluation—Reporting.
388-880-031	Sexual predator program annual evaluation—Reporting.
388-880-032	Recommendation for release to a less restrictive alterna- tive (LRA).
388-880-040	Individual treatment.
388-880-042	Resident records—Purposes.
388-880-043	Resident clinical records—Location and custody.
388-880-044	Resident records—Access.
388-880-045	Resident records—Retention.
388-880-050	Rights of a person court-detained or committed to the special commitment center.
388-880-060	Sexual predator program reimbursement.
388-880-070	Escorted leave—Purpose.
388-880-080	Reasons allowed.
388-880-090	Conditions.
388-880-100	Application requests and approval for escorted leave.
388-880-110	Escort procedures.
388-880-120	Expenses.
388-880-130	Expenses—Paid by resident.
388-880-140	Expenses—Paid by department.

**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.]

(2003 Ed.)

**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, step-parents, 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

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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 trial 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.]

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**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:

[Title 388 WAC—p. 1169]

- (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 388-880-060 Sexual predator program reimbursement.** (1) The department shall obtain reimbursement under RCW 43.20B.330, 43.20B.335, 43.20B.340, 43.20B.345, 43.20B.350, 43.20B.355, 43.20B.360, and 43.20B.370 for the cost of care of a person committed to a SPP to the extent of the person's ability to pay.

(2) The department shall calculate ability to pay and assess liability under chapter 275-16 WAC.

[99-21-001, recodified as § 388-880-060, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-060, filed 8/21/90, effective 9/21/90.]

**WAC 388-880-070 Escorted leave—Purpose.** The purpose of WAC 275-155-070 through 275-155-140 is:

(1) To set forth the conditions under which residents will be granted leaves of absence;

(2) To provide for safeguards to prevent escape, the obtaining of contraband, and the commission of new crimes, while on leaves of absence; and

(3) To outline the process for the reimbursement of the state by the resident and the resident's family for the costs of the leave of absence.

[99-21-001, recodified as § 388-880-070, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-070, filed 12/1/97, effective 1/1/98.]

**WAC 388-880-080 Reasons allowed.** An escorted leave of absence may be granted by the superintendent, or designee, subject to the approval of the secretary, to residents to:

(1) Go to the bedside of a member of the resident's immediate family as defined in WAC 275-155-010, who is seriously ill;

(2) Attend the funeral of a member of the resident's immediate family as defined in WAC 275-155-010; and

(3) Receive necessary medical or dental care which is not available in the institution.

[99-21-001, recodified as § 388-880-080, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-080, filed 12/1/97, effective 1/1/98.]

**WAC 388-880-090 Conditions.** (1) An escorted leave shall be authorized only for trips within the boundaries of the state of Washington.

(2) The duration of an escorted leave to the bedside of a seriously ill member of the resident's immediate family or attendance at a funeral shall not exceed forty-eight hours unless otherwise approved by the superintendent, or designee.

(3) Other than when housed in a city or county jail or state institution the resident shall be in the visual or auditory contact of an approved escort at all times.

(4) The resident shall be housed in a city or county jail or state institution at all times when not in transit or actually engaged in the activity for which the escorted leave was granted.

(5) Unless indigent, the resident and immediate family member shall, in writing, make arrangements to reimburse the state for the cost of the leave prior to the date of the leave.

(6) The superintendent, or designee, shall notify county and city law enforcement agencies with jurisdiction in the area of the resident's destination before allowing any escorted leave of absence.

[99-21-001, recodified as § 388-880-090, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-090, filed 12/1/97, effective 1/1/98.]

**WAC 388-880-100 Application requests and approval for escorted leave.** The superintendent, or designee, shall establish a policy and procedures governing the method of handling the requests by individual residents. The superintendent, or designee, shall evaluate each leave request and, in writing, approve or deny the request within forty-eight hours of receiving the request based on:

- (1) The nature and length of the escorted leave;
- (2) The community risk associated with granting the request based on the resident's history of security or escape risk;
- (3) The resident's overall history of stability, cooperative or disruptive behavior, and violence or other acting out behavior;
- (4) The resident's degree of trustworthiness as demonstrated by his/her performance in unit assignments, security level, and general cooperativeness with facility staff;
- (5) The resident's family's level of involvement and commitment to the escorted leave planning process;
- (6) The rehabilitative or treatment benefits which could be gained by the resident; and
- (7) Any other information as may be deemed relevant.

The resident's, and family's, ability to reimburse the state for the cost of the escorted leave shall not be a determining factor in approving or denying a request.

[99-21-001, recodified as § 388-880-100, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-100, filed 12/1/97, effective 1/1/98.]

**WAC 388-880-110 Escort procedures.** (1) Only persons approved by the superintendent, or designee, will be authorized to serve as escorts. All escorts from the total confinement facility must be employees of either the department of social and health services or the department of corrections

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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.]

**WAC 388-880-120 Expenses.** (1) Staff assigned escort duties shall be authorized per diem reimbursement for meals, lodging, and transportation at the rate established by the state travel policy.

(2) Staff assigned escort duties shall receive appropriate compensation at regular salary or overtime for all hours spent in actual escort of the resident, but not including hours spent sleeping or not engaged in direct supervision of the resident. The salary shall be paid at the appropriate straight time and overtime rates as provided in the merit system rules.

(3) Cost of housing the resident in a city or county jail shall be charged to the resident in accordance with WAC 275-155-130.

[99-21-001, recodified as § 388-880-120, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-120, filed 12/1/97, effective 1/1/98.]

**WAC 388-880-130 Expenses—Paid by resident.** (1) The expenses of the escorted leave as enumerated in WAC 275-155-120 shall be reimbursed by the resident or his/her immediate family member unless the superintendent, or designee, has authorized payment at state expense in accordance with WAC 275-155-140.

(2) Payments by the resident, or the resident's immediate family member, shall be made to the facility's business office and applied to the appropriate fund as defined by law, applicable provisions of the Washington Administrative Code, or department policy.

[99-21-001, recodified as § 388-880-130, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-130, filed 12/1/97, effective 1/1/98.]

**WAC 388-880-140 Expenses—Paid by department.** The expenses of the escorted leave shall be absorbed by the state if:

- (1) The resident and his/her immediate family are indigent as defined in WAC 275-155-010; or
- (2) The expenses were incurred to secure medical care.

[99-21-001, recodified as § 388-880-140, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-140, filed 12/1/97, effective 1/1/98.]



**Chapter 388-881 WAC****SEXUAL PREDATOR PROGRAM—EXTERNAL OVERSIGHT**

(Formerly chapter 275-155)

**WAC**

388-881-010	External oversight of the special commitment center.
388-881-015	External oversight—Governing body.
388-881-020	External oversight—Professional standards.
388-881-025	External oversight—Annual inspection of care (IOC).
388-881-030	External oversight—Ombudsman service.
388-881-035	External oversight—Investigation of incidents.

**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.

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(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.]

**Chapter 388-885 WAC****CIVIL COMMITMENT COST REIMBURSEMENT**

(Formerly chapter 275-156)

**WAC**

388-885-005	Purpose.
388-885-010	Definitions.
388-885-015	Limitation of funds.
388-885-020	Maximum allowable reimbursement for civil commitment cost.
388-885-025	Billing procedure.
388-885-030	Exceptions.

(2003 Ed.)

388-885-035 Effective date.  
388-885-040 Audits.

**WAC 388-885-005 Purpose.** These rules establish the standards and procedures for reimbursing counties for the cost incurred during civil commitment trial, annual evaluation, and review processes and release procedures related to chapter 71.09 RCW. The department's reimbursement to counties is limited to appropriated funds.

[99-21-002, recodified as § 388-885-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-005, filed 10/8/91, effective 11/8/91.]

**WAC 388-885-010 Definitions.** (1) "Attorney cost" means the fully documented fee directly related to the violent sexual predator civil commitment process for:

- (a) A single assigned prosecuting attorney;
- (b) When the person is indigent, a single court-appointed attorney; and
- (c) Additional counsel, when additional counsel is approved by the trial judge for good cause. Said fee includes the cost of paralegal services.

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

(3) "Evaluation by expert cost" means a county-incurred service fee directly resulting from the completion of a comprehensive examination and/or a records review, by a single examiner selected by the county, of a person:

- (a) Investigated for "sexually violent predator" probable cause;
- (b) Alleged to be a "sexually violent predator" and who has had a petition filed; or
- (c) Committed as a "sexually violent predator" and under review for release.

In the case where the person is indigent, "evaluation by expert cost" includes the fee for a comprehensive examination and/or records review by a single examiner selected by the person examined. When additional examiners are approved by the trial judge for good cause, "evaluation by expert cost" includes the cost of additional examiners.

(4) "Incidental cost" means county-incurred efforts or costs that are not otherwise covered and are exclusively attributable to the trial of a person alleged to be a "sexually violent predator."

(5) "Investigative cost" means a cost incurred by a police agency or other investigative agency in the course of investigating issues specific to:

- (a) Filing or responding to a petition alleging a person is a "sexually violent predator;" or
- (b) Testifying at a hearing to determine if a person is a "sexually violent predator."

(6) "Medical cost" means a county-incurred extraordinary medical expense beyond the routine services of a jail.

(7) "Secretary" means the secretary of the department of social and health services.

(8) "Transportation cost" means the cost a county incurs when transporting a person alleged to be, or having been found to be, a "sexually violent predator," to and from a sexual predator program facility.

(2003 Ed.)

(9) "Trial cost" means the costs a county incurs as the result of filing a petition for the civil commitment of a person alleged to be a "sexually violent predator" under chapter 71.09 RCW. This cost is limited to fees for:

- (a) Judges, including court clerk and bailiff services;
- (b) Court reporter services;
- (c) Transcript typing and preparation;
- (d) Expert and nonexpert witnesses;
- (e) Jury; and
- (f) Jail facilities.

[99-21-002, recodified as § 388-885-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-010, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-010, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-010, filed 10/8/91, effective 11/8/91.]

**WAC 388-885-015 Limitation of funds.** The department shall:

- (1) Reimburse funds to a county when funds are available;
- (2) Limit a county's reimbursement to costs of civil commitment trials or hearings as described under this chapter;
- (3) Restrict a county's reimbursement to documented investigation, expert evaluation, attorney, transportation, trial, incidental, and medical costs;
- (4) Not pay a county a cost under the rules of this section when said cost is otherwise reimbursable under law;
- (5) Pay a county's claim for a trial or hearing occurring during each biennium in the order in which the claim is received at the office of accounting services, special commitment center, until the department's biennial appropriation is expended.

[99-21-002, recodified as § 388-885-015, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-015, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-015, filed 10/8/91, effective 11/8/91.]

**WAC 388-885-020 Maximum allowable reimbursement for civil commitment cost.** The department shall reimburse a county for actual costs incurred up to the maximum allowable rate as specified:

- (1) Attorney cost - Up to forty-nine dollars and forty-one cents per hour;
- (2) Evaluation by expert cost - Actual costs, within reasonable limits, plus travel and per diem according to state travel policy;
- (3) Trial costs:
  - (a) Judge - Up to forty-six dollars and five cents per hour;
  - (b) Court reporters - Up to twenty dollars and seventy-one cents per hour;
  - (c) Transcript typing and preparation services - Up to four dollars and thirteen cents per page;
  - (d) Expert witnesses - Actual costs within reasonable limits plus travel and per diem according to state travel policy;
  - (e) Nonexpert witnesses - Actual compensation, travel and per diem paid to witnesses, provided compensation is in accordance with chapter 2.40 RCW and state travel policy;

[Title 388 WAC—p. 1173]

(f) Jurors - Actual compensation, travel, and per diem paid to jurors provided compensation is in accordance with chapter 2.36 RCW and state travel policy;

(g) Jail facilities - Thirty dollars per day.

(4) Investigative cost - Up to twenty dollars and sixty-six cents per hour. Medical costs - Up to fifty dollars per day, not to exceed five consecutive days; and

(5) Transportation cost - Actual compensation paid to transport staff, plus mileage and per diem at the rate specified in the state travel policy.

[99-21-002, recodified as § 388-885-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-020, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-020, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-020, filed 10/8/91, effective 11/8/91.]

**WAC 388-885-025 Billing procedure.** (1) When a county requests the department reimburse a county's cost, the county shall:

(a) Make a claim using the state of Washington invoice voucher, Form A 19 1-A;

(b) Attach to the claim necessary documentation, support, and justification materials;

(c) Report expenses billed by the hour in one-quarter hour increments unless smaller increments are provided to the county by the vendor; and

(d) Include the name of the person for whom the costs were incurred and the cause number when it exists.

(2) The department may subject a county's claim documentation to periodic audit at the department's discretion.

(3) Only an authorized administrator, or the county administrator's designee, may submit to the department a request for a county's cost reimbursement.

(4) A county shall submit a reimbursement claim to the department within thirty days of final costs incurred to assure proper handling of the claim.

(5) When a county submits a reimbursement claim, the county shall submit a reimbursement claim to the special commitment center, offices of accounting services.

(6) If the department's reimbursement appropriation becomes exhausted before the end of a biennium, a county may continue to make a claim for reimbursement. The department may use the reimbursement claim to justify a request for adequate department funding during future biennia.

[99-21-002, recodified as § 388-885-025, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-025, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-025, filed 10/8/91, effective 11/8/91.]

**WAC 388-885-030 Exceptions.** (1) The secretary may grant exceptions to the rules of this chapter.

(2) A county seeking an exception shall request the exception, in writing from the secretary or secretary's designee.

(3) The department shall deny a claim which does not follow the rules of this chapter unless the secretary or secretary's designee granted an exception before the claim was filed.

[Title 388 WAC—p. 1174]

[99-21-002, recodified as § 388-885-030, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-030, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-030, filed 10/8/91, effective 11/8/91.]

**WAC 388-885-035 Effective date.** When a county submits a reimbursement claim according to this chapter, the claim shall be only for costs incurred as defined in this chapter, on or after July 1, 1990.

[99-21-002, recodified as § 388-885-035, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-035, filed 10/8/91, effective 11/8/91.]

**WAC 388-885-040 Audits.** The department may audit county reimbursement claims at the department's discretion.

[99-21-002, recodified as § 388-885-040, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-040, filed 10/8/91, effective 11/8/91.]

## Chapter 388-890 WAC

### REHABILITATION SERVICES FOR INDIVIDUALS WITH DISABILITIES

(Formerly chapter 490-500 WAC (part))

#### WAC

##### INDEPENDENT LIVING PROGRAM—TITLE VII

388-890-0780	What is the independent living (IL) program?
388-890-0785	What types of services does the IL program offer?
388-890-0790	Who is eligible for Title VII IL program services?
388-890-0795	What is a significant disability?
388-890-0800	Who provides IL program services?
388-890-0805	What are my responsibilities in the IL program?
388-890-0810	How do I apply for IL program services?
388-890-0815	What happens after I submit my application for IL program services?
388-890-0820	Who decides if I am eligible for IL program services?
388-890-0825	Where does the IL program get the information needed to decide if I am eligible?
388-890-0830	How do I find out if I am eligible for IL program services?
388-890-0835	What if I disagree with a decision about my eligibility for IL or a decision about IL program services?
388-890-0840	Under what conditions can I get IL program services?
388-890-0845	How are my IL program services planned?
388-890-0850	What is included on a written or verbal IL plan?
388-890-0855	Who signs and keeps a written IL plan?
388-890-0860	How often is my IL plan reviewed?
388-890-0870	What are IL advocacy services?
388-890-0875	What are IL rehabilitation technology services?
388-890-0880	What are IL communication services?
388-890-0885	What are IL counseling services?
388-890-0890	What are IL housing services?
388-890-0895	Are IL program payments for home modifications limited?
388-890-1000	What is IL skills training?
388-890-1005	What are IL information and referral services?
388-890-1010	What is IL peer counseling?
388-890-1015	What is IL mobility training?
388-890-1020	What is IL personal assistance training?
388-890-1025	Does the IL program pay for attendant services as part of personal assistance training?
388-890-1030	What are IL physical rehabilitation services?
388-890-1035	What are IL preventative services?
388-890-1040	What are IL recreational services?
388-890-1045	What are IL program services to family members?
388-890-1050	What are IL therapeutic services?
388-890-1055	What are IL transportation services?
388-890-1060	What other services does the IL program offer?
388-890-1065	How long can I receive independent living services?
388-890-1070	Why does the IL program stop providing or paying for IL program services?

(2003 Ed.)

- 388-890-1075 Am I involved in the decision to stop receiving IL program services?
- 388-890-1080 How does the IL program notify me that my services are stopping?
- 388-890-1085 If the IL program decides I am not eligible for IL program services, is the decision reviewed?
- 388-890-1090 Does the IL program keep a record of my IL program services?
- 388-890-1095 Does the IL program keep personal information confidential?
- DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER**
- 388-890-0005 What is the purpose of this chapter? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0005, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0005.
- 388-890-0010 What definitions apply to this chapter? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0010, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0010.
- 388-890-0015 What is informed choice? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0015, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0400.
- 388-890-0020 How does DVR support the informed choice process? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0020, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0410.
- 388-890-0025 What decisions can I make using informed choice? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0025, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0430.
- 388-890-0030 What if I don't know how to use the informed choice decision making process? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0030, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0420.
- 388-890-0035 Who is eligible to receive VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0035, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1000.
- 388-890-0040 How does DVR determine whether VR services will enable me to work? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0040, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1005.
- 388-890-0045 Am I eligible for VR services if I receive Social Security disability benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0045, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1020.
- 388-890-0050 What criteria are not considered in the eligibility decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0050, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1025.
- 388-890-0055 What information does DVR use to make an eligibility decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0055, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1005.
- 388-890-0060 After I submit my application to DVR, how long does it take DVR to make an eligibility decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0060, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1010.
- 388-890-0065 What happens if DVR determines that I am not eligible? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0065, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1045.

- 388-890-0070 If I am not eligible for DVR services, can DVR help me find other services and programs to meet my needs? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0070, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1050.
- 388-890-0071 If I am eligible for or ineligible for VR services, how will I be notified? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0071, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1045.
- 388-890-0075 Who can apply for vocational rehabilitation services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0075, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0900.
- 388-890-0080 Can I receive VR services if I am not a United States citizen? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0080, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0910.
- 388-890-0085 Am I required to provide proof of my identity and work status? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0085, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0910.
- 388-890-0090 If I don't live in Washington, can I receive VR or IL program services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0090, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0920.
- 388-890-0095 Can I receive VR services if I am legally blind? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0095, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0930.
- 388-890-0100 Can I receive VR or IL program services if I am Native American? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0100, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0940.
- 388-890-0105 How do I apply for VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0105, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0980.
- 388-890-0110 Under what general conditions does DVR provide vocational rehabilitation services to individuals? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0110, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300.
- 388-890-0115 Can I ask for an exception to a rule or a condition relating to VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0115, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0120 How do I ask for an exception to a rule or condition in this chapter? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0120, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0205 and 388-891-0210.
- 388-890-0125 What happens if the service I want exceeds what I need or is more expensive than a similar service? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0125, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0370.
- 388-890-0130 Can a guardian or another representative act on my behalf? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0130, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0200.
- 388-890-0135 What is the purpose of vocational rehabilitation (VR) services? [Statutory Authority: RCW 74.29.020,

- 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0135, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0140 How do I know which VR services are right for me? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0140, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0400, 388-891-0410, 388-891-0420, 388-891-0430 and 388-891-0440.
- 388-890-0145 What vocational rehabilitation services are available to individuals from DVR? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0145, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0600.
- 388-890-0150 What are assessment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0150, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0605.
- 388-890-0155 To determine whether I am eligible for VR services, who decides what assessment services I need and where to get the assessment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0155, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0430 and 388-891-1005.
- 388-890-0160 If I need assessment services to help me choose an employment goal and what VR services I need, who decides what assessment services I need and where to get the assessment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0160, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0430.
- 388-890-0165 What if I already have assessment information to help me and DVR make the decisions we need to make? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0165, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1100.
- 388-890-0170 How do I provide needed assessment information to DVR? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0170, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0175 What is an assistive technology device? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0175, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0660.
- 388-890-0180 Under what conditions does DVR provide and issue assistive technology devices? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0180, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300, 388-891-1200, 388-891-1210, 388-891-1220, 388-891-1230, and 388-891-1240.
- 388-890-0185 Under what conditions does DVR provide vehicle modifications? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0185, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0665.
- 388-890-0190 What are assistive technology services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0190, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0660.
- 388-890-0195 Under what conditions does DVR provide assistive technology services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0195, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300.
- 388-890-0200 What are counseling and guidance services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0200, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0700.







- 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0690.
- 388-890-0360 Under what conditions does DVR provide services to my family members? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0360, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300 and 388-891-0695.
- 388-890-0365 What are supported employment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0365, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0840.
- 388-890-0370 What are tools, equipment, initial stocks and supplies? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0370, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0705.
- 388-890-0375 Under what conditions does DVR provide and issue tools, equipment, initial stocks and supplies? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0375, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300, 388-891-1200, 388-891-1210, 388-891-1220, 388-891-1230, and 388-891-1240.
- 388-890-0380 What are training services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0380, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0710.
- 388-890-0385 What is on-the-job training? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0385, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0715.
- 388-890-0390 Under what conditions does DVR provide on-the-job training? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0390, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0715.
- 388-890-0395 Under what conditions does DVR provide training services and issue items for training? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0395, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300 and 388-891-0715.
- 388-890-0400 Do I have to apply for a student loan to pay for training services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0400, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0745.
- 388-890-0405 Can I receive training services from a private school, an out-of-state training agency or an out-of-state college? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0405, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0750.
- 388-890-0410 What are transition services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0410, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0755.
- 388-890-0415 Under what conditions does DVR provide transition services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0415, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300 and 388-891-0755.
- 388-890-0420 How does DVR coordinate with public high schools to provide transition services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0420, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0425 How does DVR help me plan transition services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0425, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments



- amended in August 1998. 99-18-053, § 388-890-0495, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1125.
- 388-890-0500 Who makes decisions about what to include on my IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0500, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1115.
- 388-890-0505 Can I include any VR services I want on my IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0505, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0370 and 388-891-1140.
- 388-890-0510 What if the employment goal I choose is religious in nature? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0510, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0515 What must be included on my IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0515, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1140.
- 388-890-0520 Who signs the IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0520, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1145.
- 388-890-0525 Is the IPE reviewed and updated? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0525, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1150.
- 388-890-0530 Why does DVR close a case service record? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0530, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1300.
- 388-890-0535 Under what conditions does DVR determine that I am working and no longer need VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0535, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1310.
- 388-890-0540 Am I involved in the decision to close my case? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0540, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1320.
- 388-890-0545 What is competitive employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0545, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0010.
- 388-890-0550 What is extended employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0550, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0010.
- 388-890-0555 If the job I get is in extended employment, what follow-up does DVR provide? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0555, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1330.
- 388-890-0560 Under what conditions does DVR follow up with me if I am determined ineligible for VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0560, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1330.
- 388-890-0570 What is supported employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0570, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0800.







- to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0870.
- 388-890-0650 What is required for me to change from supported employment services to extended services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0650, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0875.
- 388-890-0655 What happens if my VR counselor and I do not find a source for extended services and/or we cannot establish natural supports during the initial eighteen months of my individualized plan for employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0655, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0880.
- 388-890-0660 Under what conditions does DVR close my case service record for supported employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0660, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0885.
- 388-890-0665 Under what conditions does DVR provide supported employment services as post-employment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0665, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0890.
- 388-890-0670 What is a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0670, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0675 What happens during a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0675, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0680 Who decides if a trial work experience is needed to determine if I am eligible for DVR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0680, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1015.
- 388-890-0685 What services does DVR provide during a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0685, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0690 What if I am too significantly disabled to participate in a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0690, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1035.
- 388-890-0695 What choices can I make about the trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0695, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030 and 388-891-0430.
- 388-890-0700 Am I evaluated during the trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0700, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0705 When does DVR make an eligibility decision when I am in a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0705, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0710 Are there any vocational rehabilitation services that can be provided to a group of individuals with disabilities? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0710, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0715 Under what conditions does DVR provide services to a group of individuals with disabilities to establish, develop or improve a community rehabilitation program? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0715, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory

- Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0720 Under what conditions does DVR provide services to a group of individuals with disabilities that cannot be purchased under an individual IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0720, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0725 Under what conditions does DVR provide consulting and/or technical assistance to plan for the transition of students with disabilities? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0725, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0730 What if DVR does not have funding to serve all eligible individuals? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0730, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0500.
- 388-890-0745 If DVR has to decide in what category to place me, who decides what assessment services I need and where to get the assessment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0745, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1005 and 388-891-0430.
- 388-890-0750 What categories are used by DVR to determine the priority by which eligible individuals are served and in what order are the categories prioritized? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0750, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0510.
- 388-890-0755 What information does DVR use to determine whether I am in category one? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0755, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0520.
- 388-890-0760 What information does DVR use to determine whether I am in category two? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0760, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0530.
- 388-890-0765 What information does DVR use to determine whether I am in category three? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0765, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0540.
- 388-890-1100 How are costs for VR and IL program services paid? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1100, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300.
- 388-890-1110 What are comparable services and benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1110, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300.
- 388-890-1115 What VR or IL program services are provided without a determination of comparable services or benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1115, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0310.
- 388-890-1120 What if determining the availability of comparable services and benefits would result in a delay or interrupt my progress? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1120, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0320.
- 388-890-1125 What is extreme medical risk? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1125, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0320.
- 388-890-1130 Does DVR pay for a service if comparable services and benefits are available, but I don't want to use them? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1130,

- filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0325.
- 388-890-1135 Are awards and scholarships based on merit considered comparable services and benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1135, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.-340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1140 How do I get comparable services and benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1140, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1145 How does DVR determine whether I pay for all or part of my VR or IL services using my own financial resources? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1145, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0340.
- 388-890-1150 Do I have to report my financial status if I receive public assistance or income support from another public program? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1150, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0345.
- 388-890-1155 What financial information does DVR use to decide if I need to help pay for VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1155, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0350.
- 388-890-1160 Are any of my resources not counted in the decision about whether I have to help pay for services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1160, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0360.
- 388-890-1165 How does DVR decide whether I have resources to help pay for VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1165, filed 8/27/99, effective 11/1/99.]
- 388-890-1170 Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0355.
- 388-890-1175 How is the amount I pay for VR or IL program services determined? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1170, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0355.
- 388-890-1180 What VR or IL program services am I not required to help pay for? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1175, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0365.
- 388-890-1185 What if a VR counselor makes a decision about my VR services that I don't agree with? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1180, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0215.
- 388-890-1185 What is the client assistance program (CAP)? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1185, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0220.
- 388-890-1190 What is mediation? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1190, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0225.
- 388-890-1195 When can I ask for mediation? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1195, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0230.
- 388-890-1200 Who arranges and pays for mediation? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1200, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363,

- chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0235.
- 388-890-1205 Is information discussed during mediation confidential? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1205, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0240.
- 388-890-1210 How do I request mediation? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1210, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09-340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1215 After the mediation session, do I receive a written statement of the results? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1215, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0245.
- 388-890-1220 What is a formal hearing? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1220, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0250.
- 388-890-1225 When is a formal hearing available? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1225, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0255.
- 388-890-1230 How do I request a formal hearing? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1230, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0255.
- 388-890-1235 After I submit a request for a formal hearing, when is it held? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1235, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0260.
- 388-890-1240 Do I receive a written formal hearing decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1240, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0270.
- 388-890-1245 Is the decision after a formal hearing final? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1245, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0275.
- 388-890-1250 Can DVR suspend, reduce or terminate my services while waiting for a formal hearing decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1250, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0295.
- 388-890-1255 How do I know what personal information I must give DVR and how it is used? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1255, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1260 Does DVR keep a record of my VR services on file? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1260, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1265 Under what conditions does DVR share personal information in my record with another service provider or organization? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1265, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0100.
- 388-890-1270 When DVR gets personal information about me from another agency or service provider, is it kept confidential? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1270, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0130.
- 388-890-1275 Does DVR change incorrect information in my record? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as

amended in August 1998. 99-18-053, § 388-890-1275, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0120.

388-890-1280

How do I receive copies of information from my DVR record? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1280, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0140.

388-890-1285

Can DVR release personal information without my written consent? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1285, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0130.

388-890-1290

Under what conditions does DVR release personal information for audit, evaluation or research? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1290, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0150.

388-890-1295

How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1295, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0135.

388-890-1300

How do I contact DVR if I don't speak English? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1300, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0950.

388-890-1305

What other methods of communication does DVR use? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1305, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0960.

388-890-1310

When does DVR communicate with me using methods other than English? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabil-

itation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1310, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0960.

## INDEPENDENT LIVING PROGRAM — TITLE VII

**WAC 388-890-0780 What is the independent living (IL) program?** (1) The independent living (IL) program is authorized by the department of social and health services, division of vocational rehabilitation under Title VII of the Rehabilitation Act, as amended.

(2) Independent living (IL) is a program of services that assists adults and emancipated minors with significant disabilities to live more independently in their families and communities. IL program services are not offered in all DVR offices. Individuals interested in IL program services must be able to receive services in a region where IL program services are offered.

(3) In addition to the rules in sections WAC 388-890-0780 through 388-890-1095 covering independent living program services, the following vocational rehabilitation rules apply:

(a) Payment for VR and IL program services, WAC 388-890-1100 through 388-890-1175;

(b) Confidentiality of personal information, WAC 388-890-1265 through 388-890-1295; and

(c) How to contact DVR if you don't speak English, WAC 388-890-1300 through 388-890-1310.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0780, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0785 What types of services does the IL program offer?** If you are eligible, the IL program can help you get the following types of services, as needed, to reach your IL goals:

- (1) Advocacy services;
- (2) Rehabilitation technology services;
- (3) Communications services;
- (4) IL counseling services;
- (5) Housing services;
- (6) IL skills training;
- (7) Information and referral services;
- (8) Mobility training;
- (9) Peer counseling services;
- (10) Personal assistance services;
- (11) Physical rehabilitation services;
- (12) Preventative services;
- (13) Recreational services;
- (14) Services to family members;
- (15) Therapeutic treatment services;
- (16) Transportation services; and
- (17) Other IL program services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0785, filed 8/27/99, effective 11/1/99.]



**WAC 388-890-0790 Who is eligible for Title VII IL program services?** (1) You are eligible for IL program services under Title VII if you are an adult or emancipated minor and you:

(a) Have a significant disability, as defined under WAC 388-890-0795;

(b) Are not currently eligible for VR services; and

(c) Can receive IL program services in a region that offers the services.

(2) Eligibility is not based on your age, color, creed, gender, sexual orientation, national origin, race, religion, or type of disability.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0790, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0795 What is a significant disability?** In the Title VII IL program, you have a significant disability if:

(1) You have a physical, mental, cognitive or sensory impairment that greatly limits your level of independence in your family or community; and

(2) IL program services are likely to improve or maintain your level of independence in any of these areas.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0795, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0800 Who provides IL program services?** (1) An IL counselor provides IL program services; or  
(2) The IL counselor may refer you to a service provider who meets standards established by the IL program.

(3) When a service provider is used, the service provider must provide IL program services that you, the IL counselor, and the service provider have agreed to in advance of starting the service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0800, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0805 What are my responsibilities in the IL program?** To receive independent living services, you must:

(1) Complete tasks that you have agreed to complete to reach your IL goals;

(2) Be willing to learn new skills and try new things; and

(3) Accept responsibility for your decisions and actions related to your IL goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0805, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0810 How do I apply for IL program services?** To apply for IL program services you:

(1) Fill out and sign an IL program services application form; or

(2) Submit the following information:

(a) Your name, address and the county where you live;

(b) Your birthdate and gender;

(c) Your Social Security Number (optional);

(d) A short description of the type of disability; and

(e) The date of your application.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0810, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0815 What happens after I submit my application for IL program services?** After you apply for IL program services, you meet with an IL counselor to:

(1) Fill out other forms and releases needed by the IL program to collect the information needed to decide if you are eligible for services;

(2) Complete an assessment to:

(a) Verify whether you have a significant disability that greatly limits your level of independence in your family or community;

(b) Identify your IL needs; and

(c) Decide if IL program services can help you to improve or maintain your level of independence in your family or community.

(3) The assessment may include, but is not limited to, the following areas:

(a) Your home and living environment, including housing, ability to get around, and safety;

(b) Financial issues, such as budgeting, paying bills, and managing money;

(c) Your basic skills in cooking, cleaning, shopping and general home and family care;

(d) How you relate to your family or others socially, and how you spend your free time;

(e) How you manage your own personal care;

(f) School or work interests.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0815, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0820 Who decides if I am eligible for IL program services?** (1) An IL counselor determines whether you meet the eligibility requirements as outlined under WAC 388-890-0790; or

(2) If an individual or organization has a contract with the IL program to offer IL program services, the individual or organization may determine whether you meet the eligibility requirements under WAC 388-890-0790.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0820, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0825 Where does the IL program get the information needed to decide if I am eligible?** The IL program uses information that you, your family, your doctor, or other organizations submit to decide if you are eligible.

(1) If the information does not verify whether you are eligible for IL program services, you may need to get additional assessments, exams, or tests to get the information.

(2) The IL program pays for services needed to verify whether you are eligible.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0825, filed 8/27/99, effective 11/1/99.]



**WAC 388-890-0830 How do I find out if I am eligible for IL program services?** (1) If the IL program verifies you are eligible, the IL program notifies you of the decision.

(2) If the IL program determines you are not eligible, the IL program must:

(a) Talk with you about the decision;

(b) Send you, or your representative, a notice of the decision in writing, including information about the services offered by the client assistance program and how to ask for services; and

(c) When possible, refer you to other agencies or programs that offer services to meet your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0830, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0835 What if I disagree with a decision about my eligibility for IL or a decision about IL program services?** If an IL counselor makes a decision about your IL program services that you don't agree with, you have the following options:

(1) Try to resolve the disagreement by talking to the IL counselor, his or her supervisor, or regional administrator;

(2) Contact the client assistance program as outlined under WAC 388-890-1185; and/or

(3) Request mediation as outlined under WAC 388-890-1190 through 388-890-1215.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0835, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0840 Under what conditions can I get IL program services?** (1) The IL program offers services as needed to:

(a) Establish your eligibility;

(b) Assess your IL needs;

(c) Develop an IL plan; and

(d) Reach your IL goals.

(2) The IL program provides services only if you are not eligible to receive a comparable service from another organization or program.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0840, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0845 How are my IL program services planned?** (1) If you are eligible for IL program services, you work with an IL counselor to develop a written IL plan or a verbal IL plan.

(a) You can get the same IL program services under a written IL plan and a verbal IL plan.

(b) If you choose a verbal IL plan, you must sign a waiver declining a written IL plan.

(2) Before the IL program purchases services under a written IL plan or verbal IL plan, you must complete a financial statement as outlined under WAC 388-890-1145, unless you receive public assistance or support from another program as outlined under WAC 388-890-1150.

[Title 388 WAC—p. 1190]

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0845, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0850 What is included on a written or verbal IL plan?** The written or verbal IL plan includes:

(1) Your goals for addressing the barriers that limit your level of independence in your family or community;

(2) The IL program services you are using to achieve each goal; and

(3) How long you expect to use each service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0850, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0855 Who signs and keeps a written IL plan?** (1) You and an IL counselor sign the written IL plan.

(2) The IL counselor gives you a copy of the written IL plan in a format that you can understand and use.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0855, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0860 How often is my IL plan reviewed?** (1) You and an IL counselor review your IL plan at least once a year, and more often if needed to decide whether:

(a) IL program services should continue, change or stop;

(b) You can and want to be referred to DVR to apply for vocational rehabilitation services as outlined under WAC 388-890-105; and

(c) You should be referred to another program or service.

(2) You may develop a new plan, if changes are needed.

(3) When you develop a new plan, the new plan is developed as outlined in WAC 388-890-0845 through 388-890-0855.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0860, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0870 What are IL advocacy services?** IL advocacy services support and assist you to express your interests or concerns to others to:

(1) Reach your IL goals; or

(2) Get other benefits and services you need.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0870, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0875 What are IL rehabilitation technology services?** IL rehabilitation technology services assist you to use devices, equipment, or technology services that enable you to reach your IL goals. IL rehabilitation technology services assist you to:

(1) Assess your technology needs;

(2) Try out different types of devices, equipment, and services;

(3) Obtain devices; and/or

(4) Receive training on the use of devices or equipment.

(2003 Ed.)

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0875, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0880 What are IL communication services?** IL communication services assist you to learn skills or use services that enable you to understand and share information. Examples of communication services include, but are not limited to:

- (1) How to get and use interpreter services, including tactile interpreter services;
- (2) Training in the use of equipment that helps you communicate;
- (3) Braille training;
- (4) How to get and use reader services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0880, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0885 What are IL counseling services?** (1) IL counseling services include support and advice from an IL counselor to help you reach your IL goals by finding out about issues that get in the way of your independence.

- (2) IL counseling services also includes therapeutic counseling services purchased from a qualified therapist on a short-term basis to help you:
  - (a) Adjust to your disabling condition; and
  - (b) Deal with issues about being more independent.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0885, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0890 What are IL housing services?** IL housing services assist you to find or keep a suitable living arrangement and take steps needed to move, if needed. Housing services include, but are not limited to, assisting you to:

- (1) Find out about low-income housing resources and different types of housing;
- (2) Find housing that accommodates your disability;
- (3) Assess what is needed in your current housing to accommodate your disability;
- (4) Find out about ways to make your home accessible.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0890, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-0895 Are IL program payments for home modifications limited?** (1) The IL program pays for home modifications if:

- (a) The modifications are related to a disability and will improve or maintain independence or safety.
- (b) You and/or a family member with whom you live:
  - (i) Own the place where you live; and
  - (ii) Complete a financial statement based on the family income to determine whether you must pay, in whole or in part, for home modifications.
- (c) The housing construction complies with appropriate building codes and permit requirements.

(2) The IL program does not pay for the cost of labor to construct home modifications.

(2003 Ed.)

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0895, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1000 What is IL skills training?** IL skills training teaches you skills to manage and balance your life in areas including, but not limited to:

- (1) Budgeting;
- (2) Meal planning and/or preparation;
- (3) Consumer skills;
- (4) Personal care;
- (5) Social interaction.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1000, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1005 What are IL information and referral services?** IL information and referral services help you to find out about and get help from other community programs and services. IL information and referral services include, but are not limited to:

- (1) Information about a variety of disability issues;
- (2) Information about health insurance and where it is available;
- (3) Help with contacting other programs and services in the community.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1005, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1010 What is IL peer counseling?** IL peer counseling is support, advice, teaching, and information sharing with people with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1010, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1015 What is IL mobility training?** IL mobility training improves your ability to get around in your home or your community, including but not limited to:

- (1) How to use a wheelchair;
- (2) How to make transfers;
- (3) Training on the use of public transportation.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1015, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1020 What is IL personal assistance training?** IL personal assistance training helps you develop the skills to get or keep the services of an attendant or assistant to meet your personal assistance needs. Personal assistance training includes, but is not limited to:

- (1) How to find an attendant or assistant;
- (2) How to manage services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1020, filed 8/27/99, effective 11/1/99.]

[Title 388 WAC—p. 1191]

**WAC 388-890-1025 Does the IL program pay for attendant services as part of personal assistance training?**

The IL program does not pay for attendant services as part of personal assistance training.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1025, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1030 What are IL physical rehabilitation services?** IL physical rehabilitation services include medical assessments or short-term services to assist you to identify or reach your IL goals. Physical rehabilitation services include, but are not limited to:

- (1) Occupational therapy;
- (2) Speech therapy;
- (3) Physical therapy.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1030, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1035 What are IL preventative services?** IL preventative services enable you to prevent or limit conditions that result from your disability. IL preventative services enable you to reduce the risk that conditions or limitations worsen. IL preventative services may include, but are not limited to, the purchase of items used to prevent decubitus ulcers.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1035, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1040 What are IL recreational services?** IL recreational services assist you to find ways to enjoy activities or hobbies of personal interest to you. IL recreational services may include but are not limited to:

- (1) Assisting you to find information and contact local programs or organizations that offer activities you are interested in;
- (2) Getting short-term instruction in an area of interest to you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1040, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1045 What are IL program services to family members?** (1) IL program services to family members assist you and your family members with issues related to your disability or independence. Services to family members may include, but are not limited to:

- (a) Giving your family training to understand disability issues;
  - (b) Assisting you to get child care needed to allow you to use IL program services.
- (2) Family member means:
- (a) Your legal guardian;
  - (b) Someone related to you; or
  - (c) Someone you live with who has a strong interest in your well being and who needs IL program services for you to achieve your IL goals.

[Title 388 WAC—p. 1192]

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1045, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1050 What are IL therapeutic services?** IL therapeutic services include evaluations to assist you to get specific information from a medical professional, such as a psychologist or neuropsychologist, to help you:

- (1) Identify your IL goals; and/or
- (2) Decide best methods for you to receive services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1050, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1055 What are IL transportation services?** (1) IL transportation services help you participate in other IL program services and include, but are not limited to:

- (a) Public transportation fares or passes,
- (b) Estimated cost of gasoline,
- (c) Parking fees.

(2) IL transportation services do not include the purchase of vehicles.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1055, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1060 What other services does the IL program offer?** The IL program may offer other services needed to help you to understand IL program services and options or achieve your IL goals. Other IL program services may include, but are not limited to support to attend a class, and support to find volunteer work.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1060, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1065 How long can I receive independent living services?** There is no limit on how long IL program services may be provided.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1065, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1070 Why does the IL program stop providing or paying for IL program services?** (1) The IL program stops providing or paying for IL program services if you:

- (a) Agree with an IL counselor that you have completed the goals and objectives in your IL plan.
- (b) Are no longer available to receive services at a DVR office where IL program services are offered.
- (c) Choose to quit using IL program services.
- (d) Are eligible and plan to use vocational rehabilitation services.

(2) The IL program stops providing or paying for IL program services if an IL counselor:

- (a) Determines you no longer need IL program services.
- (b) Determines you are not progressing in your IL plan.
- (c) Determines that you are no longer eligible for IL program services.

(d) Refers you to another service or program that offers services that are more likely to meet your needs.

(e) Cannot locate you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1070, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1075 Am I involved in the decision to stop receiving IL program services?** Before the IL program decides to stop providing or paying for your IL program services, an IL counselor must give you an opportunity to discuss the reasons for the decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1075, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1080 How does the IL program notify me that my services are stopping?** (1) If an IL counselor decides that you are no longer eligible for IL program services, the IL counselor must follow the procedures in WAC 388-890-0065 to notify you about the decision.

(2) If you and an IL counselor have decided to stop IL program services for another reason, the IL program must send you a written notice. The written notice must explain:

(a) The reason the IL program has decided to stop providing or paying for IL program services; and

(b) The services offered by the client assistance program as outlined under WAC 388-890-1185 and how to ask for those services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1080, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1085 If the IL program decides I am not eligible for IL program services, is the decision reviewed?** (1) If the IL program decides that you are not eligible for IL program services, an IL counselor must contact you to review the decision within twelve months.

(2) If you have a change in your life that affects your eligibility for IL program services, you may ask the IL program to review the decision.

(3) The IL program is not required to review your eligibility if you:

(a) Refuse or decline a review;

(b) Are no longer available to receive services at a DVR office that provides IL program services; or

(c) Cannot be located.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1085, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1090 Does the IL program keep a record of my IL program services?** The IL program keeps a record of your services, either electronically or in writing for three years after you stop receiving IL program services. The record includes, but is not limited to:

(1) Records that verify your eligibility or ineligibility;

(2) IL goals and objectives that are:

(a) Established with your input, whether on a written IL plan or not; and

(b) Achieved by you.

(3) Services you requested and received;

(4) A written IL plan or a written form signed by you declining a plan.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1090, filed 8/27/99, effective 11/1/99.]

**WAC 388-890-1095 Does the IL program keep personal information confidential?** (1) The IL program protects your personal information as outlined in WAC 388-890-1255 through 388-890-1295.

(2) When a service provider is used, the service provider must have and follow policies and procedures that are consistent with WAC 388-890-1255 through 388-890-1295.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1095, filed 8/27/99, effective 11/1/99.]

**Chapter 388-891 WAC**

**VOCATIONAL REHABILITATION SERVICES FOR INDIVIDUALS WITH DISABILITIES**

(Formerly chapter 388-890 WAC (part))

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## PURPOSE

**WAC 388-891-0005** What is the purpose of this chapter? This chapter explains the types of vocational rehabilitation services (referred to as "VR services" in this chapter) available to individuals who are eligible through the department of social and health services (DSHS), division of vocational rehabilitation (DVR).

VR services are offered to assist individuals with disabilities to prepare for, get, and keep jobs that are consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. This chapter is consistent with the Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1998 and codified in 34 Code of Federal Regulations, Parts 361 and 363 and with state laws and DSHS requirements.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0005, filed 12/20/02, effective 2/3/03.]

## DEFINITIONS

**WAC 388-891-0010** What definitions apply to this chapter? "**Competitive employment**" means:

- (1) Part-time or full-time work;
- (2) Work that is performed in an integrated setting;
- (3) Work for which an individual is paid at or above the minimum wage; and

(2003 Ed.)

(4) Work for which an individual earns the same wages and benefits as other employees doing similar work who are not disabled.

"**Employment outcome**" means competitive employment, supported employment, self-employment, telecommuting, business ownership, or any other type of employment in an integrated setting that is consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

"**Extended employment**" means work in a nonintegrated or sheltered setting for a public or private nonprofit agency or organization that provides compensation in accordance with the Fair Labor Standards Act.

"**Extreme medical risk**" means medical conditions that are likely to result in substantial physical or mental impairments or death if services, including mental health services, are not provided quickly.

"**Family member**" means a person who is your relative or legal guardian; or someone who lives in the same household as you and has a substantial interest in your well being.

"**Individual with a disability**" means an individual:

- (1) Who has a physical or mental impairment;
- (2) Whose impairment results in a substantial impediment (medical, psychological, vocational, educational, communication, and others) hindering her or his ability to achieve an employment outcome; and
- (3) Who can achieve an employment outcome as a result of receiving VR services.

"**Integrated setting**" means:

(1) The setting in which you receive a VR service is integrated if it is a setting commonly found in the community (such as a store, office or school) where you come into contact with nondisabled people while you are receiving the service. The nondisabled people you come into contact with are not the same people providing VR services to you.

(2) The setting in which you work is integrated if it is a setting commonly found in the community where you come into contact with nondisabled people as you do your work. The amount of contact you have with nondisabled people is the same as what a nondisabled person in the same type of job would experience.

"**Most recent tax year**" means the most recent calendar year for which you filed or were required to file an income tax return with the United States Internal Revenue Service (IRS).

"**Physical, mental or sensory impairment**" means:

(1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculo-skeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or

(2) Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"**Representative**" means any person chosen by an applicant or eligible individual, including a parent, family member or advocate, unless a representative has been appointed by a court to represent the individual, in which



case the court-appointed representative is the individual's representative.

**"Substantial impediment to employment"** means the limitations you experience as a result of a physical, mental or sensory impairment that hinder your ability to prepare for, find, or keep a job that matches your abilities and capabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0010, filed 12/20/02, effective 2/3/03.]

## PROTECTION AND USE OF CONFIDENTIAL INFORMATION

**WAC 388-891-0100 What personal information about me does DVR keep on file?** DVR keeps a case service record while you are receiving services and for three years after your case is closed. The case service record includes, but is not limited to:

(1) The DVR application form or written request for VR services.

(2) Documentation explaining the need for the trial work experience or extended evaluation, if conducted, and the written plan for conducting the trial work experience or extended evaluation, and documentation of progress reviews.

(3) Documentation and records that support the determination of eligibility or ineligibility.

(4) Documentation supporting the severity of disability and priority category determination.

(5) Financial statement and/or related records.

(6) Plan for employment, amendments to the plan, if amended, and information supporting the decisions documented on the plan.

(7) Documentation describing how you used informed choice to make decisions throughout the process, including assessment services, selection of an employment outcome, VR services, service provider, type of setting and how to get VR services.

(8) If VR services are provided in a setting that is not integrated, documentation of the reason(s) for using a nonintegrated setting;

(9) If you achieve a competitive employment outcome, documentation to show:

(a) Your wages and benefits;

(b) That the job you have is:

(i) Described in your plan for employment;

(ii) Consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice; and

(iii) In an integrated setting.

(c) That the services provided to you in your plan for employment helped you become employed;

(d) That you have been employed for at least ninety days and that you no longer need vocational rehabilitation services;

(e) That you and your VR counselor agree that your employment is satisfactory and that you are performing well; and

(f) That you have been informed, through appropriate modes of communication about the availability of post-employment services.

(10) If you are referred to another state or federal program for services to prepare for, find or keep a job, documentation of the referral, the reason(s) for the referral, and the name of the program(s) to which you are referred.

(11) Documentation of case closure, including:

(a) Reasons for closing the case service record;

(b) How you were involved in the decision to close the case; and

(c) A copy of the closure letter that explains the reason(s) for case closure and your rights if you disagree with the decision.

(12) Documentation of the results of mediation or fair hearings, if held;

(13) Documentation of annual reviews after your case service record is closed as outlined in WAC 388-891-1330 if:

(a) You choose extended employment in a nonintegrated setting;

(b) You achieve a supported employment outcome in an integrated setting for which you are paid in accordance with section 14(c) of the Fair Labor Standards Act; or

(c) DVR determines you are ineligible because you are too severely disabled to benefit from VR services.

(14) Other documentation that relates to your participation in VR services, including your progress, throughout the VR process.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0100, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0110 What happens if DVR receives information that indicates I have a previous history of behavior involving violent or predatory acts?** (1) If a VR counselor receives information or records that reasonably lead the VR counselor to believe you have a previous history of violent or predatory behavior, you must participate in an assessment conducted by a licensed psychiatrist, psychologist, counselor, certified sex offender treatment provider, or other qualified professional prior to developing a plan for employment. The assessment is for the purpose of determining the level of risk you present to yourself or others in an employment situation.

(2) The VR counselor must consider the results and recommendations of the assessment in developing the plan for employment, including any restrictions relating to employment outcome or employment setting.

(3) If the results of the assessment indicate a potential risk to a service provider or employer, the individual must consent to release information about the behavior to a potential service provider or potential employer prior to referral for services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0110, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0120 Can I ask DVR to change incorrect information in my case service record?** You may ask DVR to correct information in your case service record that you believe is incorrect. DVR corrects the information, unless DVR disagrees that the information is incorrect. If there is a disagreement about the accuracy of the information, you may provide a written document explaining the information you believe incorrect. DVR puts the document in your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0120, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0130 Can DVR share personal information in my record with others?** (1) DVR shares personal information with others only if:

- (a) Another organization or program involved in your VR services needs the information to serve you effectively;
- (b) You request information in the case service record be shared with another organization for its program purposes;
- (c) You select an employment outcome in a field that customarily requires a criminal history background check as a condition of employment; and
- (d) You sign a written consent giving DVR permission to release, exchange, or obtain the information.

(2) DVR may release personal information without your written consent only under the following conditions:

- (a) If required by federal or state law;
- (b) To a law enforcement agency to investigate criminal acts, unless prohibited by federal or state law;
- (c) If given an order signed by a judge, magistrate, or authorized court official;
- (d) If DVR reasonably believes you are a danger to yourself or others;
- (e) To the DSHS division of child support; or
- (f) To an organization, agency or person(s) conducting an audit, evaluation or research.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0130, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0135 How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases?** (1) DVR uses special protections when you share personal information about drug or alcohol abuse or about HIV/AIDS and sexually transmitted diseases.

(2) DVR asks for your specific permission to copy information of this nature before sharing it with a service provider or organization that is helping you reach your employment goals.

(3) Information about drug and alcohol abuse must be handled in accordance with RCW 70.96A.150 and applicable federal and state laws and regulations.

(4) Information about HIV/AIDS or other sexually transmitted diseases must be handled in accordance with RCW 70.24.105 and applicable federal and state laws and regulations.

(2003 Ed.)

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0135, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0140 Can I obtain copies of information in my case service record?** (1) You may review or obtain copies of information contained in your case service record by submitting a written request to DVR. DVR provides access to or provides copies of records upon request, except in the following circumstances:

(a) If DVR believes the medical, psychological, or other records in your case service record may be harmful to give to you, DVR only releases the records to a third party that you choose, such as your representative, parent, legal guardian or a qualified medical professional.

(b) If DVR receives personal information about you from another agency or service provider, DVR may only share the records as authorized by the agency or service provider that provided the information.

(c) If a representative has been appointed by a court to represent you, the information must be released to the representative.

(2) DVR provides access or gives you copies of records within ten business days of receiving your written request. If DVR cannot fulfill your request within ten business days, DVR will send you a written notice of the reason(s) the request cannot be met and the date you are granted access or the date the requested information will be provided.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0140, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0150 How does DVR protect personal information that is released for audit, evaluation or research?** DVR may release personal information for audit, evaluation or research if the results would improve the quality of life or VR services for people with disabilities. Before any personal information is shared, the organization, agency, or individual must agree to the following conditions:

(1) The information must only be used by people directly involved in the audit, evaluation or research;

(2) The information must only be used for the reasons approved by DVR in advance;

(3) The information must be kept secure and confidential;

(4) The information must not be shared with any other parties, including you or your representative; and

(5) The final product or report must not contain any personal information that would identify you without your written consent.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0150, filed 12/20/02, effective 2/3/03.]

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**CUSTOMER RIGHTS**

**WAC 388-891-0200 Can a guardian or another representative act on my behalf with DVR?** (1) You may select someone to act as your representative, as appropriate, during the VR program.

(2) If you have a legal guardian or a court-appointed representative, he or she must act as your representative.

(a) A legal guardian or court-appointed representative must provide DVR with documentation of guardianship.

(b) Your legal guardian or court-appointed representative must sign the application and other documents that require your signature.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0200, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0205 How do I ask for an exception to a rule in this chapter?** (1) A request for exception to a rule in this chapter is submitted to the DVR director or designee in writing, and must include:

- (a) A description of the exception being requested;
- (b) The reason you are asking for the exception; and
- (c) The duration of the exception, if applicable.

(2) An exception requesting a medical service that is otherwise not provided by DVR may only be requested on a trial basis or for a short duration to be specified in the request.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0205, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0210 What happens after I submit a request for an exception?** (1) After receiving your request for an exception, the DVR director or designee decides whether to approve the request based on:

(a) The impact of the exception on accountability, efficiency, choice, satisfaction, and quality of services;

(b) The degree to which your request varies from the WAC; and

(c) Whether the rule or condition is a federal regulation that cannot be waived.

(2) The DVR director or designee responds to the request for an exception within ten working days of receiving the request.

(a) If the request is approved, the DVR director or designee provides a written approval that includes:

- (i) The specific WAC for which an exception is approved;
- (ii) Any conditions of approval; and
- (iii) Duration of the exception.

(b) If the request is denied, the DVR director or designee will provide a written explanation of the reasons for the denial.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130,

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and chapter 26.44 RCW. 03-02-014, § 388-891-0210, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0215 What if a DVR counselor makes a decision about my VR services that I don't agree with?**

(1) If a DVR counselor makes a decision that affects the VR services provided to you that you don't agree with, you may try to resolve the disagreement by any one of the following or a combination of the following:

(a) Seek assistance from the client assistance program, talk to the VR counselor, talk to the VR supervisor, or talk to the DVR director or his or her designee;

(b) Request mediation; and/or

(c) Request a fair hearing.

(2) You may request a fair hearing and/or mediation while you continue to work with the DVR counselor, VR supervisor or DVR director or designee to resolve the disagreement. If you reach agreement prior to the date of the scheduled mediation or fair hearing, the request may be withdrawn.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0215, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0220 What is the client assistance program (CAP)?** The client assistance program (CAP) is a program independent of DVR that offers information and advocacy about your rights as a DVR customer and offers assistance to help you receive services. You may ask for help or information from CAP at any time during the rehabilitation process by asking a DVR staff person for information about how to contact CAP or by calling CAP toll free at 1-800-544-2121 voice/TTY. A CAP representative may represent you with DVR if a disagreement occurs that you cannot resolve on your own. CAP attempts to resolve disagreements informally through discussions with the DVR employee(s) involved as a first step. If informal efforts are not successful, CAP may represent you in mediation and/or a fair hearing. CAP services are available at no cost to you.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0220, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0225 What is mediation?** (1) Mediation is a process in which a trained mediator conducts a meeting with you and a representative from DVR, usually your DVR counselor to help you settle a disagreement.

(a) The mediator does not work for DVR.

(b) The mediator does not make decisions about your case.

(c) Mediation is voluntary for all parties.

(2) During mediation:

(a) Each party presents information or evidence;

(b) The mediator reviews and explains the laws that apply; and

(c) The mediator helps you and the VR representative reach an agreement, if possible.

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(3) You may ask someone to represent you during the mediation, including a CAP representative, however, you must be present.

(4) Agreements you and DVR reach through mediation are not legally binding.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0225, filed 12/20/02, effective 2/3/03.]

#### **WAC 388-891-0230 When can I ask for mediation?**

You may ask for mediation any time you disagree with a decision DVR makes that affects the VR services that DVR provides to you. Mediation is not used to deny or delay your right to a fair hearing. You may request both mediation and a fair hearing at the same time. If an agreement is reached during mediation, the fair hearing is cancelled.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0230, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0235 Who arranges and pays for mediation?** DVR schedules mediation in a timely manner at a location that is convenient to all parties. DVR pays for costs related to mediation, except costs related to a representative or attorney you ask to attend. DVR may pay for VR services you require to participate in mediation, such as transportation or child care.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0235, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0240 Is information discussed during mediation confidential?** Discussions during mediation are confidential and may not be used in a later fair hearing or civil proceeding, if one is held. Before beginning a mediation session, all parties must sign a statement of confidentiality.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0240, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0245 If the mediation session results in an agreement, do I receive a written statement of the results?** If you and the DVR representative reach an agreement during mediation:

- (1) The agreement is documented in writing;
- (2) You and the DVR representative sign the written agreement; and
- (3) DVR provides you with a copy of the agreement.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0245, filed 12/20/02, effective 2/3/03.]

(2003 Ed.)

**WAC 388-891-0250 What is a fair hearing?** A fair hearing is a review process outlined under the Administrative Procedure Act, chapter 34.05 RCW and chapter 388-02 WAC that is conducted by an administrative law judge who works for the office of administrative hearings. During a fair hearing, both you and DVR may present information, witnesses, and/or documents to support your position. You may ask someone to represent you, such as an attorney, a friend, a relative, a representative from the client assistance program, or someone else you choose. The administrative law judge makes a decision after hearing all of the information presented; reviewing any documents submitted, and reviewing relevant laws and regulations.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0250, filed 12/20/02, effective 2/3/03.]

#### **WAC 388-891-0255 How do I request a fair hearing?**

(1) To ask for a fair hearing, send a written request to the office of administrative hearings. You must include the following information in your written request:

- (a) Your name, address, and telephone number;
- (b) The name of the DSHS program that the fair hearing involves (such as DVR);
- (c) A written statement describing the decision and the reasons you disagree; and
- (d) Any other information or documents that relate to the matter.

(2) You must submit your request for a fair hearing within twenty days of the date the VR counselor makes the decision with which you disagree.

(3) You may ask any DVR employee for instructions or assistance to submit a request for a fair hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0255, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0260 After I submit a request for a fair hearing, when is it held?** The office of administrative hearings holds a fair hearing within sixty days of receipt of your written request for a hearing, unless you or DVR ask for a later hearing date and the office of administrative hearings determines there is a reasonable cause for the delay.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0260, filed 12/20/02, effective 2/3/03.]

#### **WAC 388-891-0265 What is a pre-hearing meeting?**

After you submit a request for a fair hearing, DVR offers you a pre-hearing meeting. The pre-hearing meeting can be conducted in person, by telephone, or by another method agreeable to all parties. The purpose of the pre-hearing meeting is to:

- (1) Clarify the decision with which you disagree;

- (2) Exchange copies of laws, rules or other information to be presented in the fair hearing;
- (3) Explain how the fair hearing is conducted; and
- (4) Settle the disagreement, if possible.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0265, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0270 Do I receive a written fair hearing decision?** The office of administrative hearings sends you a written report of the findings and decision within thirty days of the fair hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0270, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0275 Is the fair hearing decision final?**

- (1) The office of administrative hearings decision is final and DVR must implement the decision.
- (2) If you do not agree with the office of administrative hearings decision, you may pursue civil action through superior court to review that decision.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0275, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0295 Can DVR suspend, reduce or terminate my services if I request a fair hearing?** DVR may not suspend, reduce, or terminate agreed upon services if you have requested a fair hearing, unless DVR provides evidence that you provided false information, committed fraud or other criminal acts involving VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0295, filed 12/20/02, effective 2/3/03.]

## PAYING FOR VR SERVICES

**WAC 388-891-0300 Under what conditions does DVR provide and/or pay for vocational rehabilitation services to individuals?** DVR provides and pays for VR services if:

- (1) You have completed the application requirements;
- (2) You have provided documents that verify your identity and legal work status;
- (3) DVR authorizes the services before the services begin;
- (4) The services are needed to:
  - (a) Determine your eligibility for services;
  - (b) Identify your vocational rehabilitation needs; and/or
  - (c) Help you get and/or keep a job.
- (5) The services to be provided, except services listed in WAC 388-891-0310, are not provided to you or paid for, in

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whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits;

(6) You have completed the financial statement, if required, and have agreed upon what portion, if any, you are required to for your VR services; and

(7) The service provider meets all federal, state, and agency requirements for approval as a DVR service provider.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0300, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0310 What VR services are provided without determining whether services or benefits are available from another program or organization?** DVR is not required to determine whether the following services or benefits can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits:

- (1) Assessment services to determine eligibility and/or VR needs;
- (2) Counseling and guidance, including information and referral;
- (3) Independent living services and evaluations provided by DVR staff;
- (4) Job placement and job retention services;
- (5) Rehabilitation technology services;
- (6) Post-employment services when providing the services listed in subsection (1) through (5) above.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0310, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0320 What if looking for services and benefits available from another program would delay or interrupt my progress toward achieving an employment outcome?** (1) A DVR counselor may begin providing VR services without conducting a review to determine whether services or benefits can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits if the review would delay or interrupt:

- (a) VR services to an individual determined to be at extreme medical risk, based on medical evidence provided by a qualified professional;
  - (b) An immediate job placement; or
  - (c) Your progress toward achieving the employment outcome identified on your individual plan for employment.
- (2) If you receive VR services before services or benefits are available from another program, you begin using the services and benefits from the other program when they become available.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0320, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0325 Does DVR pay for a VR service if services and benefits are available from another program or organization, but I don't want to use them?** Except for the services outlined in WAC 388-891-0310, DVR does not pay for services or benefits that can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits. If you choose not to apply for and use the services or benefits, you are responsible for the cost of the services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0325, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0330 Does DVR consider academic awards and scholarships as income?** Academic awards and scholarships you earn based on merit are not counted as income for purposes of determining your participation in the cost of services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0330, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0340 How does DVR determine whether I must pay part of my VR services using my own financial resources?** (1) To determine whether you are required to pay a portion of VR services using your own financial resources:

(a) You must complete a DVR financial statement to document your financial status, except for the services outlined in WAC 388-891-0365;

(b) You must provide copies of financial records requested by DVR to establish your financial status.

(2) Depending on your income tax filing status for the most recent tax year, you must provide financial information based on your own individual resources or based on your family resources.

(a) If your income tax status was reported as married filing jointly, married filing separately, or you were listed as a dependent of another person, complete the financial statement based on family resources.

(b) If your income tax status was reported as single, complete the financial statement based on your own financial resources.

(3) If you fail to report your financial status accurately or fail to provide the required information, DVR may deny or suspend services at any time in the rehabilitation process, except the services listed under WAC 388-891-0365.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0340, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0345 Do I have to pay a portion of my VR services if I receive assistance or income support from another public program?** If you provide verification that

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you receive benefits from one of the following programs, you are not required to pay any portion of your VR services.

(1) Department of social and health services (DSHS) income assistance;

(2) Medicaid; or

(3) Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0345, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0350 What financial information does DVR use to decide if I need to help pay for VR services?**

(1) You complete a DVR financial statement to disclose the following information used to determine whether you must pay any part of the cost of VR services:

(a) Income from all sources, assets, including but not limited to bank accounts, vehicles, personal property, stocks, bonds, and trusts; and

(b) Living expenses, including household expenses, credit or loan payments, disability-related expenses and other financial obligations.

(2) If the results of the financial statement show that you do not have resources available to help pay for your VR services, DVR provides the services at no cost to you.

(3) If you decline to complete the financial statement or decline to contribute to the cost of VR services, DVR provides only those services listed under WAC 388-891-0365.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0350, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0355 How is the amount I pay for VR services determined?** After completing the financial statement, you and a DVR counselor agree how to use the resources identified on the financial statement to help pay for VR services. The costs you agree to pay are documented on the individualized plan for employment (IPE). If your financial status changes, you are required to report the changes to your DVR counselor.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0355, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0360 What personal resources are not counted in the decision about whether I have to help pay for services?** DVR does not count the following resources when deciding whether you need to help pay for DVR:

(1) The value of your primary home and furnishings;

(2) The value of items that you keep because of personal attachment, rather than because of monetary value;

(3) The value of one vehicle per household member needed for work, school, or to participate in VR services;

(4) Retirement, insurance, or trust accounts that do not pay a current benefit to you or your family;



(5) If a retirement, insurance or trust account pays a current benefit, only the monthly benefit is counted as income and the balance of the account is excluded;

(6) Awards or scholarships you earn based on merit;

(7) Up to five thousand dollars of your total assets are excluded as exempt;

(8) Equipment or machinery used to produce income;

(9) Livestock used to produce income; and

(10) Disability-related items and/or services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0360, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0365 What VR program services am I not required to help pay for?** You are not required to pay any portion of the following VR services, regardless of your financial status:

(1) Assessment services to determine eligibility or VR needs, including independent living evaluations;

(2) Counseling and guidance services provided by DVR staff;

(3) Information and referral services;

(4) Interpreter and reader services;

(5) Personal assistance services;

(6) Job placement;

(7) Job retention services;

(8) Independent living services provided directly by DVR staff; and

(9) Post-employment services that include any of the services in subsections (1) through (8) above.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0365, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0370 Can I select the services and service provider of my choice?** (1) You may select VR services that you need to achieve an employment outcome that is consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

(2) You may select the service provider of your choice if the service provider meets the following conditions:

(a) DVR pays for services that meet your needs at the least cost possible.

(i) If two or more service providers or programs offer comparable services but differ in cost, and you choose the higher cost service or program, you are responsible for those costs in excess of the lower cost service. You can use resources other than DVR funds to pay the remaining cost.

(ii) DVR may pay for a service or program at a higher cost than another service or program if the costs are reasonably comparable.

(b) The service provider meets all federal, state, and DVR requirements for DVR approval.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130,

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and chapter 26.44 RCW. 03-02-014, § 388-891-0370, filed 12/20/02, effective 2/3/03.]

## INFORMED CHOICE

### WAC 388-891-0400 What is informed choice?

Informed choice is the process by which an individual receiving services from DVR makes decisions about VR goals and the VR services and service providers necessary to reach those goals. The decision-making process takes into account the individual's values, lifestyle, and characteristics, the availability of resources and alternatives, and general economic conditions. Informed choice involves communicating clearly with an individual receiving VR services to assure the individual understands and uses pertinent information in the decision making process. The intent of informed choice is to ensure VR services are provided in a manner that promotes respect for individual dignity, personal responsibility, self-determination, and the pursuit of meaningful careers.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0400, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0410 How does DVR support the informed choice process?** DVR supports the informed choice process by providing counseling and guidance, information and support to help you make choices that match your strengths, resources, priorities, concerns, abilities, capabilities, and interests, including:

(1) Explaining what choices you can make throughout the rehabilitation process;

(2) Assisting you to identify and get the information you need to explore the options available; and

(3) Helping you understand and evaluate the options.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0410, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0420 What if I don't know how to use the informed choice decision making process?** DVR explains how to use informed choice to make decisions about VR goals and services. If it is difficult for you to make informed choices, DVR can help you understand the options available and choose the one that meets your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0420, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0430 What decisions can I make using informed choice?** You have the right to make informed choices about VR goals and services throughout the rehabilitation process, including but not limited to:

(1) What assessment services and/or service provider(s) you will use to get the information necessary for DVR to determine eligibility and/or identify your VR needs;

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(2) What to include on your individualized plan for employment (IPE), including:

- (a) Type of employment outcome and setting;
- (b) VR services needed to achieve the employment outcome;
- (c) Service provider(s) that will provide the service and setting in which to receive the services; and
- (d) Method(s) of arranging and paying for services, from the methods available to DVR under state law and agency policy.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0430, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0440 What information and assistance will DVR provide to help me make informed choices about VR services and service providers?** To help you select the VR services you need to achieve an employment outcome and the service provider(s) to use, DVR will help you get the following information, to the extent the information is available and/or appropriate:

- (1) Cost, accessibility, and duration of services;
- (2) Consumer satisfaction with those services;
- (3) Qualifications of potential service providers;
- (4) Type(s) of services offered by each service provider;
- (5) Type of setting in which the services are provided, including whether the setting is integrated or nonintegrated; and
- (6) Outcomes achieved by others served by the service provider.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0440, filed 12/20/02, effective 2/3/03.]

## ORDER OF SELECTION

**WAC 388-891-0500 What happens if DVR cannot serve every eligible person?** If DVR cannot serve all eligible individuals, because there are not enough funds or other resources, DVR must:

- (1) Establish a statewide waiting list for services;
- (2) Implement a process called order of selection that establishes the order in which DVR selects eligible individuals from the waiting list to begin receiving VR services; and
- (3) Provide you with information and guidance (which may include counseling and referral for job placement) about other federal or state programs that offer services to help you meet your employment needs, if available.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0500, filed 12/20/02, effective 2/3/03.]

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**WAC 388-891-0510 How are individuals selected for services when DVR is operating under an order of selection?** When DVR is operating under an order of selection, individuals are selected for services as follows:

- (1) At the time you are determined eligible for VR services, a DVR counselor establishes a priority for services category based on the severity of your disability.
- (2) As resources become available for DVR to serve additional individuals, DVR selects names from the waiting list in the priority category being served at that time.
- (3) The priority categories include:
  - (a) Priority category 1—Individuals with most severe disabilities;
  - (b) Priority category 2—Individuals with severe disabilities; and
  - (c) Priority category 3—Individuals with disabilities.
- (4) Within a priority category, the date you applied for VR services determines the order in which you are selected from the waiting list.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0510, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0520 What is the criteria for priority category 1—Individuals with most severe disabilities?** DVR determines you are in priority category 1—Individuals with most severe disabilities, if you meet the following criteria:

- (1) You require supported employment; and/or
- (2) You meet the criteria for an individual with a severe disability as defined in WAC 388-891-0530, you require two or more VR services over an extended period of time (twelve months or more) and you experience serious functional losses in four or more of the following areas in terms of an employment outcome:
  - (a) Mobility;
  - (b) Communication;
  - (c) Self-care;
  - (d) Self-direction;
  - (e) Interpersonal skills;
  - (f) Work tolerance; or
  - (g) Work skills.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0520, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0530 What is the criteria for priority category 2—Individuals with severe disabilities?** DVR determines you are in priority category 2—Individuals with severe disabilities if:

- (1) You are receiving disability benefits under Title II or Title XVI of the Social Security Act, but do not meet the criteria for priority category 1; and/or
- (2) You meet the eligibility requirements outlined in WAC 388-891-0540, you require two or more VR services over an extended period of time (twelve months or more)

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and, you experience serious functional losses in one to three of the following areas in terms of an employment outcome:

- (a) Mobility;
- (b) Communication;
- (c) Self-care;
- (d) Self-direction;
- (e) Interpersonal skills;
- (f) Work tolerance; or
- (g) Work skills.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0530, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0540 What is the criteria for priority category 3—Individuals with disabilities?** DVR determines you are in priority category 3—Individuals with disabilities if you meet the eligibility requirements outlined in WAC 388-891-1000, but you do not meet the criteria for priority category 1 or priority category 2.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0540, filed 12/20/02, effective 2/3/03.]

## VR SERVICES

**WAC 388-891-0600 What vocational rehabilitation services are available to individuals from DVR?** The following VR services are available to individuals from DVR:

- (1) Assessment services;
- (2) Independent living evaluation and services;
- (3) Information and referral services;
- (4) Interpreter services;
- (5) Job placement services;
- (6) Job retention services;
- (7) Maintenance services;
- (8) Occupational licenses;
- (9) Personal assistance services;
- (10) Physical and mental restoration services;
- (11) Rehabilitation technology services;
- (12) Self-employment services;
- (13) Services to family members;
- (14) Substantial counseling and guidance services;
- (15) Tools, equipment, initial stocks and supplies;
- (16) Training services;
- (17) Transition services;
- (18) Translation services;
- (19) Transportation services;
- (20) Other services; and
- (21) Post-employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0600, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0605 What are assessment services?** Assessment services, including services provided in a trial

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work experience or extended evaluation, are provided to obtain information necessary to determine:

- (1) Whether you are eligible for VR services;
- (2) Severity of disability and priority category; and/or
- (3) The employment outcome and VR services to be included in an individualized plan for employment.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0605, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0610 What are independent living services and/or evaluation?** Independent living services and/or evaluation includes services provided to:

- (1) Identify issues that present problems for you in achieving an employment outcome and services you need to address the issues.
- (2) Help you manage the services you need to live independently, get information about benefits available to you and about your rights and responsibilities.
- (3) Help you set personal goals, make decisions about life issues and employment, and help your family with issues related to your disability and independence.
- (4) Help you manage and balance your life in areas such as budgeting, meal preparation and nutrition, shopping, hygiene, time management, recreation, community resources, and attendant management.
- (5) Find out about housing resources and the qualifications, make decisions about the living arrangements and about changing to a more independent living arrangement.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0610, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0615 What are information and referral services?** Information and referral services include information and guidance provided to help you explore employment services or benefits available to you from other programs, including other programs within the workforce development system.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0615, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0620 What are interpreter services?** Interpreter services include sign language or oral interpretation services for individuals who are deaf or hard of hearing, and tactile interpretation services for individuals who are deaf-blind.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0620, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0625 What are job placement services?** Job placement means referral to a specific job that results in a job placement.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0625, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0630 What are job retention services?** Job retention means services provided after you have been placed in a job to help you achieve satisfactory performance and keep the job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0630, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0635 What are maintenance services?** Maintenance includes monetary support for expenses such as food, shelter, or clothing that are in excess of your usual living expenses that you need to participate in another VR service. The following examples include, but are not limited to, the ways maintenance may be used:

- (1) A uniform or other suitable clothing required to look for or get a job;
- (2) Short-term lodging and meals required to participate in assessment or training services not within commuting distance of your home; and
- (3) A security deposit or utility hook-ups on housing you need to relocate for a job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0635, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0640 What are occupational licenses?** Occupational licenses are licenses, permits, certificates or bonds showing you meet certain standards or have accomplished certain achievements and/or have paid dues, fees or otherwise qualify to engage in a business, a specific occupation or trade, or other work.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0640, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0645 What are personal assistance services?** (1) Personal assistance services include a range of services provided by at least one person to help you perform daily living activities on or off the job that you would perform without assistance if you did not have a disability. Examples include, but are not limited to:

- (a) Reader services for individuals who cannot read print because of blindness or other disability. In addition to reading aloud, reader services include transcription of printed information into Braille or sound recordings. Reader services are generally for people who are blind, but may also include individuals unable to read because of serious neurological disor-

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ders, specific learning disabilities, or other physical or mental impairments.

(b) Personal attendant services are personal services that an attendant performs for an individual with a disability, including, but not limited to, bathing, feeding, dressing, providing mobility and transportation.

(2) Personal assistance services are only provided in connection with one or more other VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0645, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0650 What are physical and mental restoration services?** (1) Physical and mental restoration services are used to diagnose and treat physical and mental impairments.

(2) DVR provides physical and mental restoration services if your disabling condition is stable or slowly progressive and the service is expected to substantially modify, correct, or improve a physical or mental impairment that is a substantial impediment to employment for you within a reasonable length of time and financial support is not readily available from another source, such as health insurance.

(3) Physical and mental restoration services include:

(a) Corrective surgery or therapy;

(b) Diagnosis and treatment of mental or emotional disorders by qualified personnel who meet state licensing requirements;

(c) Dental treatment if the treatment is directly related to an employment outcome, or in emergency situations involving pain, acute infections, or injury;

(d) Nursing services;

(e) Hospitalization (in-patient or outpatient) in connection with surgery or treatment and clinic services;

(f) Drugs and supplies;

(g) Prosthetic and orthotic devices;

(h) Eyeglasses and visual services, including visual training, and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other special visual aids;

(i) Podiatry;

(j) Physical therapy;

(k) Occupational therapy;

(l) Speech or hearing therapy;

(m) Mental health services;

(n) Treatment of acute or chronic medical conditions and emergencies that result from providing physical and mental restoration services, or that are related to the condition being treated;

(o) Special services for the treatment of end-stage renal disease; and

(p) Other medical or medically-related rehabilitation services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0650, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0655 What are the medical treatments DVR does not pay for?** DVR does not pay for the following medical treatments:

(1) Maintenance of your general health or fitness, including, but not limited to, vitamins, in-patient hospital based weight loss programs or for-profit weight loss programs, exercise programs, health spas, swim programs and athletic fitness clubs;

(2) Cosmetic procedures, such as facelifts, liposuction, cellulite removal;

(3) Maternity care;

(4) Hysterectomies, elective abortions, sterilization, and contraceptive services as independent procedures;

(5) Drugs not approved by the Federal Drug Administration for general use or by state law;

(6) Life support systems, services, and hospice care;

(7) Transgender services including surgery and medication management;

(8) Homeopathic and herbalist services, Christian Science practitioners or theological healers; and

(9) Treatment that is experimental, obsolete, investigational, or otherwise not established as effective medical treatment.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0655, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0660 What is rehabilitation technology?** Rehabilitation technology includes the use of technology, engineering methods and sciences to design, develop, test, evaluate, apply and distribute technology to address problems faced by individuals with disabilities in functional areas such as mobility, communication, hearing, vision and cognition. Rehabilitation technology includes:

(1) Assistive technology devices, equipment, or products used to increase, maintain, or improve the functional capabilities of an individual with a disability including, but not limited to:

(a) Telecommunications devices;

(b) Sensory aids and devices, including hearing aids, telephone amplifiers and other hearing devices, captioned videos, taped text, Brailled and large print materials, electronic formats, graphics, simple language materials, and other special visual aids;

(c) Vehicle modifications; and

(d) Computer and computer-related hardware and software that is provided to address a disability-related limitation.

(2) Services that assist you in the selection, acquisition, or use of an assistive technology device, including services to:

(a) Evaluate your needs in performing activities in your daily environment;

(b) Select, design, fit, customize, adapt, apply, maintain, repair, or replace an assistive technology device;

(c) Coordinate and use other therapies or services with assistive technology devices, such as education and rehabilitation plans and programs;

(d) Train or give technical assistance to professionals, employers, family members or others who provide services to you, hire you, or are involved in your major life activities.

(3) Real time captioning services;

(4) A written policy, plan, guarantee or warranty (initial or extended) that covers the cost to repair or replace an assistive technology device, a piece of equipment, or another assistive technology product if it is lost or damaged.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0660, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0665 Under what conditions does DVR provide vehicle modifications as a rehabilitation technology service?** DVR provides vehicle modifications under the following conditions:

(1) DVR does not have a question about your driving safety as outlined in WAC 388-891-0775.

(2) The DVR counselor has determined based on disability-related documentation that your disability is stable or slowly progressive and not likely to impair your driving ability in the future, if you plan to drive the vehicle.

(3) You have provided documentation verifying that you and/or a family member is the registered and/or legal owner of the vehicle.

(4) You have provided a copy of a current driver's license and vehicle license with required endorsements for you and/or family member(s) who will operate the vehicle.

(5) If a used vehicle is to be modified, you have provided documentation of an inspection from a certified or journey level auto mechanic that verifies the vehicle is in good condition and capable of being modified.

(6) DVR has obtained documentation from a specialist in evaluation and modification of vehicles for individuals with disabilities that prescribes and inspects the modification, except prescriptions are not required for:

(a) Placement of a wheelchair lift, ramp, or scooter lift and tie downs for passenger access only;

(b) Replacement of hand controls;

(c) Wheelchair carriers; and

(d) Other minor driving aids.

(7) You have provided documentation of vehicle insurance adequate to cover the cost of replacement for loss or damage, including the cost of the modification.

(8) You have demonstrated or provided documentation that verifies you and/or family member(s) designated as a driver can safely operate the vehicle as modified.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0665, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0670 What types of insurance can DVR pay for?** (1) DVR may pay for insurance for assistive technology devices, equipment and products.

(2) DVR does not pay for other types of insurance including, but not limited to, health, vehicle, home, and life insurance.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0670, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0675 What types of assistive technology insurance can DVR pay for?** DVR may pay for insurance for assistive technology devices, equipment, and products which covers the cost to repair or replace them if they are lost or damaged if:

(1) The individual with a disability is the holder of the device, equipment or product and is the named insured under the policy; and

(2) The insurer pays for replacement or repair directly to the manufacturer or service provider.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0675, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0680 What types of assistive technology warranties can DVR pay for?** (1) DVR may pay for an initial warranty for an assistive technology device, piece of equipment, or product for a specified period of time following the date of purchase if the warranty is available at the time of purchase by the manufacturer. An initial warranty may guarantee repair and/or replacement of parts or the entire device, equipment, or product when the parts and/or workmanship are faulty.

(2) DVR may pay for an initial warranty or for a warranty that extends beyond the period of coverage of an initial warranty for an assistive technology device, piece of equipment, or product if:

(a) The individual with a disability is the holder of the device, equipment, or product;

(b) The manufacturer provides a written guarantee for the materials and workmanship of the device, equipment, or product; and

(c) The manufacturer replaces or repairs faulty parts and workmanship or replaces the device, equipment, or product in whole or the manufacturer directly pays a service provider to repair or replace parts and workmanship or the device, equipment, or product in whole.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0680, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0685 What are self-employment services?** Self-employment services include consultation and technical assistance to help you establish a small business to become self-employed and equipment, tools, initial stocks and supplies. Before a DVR counselor agrees to an IPE that includes a self-employment outcome, you must complete assessment services, including the development of a business plan that demonstrates that the self-employment you are considering is feasible, sustainable, and results in an employment

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outcome. DVR does not support hobbies or activities that do not result in an income-producing self-employment outcome.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0685, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0690 What vocational rehabilitation services can DVR provide to my family member(s)?** Vocational rehabilitation services may be provided to a family member if the services are necessary for you to achieve an employment outcome. A family member includes a relative or guardian of an applicant or eligible individual or an individual who lives in the same household as the applicant or eligible individual and has a substantial interest in her or his well being.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0690, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0695 What types of child care does DVR provide to my family members?** (1) DVR pays for the following types of licensed child care and child care exempt from licensing in conformance with DSHS licensing or certification requirements and background check requirements:

(a) Child day care centers;

(b) Family child day care homes; and

(c) School-age child care centers.

(2) DVR pays for in-home or relative child care including:

(a) Child care provided to your child(ren) in your home by a relative or other person; and

(b) Child care provided to your child(ren) by a relative outside of your home.

(3) To be authorized as an in-home/relative child care provider for DVR payment, your in-home or relative child care provider must comply with background check requirements outlined in chapter 388-290 WAC.

(4) DVR pays for child care in states bordering Washington if the child care provider meet their state's licensing regulations.

(5) DVR pays the child care provider's usual rates for child care services directly to the child care provider.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0695, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0700 What is substantial counseling and guidance?** Substantial counseling and guidance includes intensive counseling and guidance provided by a DVR counselor throughout the rehabilitation process to help you address medical, family or social issues, vocational counseling, or other counseling and guidance that is over and above the usual counseling and guidance relationship. Substantial counseling and guidance services include counseling and guidance to support a self-directed job search.

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[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0700, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0705 What are tools, equipment, initial stocks and supplies?** Tools, equipment, initial stocks and supplies are materials and hardware required to carry out the duties of a job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0705, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0710 What are training services?** Training services are designed to help you gain knowledge, skills and abilities needed to achieve an employment outcome. Training services, include, but are not limited to:

- (1) On-the-job training;
- (2) Post-secondary training;
- (3) Technical or vocational training;
- (4) Basic education/literacy training;
- (5) Community rehabilitation program (CRP) training;
- (6) Other miscellaneous training.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0710, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0715 What is on-the-job training?** On-the-job training is training an employer provides to you after you are placed in a job to help you learn the skills you need. The employer must sign an agreement to include at a minimum:

- (1) Training to be provided, including skills to be learned and training methods;
- (2) Duration or number of hours of training to be provided;
- (3) How the employer will evaluate and report your progress to DVR;
- (4) An agreed-upon fee based on the employer's costs to provide the training; and
- (5) Payment criteria.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0715, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0720 What is post-secondary training?** Post-secondary training means academic training above the high school level leading to a degree, an academic certificate, or other recognized educational credential. Post-secondary training is provided by a college or university, community college, junior college or technical college.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0720, filed 12/20/02, effective 2/3/03.]

[Title 388 WAC—p. 1208]

**WAC 388-891-0725 What is technical or vocational training?** Technical or vocational training includes occupational, vocational or specific job skill training, not leading to an academic degree, provided by a community college, business school, vocational, technical or trade school to prepare for work in a specific occupation.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0725, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0730 What is basic education/literacy training?** Basic education/literacy training teaches basic academic skills, including how to read.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0730, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0735 What is community rehabilitation program (CRP) training?** Community rehabilitation program (CRP) training is training to prepare an individual for work, such as developing appropriate work habits and behaviors, getting to work on time, dressing appropriately, and/or skills to increase productivity.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0735, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0740 What other training does DVR provide?** DVR provides other miscellaneous training services that are not identified in another section, such as high school completion, speech reading or sign language training, cognitive training and tutoring.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0740, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0745 What conditions apply to receiving training services at an institution of higher education?** (1) Training at an institution of higher education (universities, colleges, community or junior colleges, vocational schools, technical institutes, or hospital schools of nursing) is provided only after you and a DVR counselor have made maximum efforts to get and use available grant funding from other sources to pay for costs related to attendance. Grant funding does not include student loans.

(2) You must provide DVR a copy of your grant funding award or denial form, statement of unmet need and/or student budget, and other related documentation.

(3) If an academic institution charges a fee to cover the cost of a student health clinic and the fee is required as a condition of registration, DVR may pay this fee.

(4) If an academic institution charges a liability fee to cover the costs of a student to register in high-risk courses/

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practicum and the fee is required as a condition of registration, DVR may pay this fee.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0745, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0750 Can I receive training services from a private school, an out-of-state training agency or an out-of-state college?** If you choose training services at a private or out-of-state program when an in-state or public program is available and adequate to meet your needs, you are responsible for costs that are in excess of the public or in-state program costs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0750, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0755 What are transition services?** (1) Transition services are work-related activities you begin while you are in high school that are coordinated with VR services to help you prepare for and go to work in the community after you leave high school.

(2) Transition services may include any of the VR services listed under WAC 388-891-0600.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0755, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0760 What are translation services?** Translation services include oral and written translation of English into the primary language of an applicant or eligible individual.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0760, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0765 What are transportation services?** Transportation services include travel and related expenses necessary for you to participate in VR services, such as a bus pass, reimbursement for gasoline, purchase or repair of a vehicle.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0765, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0770 Under what conditions does DVR provide a vehicle?** (1) DVR provides a vehicle as a transportation service only in exceptional circumstances to support another VR service on the IPE and must be approved by the director or his or her designee.

(2) A vehicle issued to you remains the property of DVR until you achieve an employment outcome that requires the

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vehicle and you maintain the employment for at least ninety days.

(3) The director or his or her designee approves the purchase of a vehicle only if:

(a) A DVR counselor determines, based on disability-related documentation that your disability is stable or slowly progressive, and is not likely to impair your ability to drive in the future;

(b) You and a DVR counselor agree it is a necessary service under your individualized plan for employment (IPE) because:

(i) No other transportation options are available and it is not feasible for you to relocate to live closer to employment or other transportation options; or

(ii) A vehicle is required as a condition of employment.

(c) You do not have a vehicle or your vehicle cannot be modified or repaired to the extent that you can drive it.

(4) Prior to issuing a vehicle to you, you must submit the following documents to DVR and you must agree to provide ongoing verification upon request of a DVR counselor:

(a) A copy of your current, valid driver's license;

(b) A copy of your driving record disclosing any moving violations and indicating no criminal convictions related to driving a vehicle;

(c) A copy of your motor vehicle insurance coverage with the following minimum coverage and conditions:

(i) Liability in the amount of fifty thousand dollars/one hundred thousand dollars/fifty thousand dollars;

(ii) Uninsured motorist in the amount of fifty thousand dollars/one hundred thousand dollars/fifty thousand dollars;

(iii) Personal injury in the amount of one hundred thousand dollars;

(iv) Replacement cost of the vehicle, including special equipment and modifications, if applicable;

(v) DVR is listed as the lien holder; and

(vi) All drivers who use the vehicle are listed on the policy.

(d) You have signed a written agreement with your DVR counselor that outlines how you will pay for vehicle maintenance and repair, as this is a requirement for subsequent ownership of the vehicle;

(e) You have signed an agreement to return the vehicle to DVR upon request as long as DVR owns the vehicle.

(5) Before DVR transfers ownership of a vehicle to you, you must submit documentation to verify:

(a) You are the registered owner of the vehicle;

(b) The vehicle is insured to cover the cost of replacement for loss or damage at the time ownership is transferred.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0770, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0775 What happens if DVR has a question about my driving safety?** (1) DVR does not provide services to facilitate your driving or that of a driver using your vehicle if:

(a) Either you or the driver are uninsured; or

[Title 388 WAC—p. 1209]

(b) DVR is aware of any fact which raises a question regarding driving safety.

(2) Services to facilitate your driving include, but are not limited to, vehicle modifications provided as a rehabilitation technology service, car repairs, gasoline money, driver license, and license tabs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0775, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0780 What other services does DVR provide?** DVR can provide other services not identified in this chapter when the service is needed for you to achieve an employment outcome.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0780, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0790 What are post-employment services?** Post employment services include one or more vocational rehabilitation services provided if:

(1) Your case was closed within the past three years because you achieved an employment outcome;

(2) Your rehabilitation needs are limited in scope and duration;

(3) You need post-employment services to maintain, regain or advance in employment that is consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0790, filed 12/20/02, effective 2/3/03.]

## SUPPORTED EMPLOYMENT

**WAC 388-891-0800 What is supported employment?**

(1) Supported employment is:

(a) Competitive work; or

(b) Work in an integrated setting while you work toward competitive work consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; or

(c) Transitional employment for an individual with a most severe disability due to chronic mental illness.

(2) Supported employment is for an individual with a most severe disability who:

(a) Has not traditionally worked in competitive employment; or

(b) Has worked in competitive employment, but the disability has caused the individual to stop working, or work off and on; and

(c) Needs intensive supported employment services and extended services to work because of the nature and severity of the disability.

[Title 388 WAC—p. 1210]

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0800, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0810 Who is eligible for supported employment?** You are eligible for supported employment services if:

(1) You are eligible for vocational rehabilitation services under WAC 388-891-1000;

(2) You have been determined to be an individual with a most severe disability; and

(3) Supported employment is appropriate for you based on a comprehensive assessment of your needs, including an evaluation of your rehabilitation, career and job needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0810, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0815 Who decides if I am eligible for supported employment?** DVR decides if you are eligible for supported employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0815, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0820 What is competitive work in supported employment?** Competitive work, as used in supported employment, is:

(1) Work in the competitive labor market that you perform on a full-time or part-time basis in an integrated setting; and

(2) Work for which you are paid at or above the minimum wage, but not less than the usual wage your employer pays to nondisabled employees who do the same or similar work as you.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0820, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0825 What is an integrated setting in supported employment?** An integrated setting in supported employment is a work setting commonly found in the community in which you interact with nondisabled people to the same extent that a nondisabled person in the same type of job interacts with other persons.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0825, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0830 Is my work setting integrated if my interactions at the work site are with nondisabled supported employment service providers?** Interactions at your

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work site between you and a nondisabled supported employment service provider do not meet the requirement for an integrated setting.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0830, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0835 What is transitional employment?** Transitional employment is a supported employment work model using a series of consecutive jobs in competitive employment for individuals with the most severe disabilities due to mental illness. In transitional employment, ongoing support services must include continuing sequential job placement until job permanency is achieved.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0835, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0840 What are supported employment services?** Supported employment services are:

- (1) Ongoing support services as described in WAC 388-891-0845; and
- (2) Vocational rehabilitation services listed in WAC 388-891-0600.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0840, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0845 What are ongoing support services?** Ongoing support is a type of supported employment service to help you get and keep a job. Ongoing support services include:

(1) An assessment of your employment situation at least twice a month, or under special circumstances and especially at your request, an assessment regarding your employment situation that takes place away from your worksite at least twice a month to:

- (a) Determine what is needed to maintain job stability; and
- (b) Coordinate services or provide specific intensive services that are needed at or away from your worksite to help you maintain job stability.

(2) Intensive job skill training for you at your job site by skilled job trainers;

(3) Job development, job placement and job retention services;

(4) Social skills training;

(5) Regular observation or supervision;

(6) Follow-up services such as regular contact with your employer, you, your representatives, and other appropriate individuals to help strengthen and stabilize the job placement;

(7) Facilitation of natural supports at the worksite;

(8) Other services similar to services described in subsection (1) through (7) above; and

(9) Any other vocational rehabilitation service.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0845, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0850 What are extended services?** Extended services help you keep your job after DVR stops providing or paying for supported employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0850, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0855 Does DVR provide extended services?** DVR does not provide extended services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0855, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0860 Who provides the extended services I need?** Extended services are provided by nonprofit private organizations such as community rehabilitation programs, state and local public agencies, employers, or any other appropriate resources.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0860, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0865 What is natural support?** Natural support is a method used to help you keep your job after DVR stops providing supported employment services. Natural support uses the people who you ordinarily come into contact with at work and/or at home to help you with work routines and social interactions at the worksite.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0865, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0870 Are supported employment services time-limited?** DVR provides supported employment services as part of your individualized plan for employment for a period not to exceed eighteen months, unless under special circumstances you and your DVR counselor jointly agree to extend the time in order to achieve the employment goals in your individualized plan for employment.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0870, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0875** What is required for me to change from supported employment services to extended services? Prior to helping you change from supported employment services to extended services, a DVR counselor must ensure the following:

(1) You have made substantial progress toward meeting the number of work hours per week you want to work as documented on your individualized plan for employment;

(2) You are stabilized in the job; and

(3) Extended services are readily available and can be provided to you without an interruption in services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0875, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0880** What happens if my DVR counselor and I do not find a source for extended services and/or we cannot establish natural supports during the initial eighteen months of my individualized plan for employment? If you and your DVR counselor do not find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for employment, DVR must determine that you are no longer eligible for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0880, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0885** Under what conditions does DVR close my case service record for supported employment? If you have achieved a supported employment outcome, DVR must wait at least ninety days after helping you change from supported employment services to extended services before closing your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0885, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0890** Under what conditions does DVR provide supported employment services as post-employment services? DVR provides supported employment services to you as post-employment services following the change from supported employment services to extended services if:

(1) Your extended service provider cannot provide the services; and

(2) You need such services as job station redesign, repair and maintenance of assistive technology devices and replacement of prosthetic and orthotic devices to keep your job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0890, filed 12/20/02, effective 2/3/03.]

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## APPLYING FOR VR SERVICES

**WAC 388-891-0900** Who can apply for vocational rehabilitation services? Any individual who intends to achieve an employment outcome may apply for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0900, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0910** Am I required to provide proof of my identity and work status? Before DVR pays for VR services, including assessment services, you must provide copies of documents requested by DVR that verify your identity and, if you are not a United States citizen, your legal work status.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0910, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0920** If I don't live in Washington, can I receive VR services? The state in which you live has the primary responsibility to provide VR services to you. If you are not a resident of Washington state, you may receive VR services if you maintain a home, are registered to vote, or are otherwise present in the state.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0920, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0930** Can I receive VR services if I am legally blind? The Washington state department of services for the blind, under an agreement with DVR, is the primary agency responsible for providing vocational rehabilitation services to individuals who are blind or have a visual impairment resulting in an impediment to employment. DSB and DVR may coordinate to provide joint services if you would benefit from such coordination.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0930, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0940** Can I receive VR services if I am Native American? DVR serves eligible Native Americans, including Native Americans who belong to an Indian tribe. If you live on an Indian reservation that operates a vocational rehabilitation program, you may apply for VR services from the tribe or from DVR, or from both agencies.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0940, filed 12/20/02, effective 2/3/03.]

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**WAC 388-891-0950 How do I contact DVR if I don't speak English?** If you don't speak English, you may request another type of communication to enable you to meet with DVR. DVR arranges and pays for services you need to communicate with DVR to apply for or receive VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0950, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0960 What other methods of communication does DVR use?** DVR uses equipment, devices or other services you need to understand and respond to information. Methods DVR can use to communicate with you include, but are not limited to, the use of:

- (1) Interpreters;
- (2) Readers;
- (3) Captioned videos;
- (4) Telecommunications devices and services;
- (5) Taped text;
- (6) Braille and large print materials; and
- (7) Electronic formats.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0960, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0970 Does DVR translate written communication for people who don't speak English?** (1) DVR translates the following written communication into the primary language of an applicant or eligible individual:

- (a) Application for VR services;
- (b) Notification of eligibility or ineligibility;
- (c) Plan for employment;
- (d) Notification of case closure;
- (e) Notification of annual review, if appropriate; and
- (f) Any notice requiring a response or a signature from the individual to continue receiving services.

(2) DVR translates the Washington Administrative Code (WAC) regarding VR services or service providers into the primary language of an applicant or eligible individual upon his or her request.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0970, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-0980 How do I apply for VR services?** You have completed the application requirements when you:

(1) Have provided information needed to begin an assessment of eligibility and VR needs.

(2) Are available to participate in assessment services necessary to determine if you are eligible for VR services.

(3) Have signed an application form provided by DVR or provided a written request that includes the following information:

- (a) Your name, address and county;
- (b) The nature of your disability;

- (c) Your birth date and gender;
- (d) The date of application; and
- (e) Your Social Security Number (optional).

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0980, filed 12/20/02, effective 2/3/03.]

## ELIGIBILITY

**WAC 388-891-1000 Who is eligible to receive VR services?** You are eligible for VR services if a DVR counselor determines that you meet all of the following criteria:

- (1) You have a physical, mental, or sensory impairment that results in a substantial impediment to employment;
- (2) You require VR services to prepare for, get or keep a job that matches your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice; and
- (3) You are capable of working as a result of receiving VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1000, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1005 How does DVR determine if I am eligible?** (1) A DVR counselor reviews and assesses information and records about the current status of your disability and determines whether you meet the eligibility requirements outlined in WAC 388-891-1000. A DVR counselor bases the determination on observations, education records, medical records, information provided by you or your family, and information provided by other agencies or professionals.

(a) If information or records are not current, not available, or not sufficient for a DVR Counselor to determine if you are eligible, DVR provides the assessment services necessary to get the information needed to make a decision.

(b) VR services used to collect additional information and records to determine eligibility can include trial work, assistive technology, personal assistant services, or any other support services necessary to determine if you are eligible.

(c) DVR assists you to make informed choices in the decisions related to assessment services needed to make an eligibility determination.

(d) If you refuse to provide or consent to the release of records or if you refuse to participate in VR services necessary to obtain information required to make an eligibility determination your VR case service record is closed.

(2) If you receive Social Security benefits under Title II or Title XVI of the Social Security Act and you are capable of working after receiving VR services, DVR determines you are eligible upon verification of benefits.

(a) If you cannot provide appropriate evidence, such as an award letter or other type of verification, DVR may request the verification for you, with your consent.

(b) DVR makes maximum efforts to obtain the verification in a reasonable period of time and to determine eligibility



within sixty days from the date you complete the application requirements.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1005, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1010 After I submit my application to DVR, how long does it take DVR to make an eligibility decision?** (1) DVR makes an eligibility decision as soon as enough information is available, but no longer than sixty days after you complete the application requirements.

(2) If DVR does not have enough information to determine your eligibility within sixty days, you and a DVR counselor must agree to:

(a) Extend the eligibility period to collect additional information or records; or

(b) Conduct a trial work experience or extended evaluation, if a DVR counselor is not certain whether VR services will enable you to achieve an employment outcome because of the severity of your disability

(3) If you do not agree to extend the eligibility period, DVR must close your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1010, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1015 What if a DVR counselor cannot presume that I am capable of working as a result of receiving VR services because of the severity of my disability?** If a DVR counselor cannot presume VR services will enable you to achieve an employment outcome because of the severity of your disability, DVR will assess your ability to perform work using a trial work experience or an extended evaluation. The DVR counselor will evaluate the results of the trial work experience or extended evaluation to determine whether you can work as a result of receiving VR services and whether you are eligible for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1015, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1020 Am I eligible for VR services if I receive Social Security disability benefits?** If you receive disability benefits under Title II or XVI of the Social Security Act (SSI or SSDI), DVR presumes that you are an eligible individual.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1020, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1025 What criteria are not considered in the eligibility decision?** In making an eligibility decision, DVR does not consider your:

- (1) Type of disability;
- (2) Age, gender, race, color, creed, religion, national origin, or sexual orientation;
- (3) Rehabilitation needs;
- (4) Type of employment outcome you expect to achieve;
- (5) Source of referral;
- (6) Anticipated cost of services;
- (7) Income.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1025, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1030 What is involved in a trial work experience?** (1) During a trial work experience, you perform in a realistic work situation with appropriate VR services and/or supports to address your rehabilitation needs, such as supported employment, on-the-job training, assistive technology or personal assistant services. A DVR counselor develops a written plan describing the VR services to be used in the trial work experience.

(2) You participate in one or more trial work experiences over a period of time necessary to produce clear and convincing evidence for a DVR counselor to determine:

(a) You can benefit from VR services and achieve an employment outcome and are eligible for VR services; or

(b) You cannot benefit from VR services and achieve an employment outcome because of the severity of your disability and you are ineligible for VR services.

(3) Trial work experiences occur in the most integrated setting possible, based on your informed choice and rehabilitation needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1030, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1035 What if I cannot participate in a trial work experience?** If you cannot participate in a trial work experience or if DVR has exhausted efforts to arrange a trial work experience, DVR conducts an extended evaluation to obtain the information necessary to determine whether you are eligible for VR services or to enable you to participate in a trial work experience.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1035, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1040 What is an extended evaluation?** An extended evaluation involves one or more VR services designed to assess whether you are capable of working as a result of receiving VR services. A DVR counselor develops a written plan outlining the VR services to be used during the extended evaluation. Only those services necessary to make an eligibility determination are provided. VR services are provided in the most integrated setting possible, based on your informed choice and rehabilitation needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1040, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1045 What happens if DVR determines that I am not eligible or no longer eligible for VR services?** (1) Before determining that you are not eligible for VR services or that you are no longer eligible for VR services, a DVR counselor consults with you and gives you an opportunity to discuss the decision.

(2) DVR sends you a notice in writing, or using another method of communication, if needed. The notice includes:

(a) An explanation of the reason(s) you are not eligible or no longer eligible;

(b) Your rights to appeal the decision; and

(c) An explanation of the services available from the client assistance program.

(3) If you are ineligible based on a determination that you cannot achieve employment because of the severity of your disability, DVR reviews the decision within twelve months.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1045, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1050 If I am not eligible for VR services, can DVR help me find other services and programs to meet my needs?** If DVR determines that you are not eligible for VR services, DVR provides you with information and refers you to other agencies or organizations that may provide services to meet your employment-related needs. This may include a referral to community rehabilitation programs offering extended employment (sheltered work) if you are determined ineligible based on a determination that you are too severely disabled to achieve employment as a result of receiving VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1050, filed 12/20/02, effective 2/3/03.]

## IPE DEVELOPMENT

**WAC 388-891-1100 What is an assessment for determining vocational rehabilitation needs?** Each person determined eligible for VR services completes an assessment of VR needs that may include:

(1) An assessment for determining vocational rehabilitation needs includes a variety of services, including counseling and guidance, to determine your unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

(2) The purpose of the comprehensive assessment is to collect and review information you need to select the type of employment outcome to achieve and the VR services you need to achieve the employment outcome.

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(3) The comprehensive assessment is limited to services necessary to select an employment outcome and to develop a plan for employment.

(4) DVR uses existing information gathered to determine eligibility, including information provided by you and your family, to the maximum extent possible and appropriate.

(5) The comprehensive assessment may include, as needed:

(a) An assessment of the personality, interests, interpersonal skills, intelligence and related functional abilities, educational abilities, work experience, vocational aptitudes, personal and social adjustments, employment opportunities, and other vocational, educational, cultural, social, recreational, and environmental factors that affect your employment and rehabilitation needs.

(b) Work in real job situations to evaluate and/or develop work behavior and capacities necessary to achieve an employment outcome, including work skills, attitudes, habits, tolerances and social behavior.

(c) Referral for assistive technology services to assess whether services or devices could increase your ability to perform work.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1100, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1105 Do I have to disclose criminal history information to DVR?** (1) You must disclose information to DVR before you develop a plan for employment about conditions or circumstances, such as a criminal record, identity and work status, that restrict the type of employment you can legally perform.

(2) If you select an employment outcome in a field that customarily requires a background check as a condition of employment, DVR must obtain a criminal history background check that verifies you are not excluded from employment in the field and/or specific job prior to IPE development.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1105, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1110 What other assessments might be required?** (1) If you have a documented history of violent or predatory behavior that reasonably leads a DVR counselor to believe you may be a threat to yourself or others, you must participate in VR services necessary to determine the level of risk.

(2) If a VR counselor determines, based on an assessment conducted by a qualified professional, that your employment may pose a threat to the safety of you or others because you meet the conditions outlined in WAC 388-891-0110, the employment outcome and employment setting you choose must be evaluated for risk by an appropriate qualified professional.

(3) If a VR counselor becomes aware of a condition or circumstance after you have developed an IPE that may affect

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your ability to achieve an employment outcome, the VR counselor may conduct necessary assessment services to determine whether you are capable of achieving the employment outcome identified on your IPE.

(4) If you decline to authorize the release of information to DVR or participate in VR services necessary to collect pertinent information which prevents the development of an appropriate IPE, the VR counselor may close your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1110, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1115 What is an individualized plan for employment (IPE)?** An individualized plan for employment (IPE) is a DVR form that documents important decisions you and a VR counselor make about vocational rehabilitation services. The decisions documented on the IPE include, but are not limited to:

- (1) The employment outcome you plan to achieve;
- (2) Each major step you need to accomplish to reach the employment outcome;
- (3) Your responsibilities in accomplishing each step of the plan;
- (4) DVR's responsibilities in assisting you to accomplish each step of the plan;
- (5) VR services needed to complete each step;
- (6) Terms and conditions you and your VR counselor agree are required for continued support from DVR.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1115, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1120 Who develops an IPE?** Each eligible individual develops an IPE, unless DVR is operating under an order of selection. If DVR is operating under an order of selection, each eligible individual in the priority category being served develops an IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1120, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1125 What information does DVR provide to help me develop my IPE?** DVR provides the following information to help you develop an IPE:

- (1) Information about the options available for developing an IPE.
- (2) Information that must be included in the IPE.
- (3) Financial conditions or restrictions that apply to an IPE.
- (4) How to get help completing forms required by DVR.
- (5) Information about your rights if you disagree with a decision a DVR counselor makes relating to the IPE.
- (6) Information about the client assistance program (CAP) and how to contact the program.

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(7) Other information you request.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1125, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1130 What are the options for developing an IPE?** (1) You may develop an individualized plan for employment (IPE) with support and assistance from:

- (a) A VR counselor employed by DVR.
  - (b) A VR counselor not employed by DVR, but who meets the minimum qualifications for a VR counselor established by DVR.
  - (c) Another person you choose, such as a representative, family member, advocate, or other individual.
- (2) If you choose to develop the IPE with someone other than a DVR counselor, DVR can help you identify individuals that may help you develop your IPE, to the extent resources are available.
- (3) You may develop an IPE on your own.
- (4) DVR does not pay for any related costs or fees charged by other parties to develop an IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1130, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1135 Does DVR support any job I choose?** (1) The employment outcome you choose must be consistent with the information and results of the assessment of your VR needs.

(2) DVR supports an individual to achieve an employment outcome as defined in WAC 388-891-0010. If you choose another type of employment, DVR refers you to other programs or organizations that offer the type of employment you choose, when available.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1135, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1140 What must be included on the IPE form?** An IPE must include:

- (1) An employment outcome that is consistent with the definition of employment outcome in WAC 388-891-0010;
- (2) The VR services you need to achieve the employment outcome;
- (3) Timeline for each service on your IPE and for achieving the employment outcome;
- (4) The name of the person or organization selected to provide each service included on the IPE and how you will obtain the services;
- (5) Criteria you will use to evaluate whether you are making progress toward achieving the employment outcome;
- (6) Terms and conditions, including:
  - (a) A description of what DVR has agreed to do to support your IPE; and

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(b) A description of what you have agreed to do to reach your employment outcome, including:

- (i) Steps you will take to achieve your employment goal;
- (ii) Services you agree to help pay for, and how much you agree to pay; and
- (iii) Services you agree to apply for and use that are available to you at no cost from another program.

(7) Expected need for post-employment services prior to closing the case service record and, if appropriate, a statement of how post employment services are arranged using comparable services and benefits;

(8) An IPE that includes a supported employment outcome must also document:

- (a) Supported employment services to be provided;
- (b) Extended services or natural supports that are likely to be needed;
- (c) Who will provide and pay for natural supports or extended services. If it is not known who will provide and/or pay for extended services or natural supports at the time the IPE is developed, the IPE must include a statement explaining the basis for determining that a resource is likely to become available;

(d) A goal for the number of hours per week you are going to work and a plan to monitor your progress toward meeting the goal;

(e) A description of how the services on your IPE are coordinated with other federal or state services you get under an individualized plan;

(f) If job skills training is provided, the IPE must reflect that the training is provided on-site;

(g) Placement in an integrated setting for the maximum number of hours possible based on your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

(9) An IPE for a high school student who is receiving special education services is coordinated with the individualized education plan in terms of the goals, objectives, and services identified to the extent possible.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1140, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1145 When does the IPE become effective?** The IPE becomes effective when it is signed by you and a DVR counselor. DVR gives you a copy of the signed IPE, in writing or in another method of communication, if needed.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1145, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1150 Is the IPE reviewed and updated?** You and a qualified VR counselor review the IPE at least once a year, or more often if needed, to assess your progress in achieving an employment outcome. You and a VR counselor amend the IPE if there are major changes in the employment goal, VR services, or service provider(s).

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Changes to an IPE take effect when you and a DVR counselor sign the amended IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1150, filed 12/20/02, effective 2/3/03.]

## LOANING EQUIPMENT

**WAC 388-891-1200 Under what conditions does DVR loan equipment, devices or other items to me?** If you need a device, tool, piece of equipment or other item to participate in VR services or to go to work, DVR loans a new or used item to you until you achieve an employment outcome. DVR loans a used item from the DVR inventory if available at the time needed and DVR determines it is adequate to meet your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1200, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1210 What if I need an item customized for my own personal needs?** A DVR counselor determines whether to loan or issue a device, tool, piece of equipment or other item based on the reasonable likelihood that the item could be used by another individual if returned to DVR. If the DVR counselor determines an item could not be used by another individual if it were returned to DVR, the DVR counselor may issue the item directly to you without a loan agreement and the item is owned by you at the time of issue.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1210, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1220 What conditions apply to the use of a device, tool, piece of equipment or other item that is loaned to me?** Before DVR loans an item to you, you must sign an agreement with DVR to comply with the following conditions:

- (1) You agree to immediately return the item upon request or to pay for the item if you cannot return it to DVR;
- (2) You agree to maintain the item according to DVR instructions and manufacturer's guidelines, if applicable, and keep it secure from damage, loss or theft.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1220, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1230 What happens if I fail to return a device, tool, piece of equipment or other item if requested by DVR?** If DVR directs you to return an item loaned to you and you do not immediately return it, DVR reports the loss to the DSHS office of financial recovery (OFR). The OFR attempts to recover the item or payment for

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the item from you. If the OFR cannot recover the item or payment for the item from you, the OFR may report the loss to the local county prosecutor for legal action.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1230, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1240 What happens to a device, tool, piece of equipment or other item if I need it when my DVR case service record is closed?** DVR may transfer ownership of the device, tool, piece of equipment or other item to you at the time a DVR counselor closes your case service record if you have achieved an employment outcome and you need the item to keep your job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1240, filed 12/20/02, effective 2/3/03.]

## CASE CLOSURE

**WAC 388-891-1300 Why does DVR close a case service record?** A DVR counselor closes your case service record for any of the following reasons:

- (1) You achieve an employment outcome;
- (2) DVR determines that you are not eligible or no longer eligible;
- (3) You are no longer available to participate in services;
- (4) You decline VR services;
- (5) You cannot be located;
- (6) You ask DVR to close your case service record; or
- (7) You refuse to cooperate in required or agreed upon services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1300, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1310 How does DVR determine that I have achieved an employment outcome?** DVR determines that you have achieved an employment outcome and no longer need VR services if:

- (1) You received services under an IPE that helped you achieve the employment outcome on your employment plan;
- (2) Your job matches your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice;
- (3) You have been working at the same job for at least ninety days to ensure the stability of your employment; and
- (4) You and a DVR counselor agree the job is satisfactory, that you are performing the job well, and that you no longer need VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1310, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1320 Am I involved in the decision to close my case?** Before closing your case, a DVR counselor gives you an opportunity to discuss the decision. DVR notifies you in writing, or another method of communication, if needed, about the reason your case is being closed and your rights if you disagree with the decision.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1320, filed 12/20/02, effective 2/3/03.]

**WAC 388-891-1330 Under what conditions does DVR follow up with me after my case is closed?** (1) DVR contacts you within twelve months after your case service record is closed and annually for two years after that to review whether anything has changed to affect your eligibility if:

- (a) DVR closes your case after determining you are ineligible because you are too severely disabled to achieve an employment outcome as a result of VR services;
- (b) You achieve a supported employment outcome and earn wages under section 14(c) of the Fair Labor Standards Act while working toward competitive employment;
- (c) You choose extended employment; or
- (d) You and your DVR counselor cannot find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for supported employment.

(2) After DVR completes the reviews annually for two years, you or your representative may request additional annual reviews.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1330, filed 12/20/02, effective 2/3/03.]